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FY 2022-23
Medi-Cal Specialty Behavioral Health External Quality Review

SAN DIEGO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 10-12, 2023

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — January 10-12, 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 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	0	4	1

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	5	1	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**23**	**3**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improved Therapeutic Support for Youth Beneficiaries who Identify as LGBTQ+	Clinical	01/22	Implementation	Moderate
Improving the Experience of Teletherapy for Older adults	Non-Clinical	04/22	Planning	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	4
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	11

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP uses a population health, health equity, and healthcare integration approach to build the service network.
- The MHP provides mobile crisis response teams (MCRT) county-wide and continues to explore expansion.
- The peer workforce is highly valued and integral to the MHP services.
- The MHP has a strong partnership with its Administrative Services Organization (ASO), Optum supporting IS and access.
- The MHP continues to expand data sources and data access.

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

- There continue to be long wait times to first appointments and psychiatry evaluations.
- There is need for greater collaboration with contract providers that would potentially improve many key challenges such as workforce recruitment and retention.
- Level of care (LOC) transitions are difficult to access and there are no apparent MHP supports or access systems to manage the process.
- The penetration rate (PR) for Hispanic/Latino beneficiaries continues to decline.

- The MHP has numerous IS-changes and initiatives that are priorities.

Recommendations for improvement based upon this review include:

- Identify barriers and conduct performance improvement to reduce wait times to services.
- Increase collaboration with contract providers.
- Evaluate needs and implement a consistent monitoring and engagement process for LOC transitions.
- Implement ways to increase the Hispanic/Latino PR.
- Develop testing, training, data conversion, integration, support, and risk-management plans to support the outpatient cutover to the Cerner Millennium EHR.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for San Diego County MHP by BHC, conducted as a virtual review on January 10-12, 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, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19). The MHP is operating under the industry wide workforce crisis. The MHP vacancies ranged 25 to 30 percent systemwide in the last year. This entails a 30 percent vacancy rate in direct service staff and 20 percent vacancy rate in administrative positions. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP continued instituting the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including policy changes and documentation expectations to meet requirements. Workgroups such as the CalAIM Planning Workgroup and the CalAIM Policy Committee continue to lead this initiative.
- The MHP completed organizational restructuring which included moving QI under the Population Health unit from Operations and Quality Assurance. The MHP also moved the Harm Reduction and Integrated Health unit under the Population Health unit.
- Initiatives related to workforce development include: completing an in-depth assessment and report of behavioral workforce shortage, continuing to implement the certified peer support program with scholarships provided, and an ongoing partnership with San Diego State University to build a local health and human services workforce.
- The MHP assumed oversight of the Office of the Public Conservator which had been under San Diego Health and Human Service Agency Aging and Independence Services.
- The MHP is transitioning to a new Electronic Health Records (EHR) system and will be implementing Cerner Millennium beginning CY 2023.
- The MHP developed a model, Optimal Care Pathways, that provides an algorithm and expands community-based care services and housing to beneficiaries with behavioral health conditions. This initiative aims to create new pathways to divert beneficiaries from acute services. Planned expansions

include: a crisis stabilization unit (CSU) in the east region, a psychiatric center with 44 inpatient beds, and a CSU at a hospital in the central region, and a 16-bed psychiatric facility in Oceanside.

- The MHP plans to implement a Community Assistance, Recovery, and Empowerment (CARE) Court in October 2023.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Investigate the reasons, develop, and implement strategies, and improve wait lists for direct outpatient children and adult services requests that are not a step down from urgent or emergent delivery systems.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- To improve service capacity, the MHP began redesigning the Adult/Older Adult System of Care Biopsychosocial Rehabilitation centers to incorporate a continuous care model for high-acuity beneficiaries and increase staffing to include care coordinators, substance use staff, and mobile outreach services. The MHP reports collaborating with contractors, peers, and MHP staff, and completing a competitive procurement process.
- The MHP reports continuing to discuss wait times with contract providers through the contract monitor staff.
- The MHP did not investigate reasons within current operations beyond the staffing shortage and develop interventions.
- This recommendation is carried over to FY 2022-23.

Recommendation 2: Investigate reasons, develop, and implement strategies, and improve timeliness to first non-urgent service request; first non-urgent rendered service request; first non-urgent request to first offered psychiatric appointment; and first

non-urgent rendered first offered psychiatric appointment for all, adults, children and foster care youth.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP examined access time data integrity concerns with a sample of providers and implemented activities to improve data collection. Activities towards analyzing and improving timeliness to services were not completed.
- Stakeholders across groups report delays accessing services and significant waitlists to receive appointments or types of services, such as therapy. Barriers outside of reported workforce shortages or potential process improvements were not examined.
- The MHP meets its timeliness standard for most of its appointments and prioritizes hospital and select system referrals. The MHP's range of time to a first offered appointment is same day to 278 days. Similarly, time to a first offered psychiatry appointment ranges same day to 798 days. Review discussions indicate time to a first appointment is up to 7 months, and time to a first psychiatry visit is up to one year in both child and adult services. Further, providers report that once a beneficiary begins services after a wait, there is an additional extended wait period for a first psychiatry evaluation.
- Anecdotally, stakeholders report that some beneficiaries leave the process due to the delays in beginning services.
- This recommendation is carried over to FY 2022-23.

Recommendation 3: Continue efforts to improve bidirectional communication with the community-based organizations (CBO) and standardization of the contract monitoring process.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP conducted two trainings aimed to increase consistency for contract monitoring in the last year. The MHP reports plans to provide more training that emphasizes contract monitoring and cross-departmental collaboration for streamlining processes. The MHP continued to convene monthly contractor executive meetings and produce monthly bulletins.
- While the MHP appears to have strengthened communication in contracting monitoring for system-wide needs, review discussions indicate bidirectional communication with contract providers does not appear to be present. There continues to be substantial opportunities to advance quality-related goals in collaboration with providers. In particular, sustaining workforce and ensuring beneficiary access between LOC are areas that would benefit from greater two-way communication and partnership.

- Communication with contractors lies primarily with MHP Contracting Officer Representatives. Review discussions across all levels show a need to increase partnership and a sense that the MHP does not want to hear issues and solutions from providers.
- This recommendation is carried over to FY 2022-23 with an emphasis on partnership.

Recommendation 4: Investigate reasons, develop strategies, and improve the QI Program Work Plan Evaluation analysis and future recommendations utilizing a (Quality Assurance and Performance Improvement) QAPI process. Analyze the reasons, develop a plan, and write this into workplan to implement.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP incorporated "planned activities" in the QI Program Work Plan. However, this recommendation is not fully address because activities are largely limited to analyzing data without leading to specific interventions and action plans to identify barriers. The MHP did not investigate reasons or develop specific strategies to improve performance. Including these elements would communicate the basis for the QI priorities and support creating alignment among all stakeholders in trying to achieve those goals.
- This recommendation is not carried over to FY 2022-23 because there are higher priority system recommendations.

Recommendation 5: Develop detailed testing, training, data conversion, integration, support and risk-management plans to support the outpatient cutover to the Cerner Millennium EHR. Ensure that all providers (CBO, 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP contracted embedded IT resources for the EHR conversion and implementation. The design/build phase of the outpatient EHR conversion has begun with the vendor, with detailed test scripts being developed as design decisions are made. Detailed conversion plans and a training plan are being finalized.
- The MHP successfully completed a go-live event with the Cerner Millennium EHR for the county hospital and are using the lessons learned to inform the outpatient implementation.
- The MHP engaged contracted providers of outpatient services with a project kickoff meeting in February 2021 and a project update meeting in April 2021; no additional progress has been made in the last year. Due to impacts to staffing

resources, the MHP delayed the project and plans to re-engage contract providers in Spring 2023.

- This recommendation is carried over to FY 2022-23.

ACCESS TO CARE

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

CalEQRO uses 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 six percent of services were delivered by county-operated/staffed clinics and sites, and 94 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 79 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: 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 and crisis line team that is responsible for linking beneficiaries to appropriate, medically necessary decentralized services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 5,544 adult beneficiaries, 6,017 youth beneficiaries, and 538 older adult beneficiaries across 11 county-operated sites and 348 contractor-operated sites. Among those served, 1,582 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

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

Table 1A: MHP Alternative Access Standards, FY 2021-22

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

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No
Contracting status:	☐ The MHP is in the process of establishing contracts with OON providers ☐ The MHP does not have plans to establish contracts with OON providers
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: OON providers are contracted through Optum as the ASO

- While the MHP was not required to allow beneficiaries to access services via OON providers, the MHP does contract with Optum as the ASO which contracts

with OON providers to ensure services are available to beneficiaries to meet time and distance standards.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP continues its approach as a public health entity driven by population health and public health principles to operate as a health plan, where “investments are optimized.” For FY 2022-23, the MHP operated an approximately $900 million budget. This reflects a 10% increase from the prior year’s budget.
- Workforce recruitment and retention within the MHP provider network continues to be significantly impacted by the COVID-19 pandemic. Contract providers have requested reduced capacity within contracts due to difficulty filling positions. This has decreased capacity and beneficiaries’ abilities to access services at various programs. In addition, there are timeliness impacts reported in the last year associated with having programs transition to different agencies. There are delays with programs hiring new staff and implementing programs. Evaluating and adjusting the request for proposal process if indicated during this staffing crisis may support ongoing timeliness and access to care.

- The MHP's cultural competence structure, including the Cultural Competence Resource Team and reports, in conjunction with the MHP's focus on population health data and goals enable the MHP to assess access, design strategies, and reduce cultural barriers to services.
- The MHP completed a media campaign to disseminate information about the MCRT that are now available county-wide. The MHP continues to discuss expansion and integration for MCRTs with schools, colleges, and tribal entities.
    - Fifty-one percent of those who received MCRT in January 2021 to December 2022 were stabilized in the field. Approximately 30 percent of the calls the MCRT responded to were directly from law enforcement agencies.
- As part of the public health approach to building the network, the MHP produced the Consumer Experience Dashboard which reports regional data online. The MHP intends for the information to advance community planning. Some contract providers have little to no analysis capacities and supplying this information aims to increase service planning.
- Review discussions indicate that the MHP's primary strategy is contract design and requirements to address population needs. Evaluation of the effectiveness of strategies to address needs of its beneficiaries is less evident. Measuring the effectiveness of strategies, especially given the MHP's long waits to services and lower PRs compared to similar sized MHPs and state average PRs, is needed.
- While there are reports for caseloads, admissions, and discharges, the current process of transition and discharge through the contracted providers appears to lack proactive monitoring or involvement by the MHP in directing the flow of beneficiaries among LOCs. Discussions across stakeholder groups participating in this review indicate that this is area to prioritize to improve access, timeliness, and beneficiary outcomes.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, the PR has decreased over the last three years, and is now below the large-county average and statewide PR.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
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
CY 2019	841,686	35,495	4.22%	$167,438,552	$4,717

- The MHP eligibles population increased 12 percent from CY 2020 to CY 2021 representing about 100,000 eligibles. From CY 2019 to CY 2020, the number of eligibles increased 2 percent which was an increase of about 15,000 individuals.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	94,380	1,205	1.28%	1.69%	1.96%
Ages 6-17	216,179	9,062	4.19%	5.40%	5.93%
Ages 18-20	48,844	1,697	3.47%	4.06%	4.41%
Ages 21-64	501,911	22,179	4.42%	4.24%	4.56%
Ages 65+	94,908	1,477	1.56%	1.69%	1.95%
Total	956,219	35,620	3.73%	3.99%	4.34%

- The MHP PR is below similar sized county averages in all age groups except ages 21-64, and below statewide averages in all age groups.
- The MHP PR for age 0-5 is 24 percent and 34 percent lower than the large MHP and the statewide averages respectively.
- The MHP PR for age 6-17 is 22 percent and 29 percent lower than the large MHP and statewide average respectively.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	4,672	13.12%
Arabic	765	2.15%
Vietnamese	338	0.95%
Tagalog	83	0.23%
Farsi	78	0.22%
Total Threshold Languages	**5,936**	**16.66%**
Threshold language source: Open Data per BHIN 20-070		

- The count of beneficiaries served in threshold languages was similar to the prior review.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	319,330	11,554	3.62%	$58,347,700	$5,050
Large MHPs	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, the MHP's overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP served a higher percentage of ACA beneficiaries than the large county average and slightly lower percentage than the statewide average.

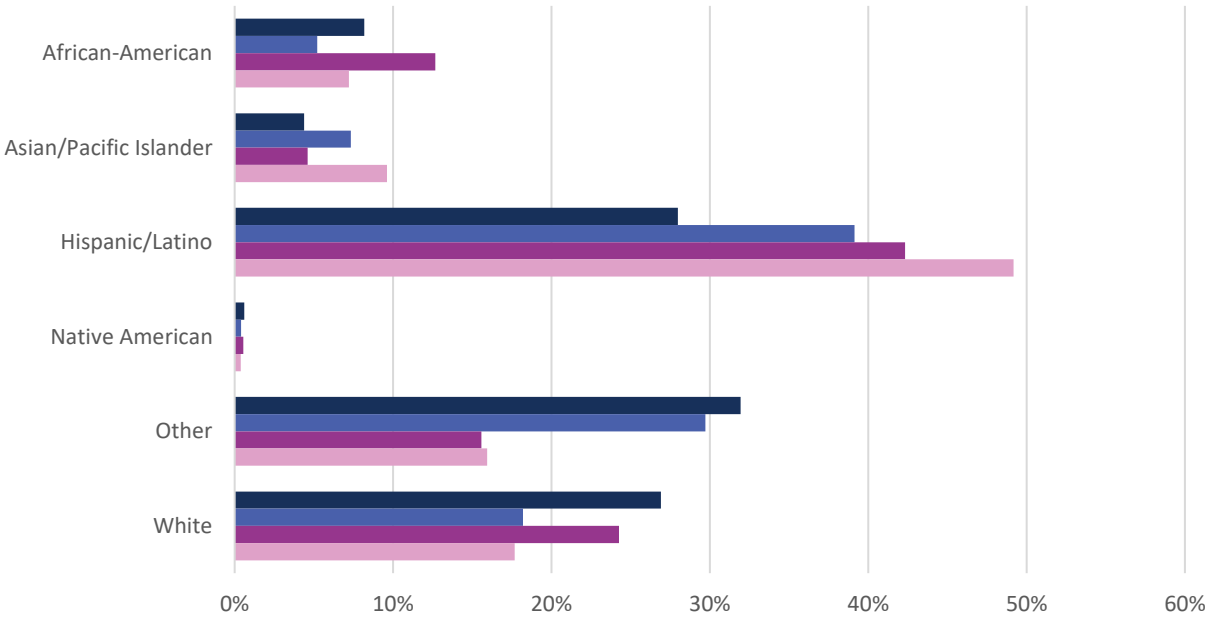
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	49,863	2,913	5.84%	7.64%
Asian/Pacific Islander	70,049	1,565	2.23%	2.08%
Hispanic/Latino	374,280	9,966	2.66%	3.74%
Native American	3,788	213	5.62%	6.33%
Other	284,205	11,377	4.00%	4.25%
White	174,038	9,586	5.51%	5.96%
Total	**956,223**	**35,620**	**3.73%**	**4.34%**

- The MHP PR by race/ethnicity groups is lower than the statewide PR except for the Asian/Pacific Islander group.
- The MHP Hispanic/Latino PR is 19 percent lower than the large MHPs average PR (3.30 percent) and 29 percent lower than the statewide PR (3.74 percent).

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

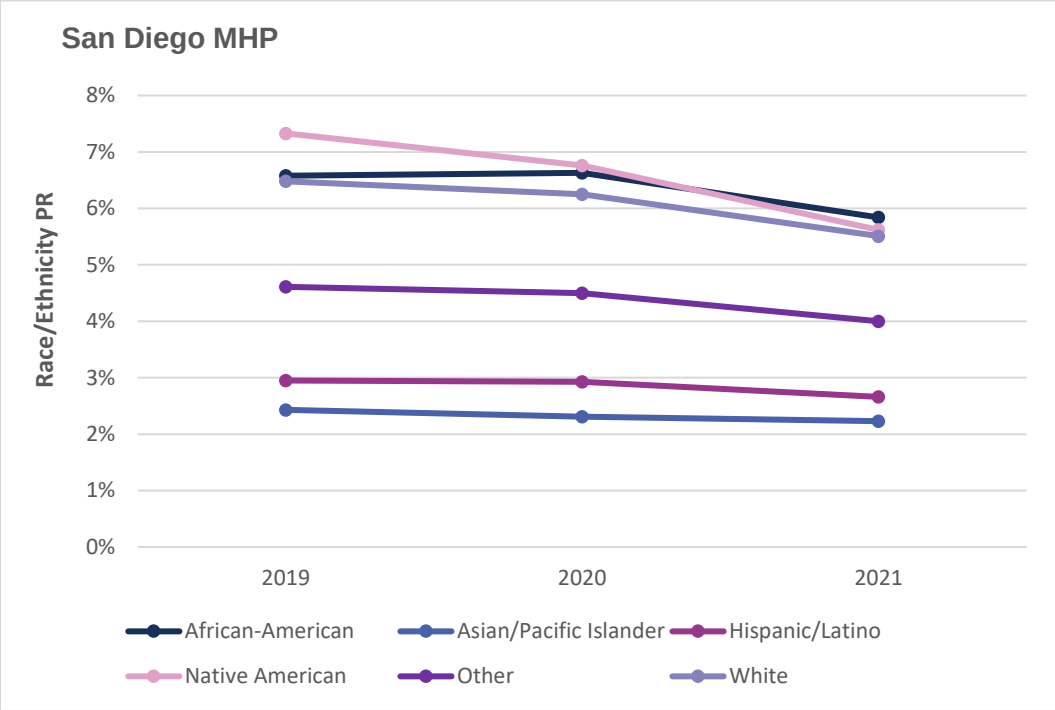


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	27%	32%	1%	28%	4%	8%
MHP % Eligible	18%	30%	0%	39%	7%	5%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The most notable underrepresented gap between beneficiaries eligible and served is seen in the Hispanic/Latino and Asian/Pacific Islander population groups.

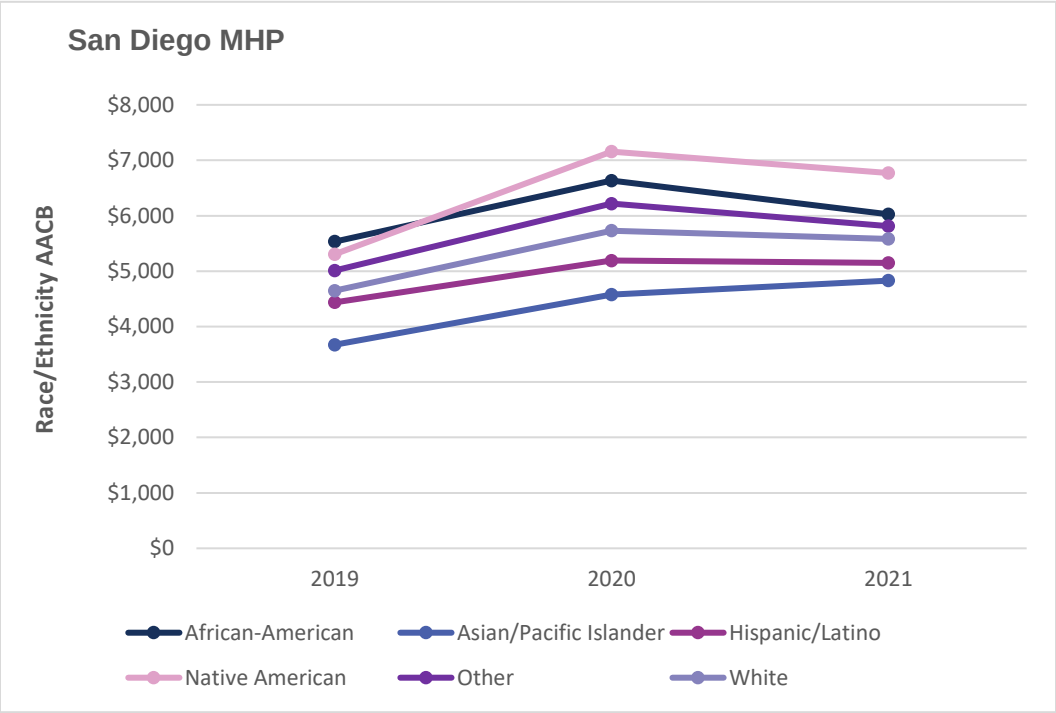
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



- The MHP PRs for all racial/ethnic groups have slightly declined over the last two years. The sharper decline in PR for the Native American group is punctuated by the low number of Native American beneficiaries.

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



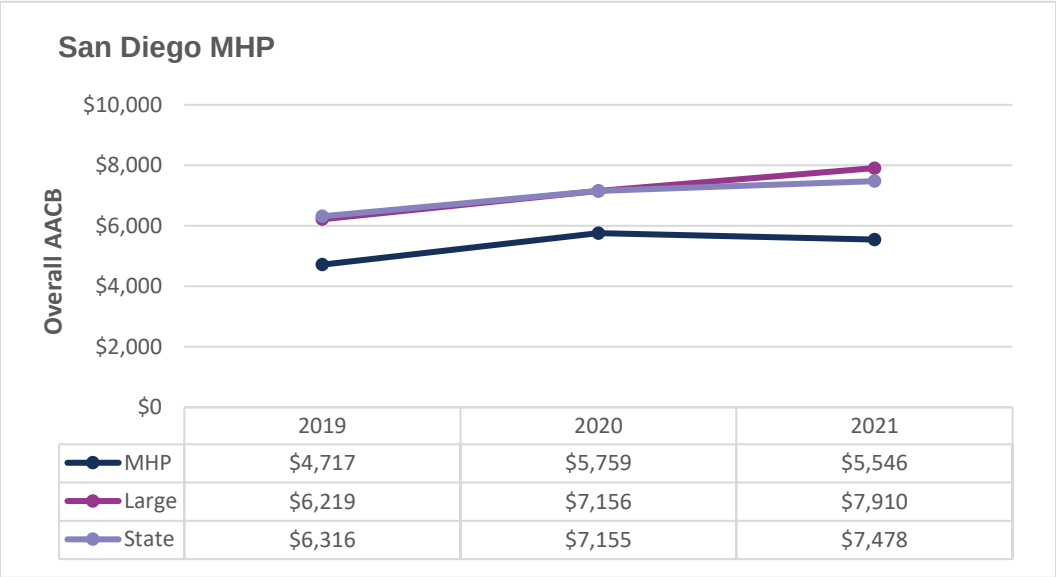
- The AACB increased in CY 2020 for all race/ethnicity groups and remained fairly static in CY 2021.

Figure 4: Overall PR CY 2019-21

	2019	2020	2021
MHP	4.22%	4.15%	3.73%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

- The overall PR has decreased over the last two years and dropped slightly below the large county and statewide PRs in CY 2021.

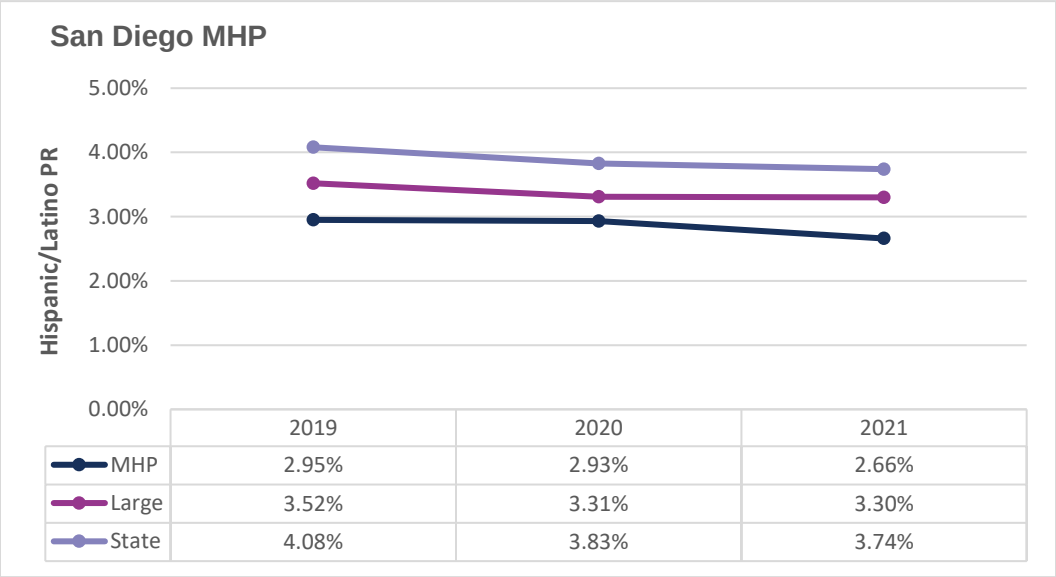
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,717	$5,759	$5,546
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

- The overall AACB is lower than the large county average as well as the statewide average. In CY 2021, the MHP's AACB is 30 percent lower than the large MHP AACB and 26 percent lower than the State AACB.

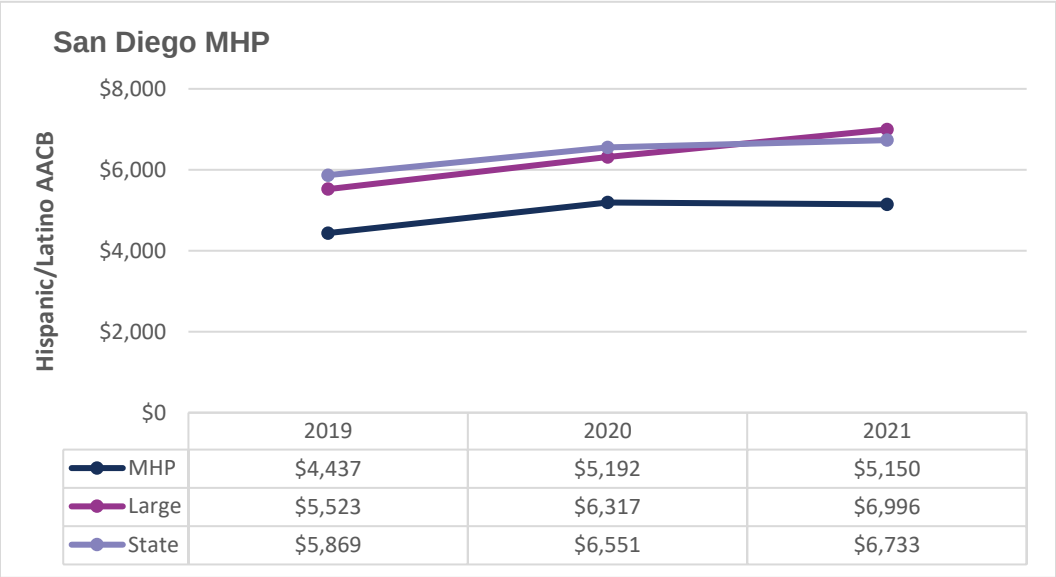
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.95%	2.93%	2.66%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

- The Hispanic/Latino PR decreased only slightly across the state, while the MHP decreased by a larger percentage and remains below the large county average. The MHP's Hispanic/Latino PR is 20 percent lower than the large MHP PR and 29 percent lower than the State PR.

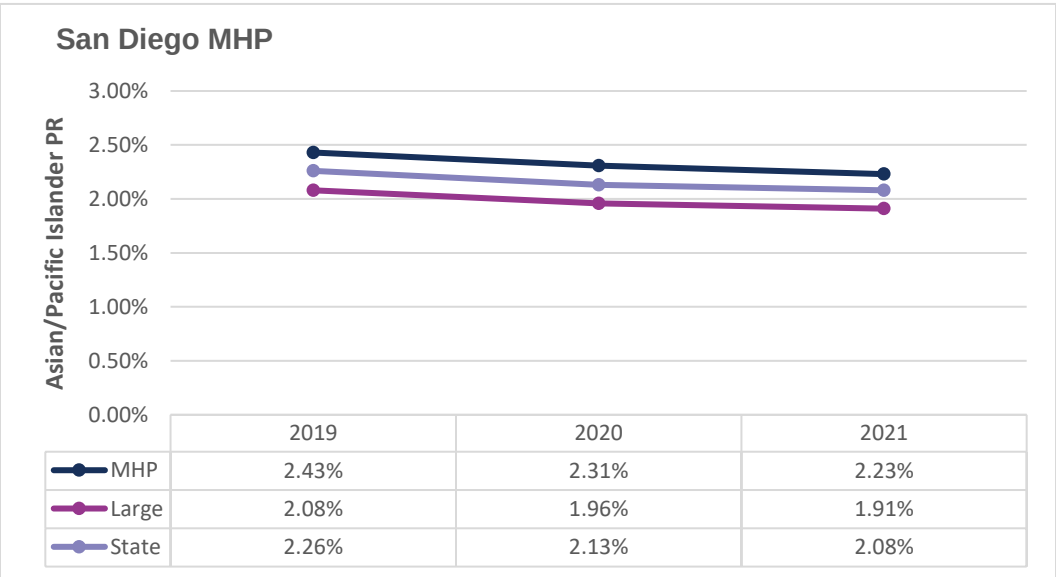
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,437	$5,192	$5,150
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

- The AACB for the Hispanic/Latino population increased across the state in CY 2021, however the MHP AACB had a slight decrease and is now 26 percent lower than the large MHP average and 24 percent lower than the statewide average.

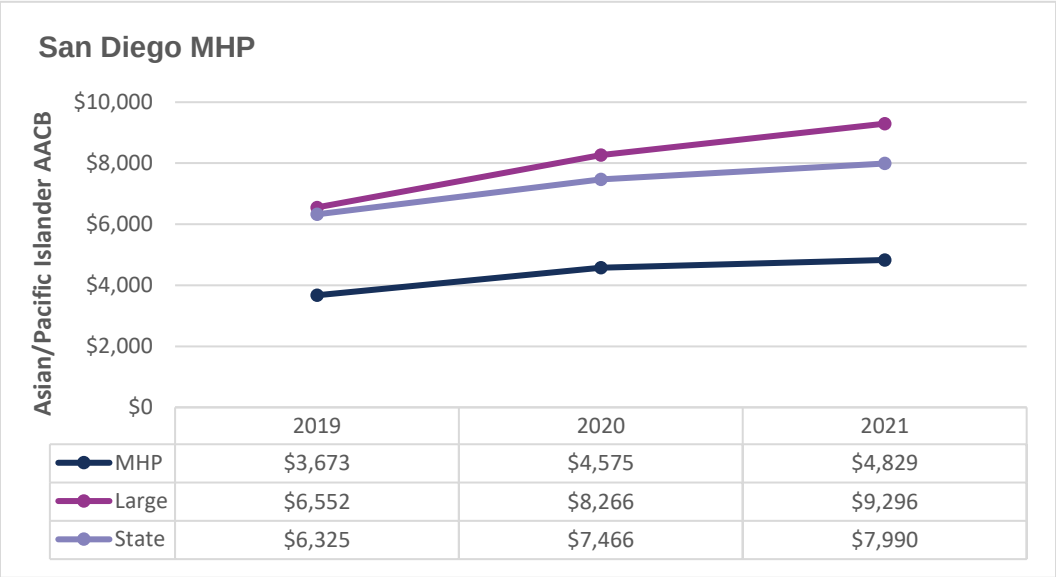
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.43%	2.31%	2.23%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

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

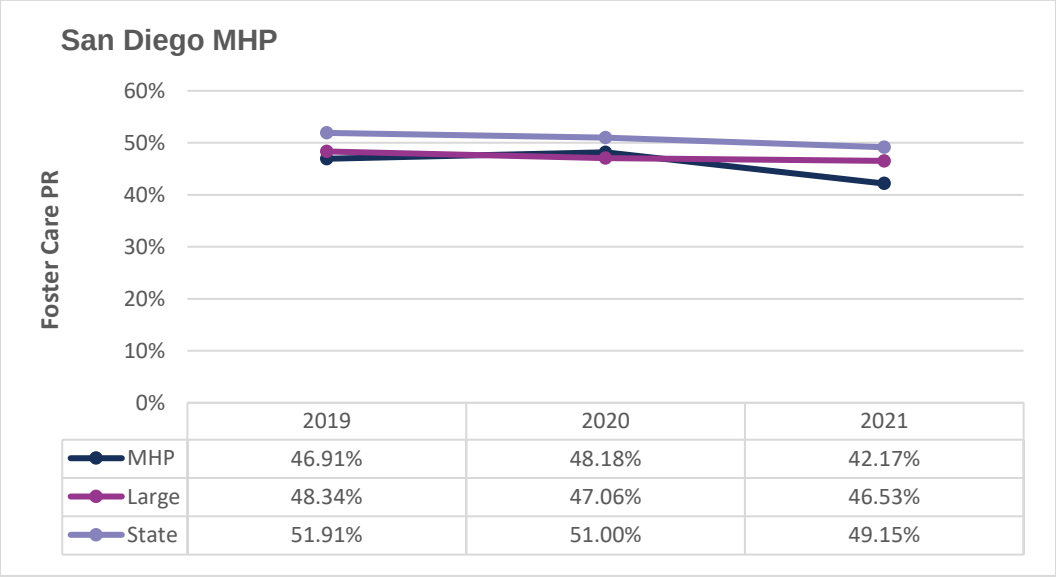
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$3,673	$4,575	$4,829
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

- The Asian/Pacific Islander AACB increased slightly in CY 2021 and remains notably lower than similar sized counties and the statewide average. The MHP Asian/Pacific Islander AACB is 45 percent and 40 percent lower than the large MHP and state AACB respectively.

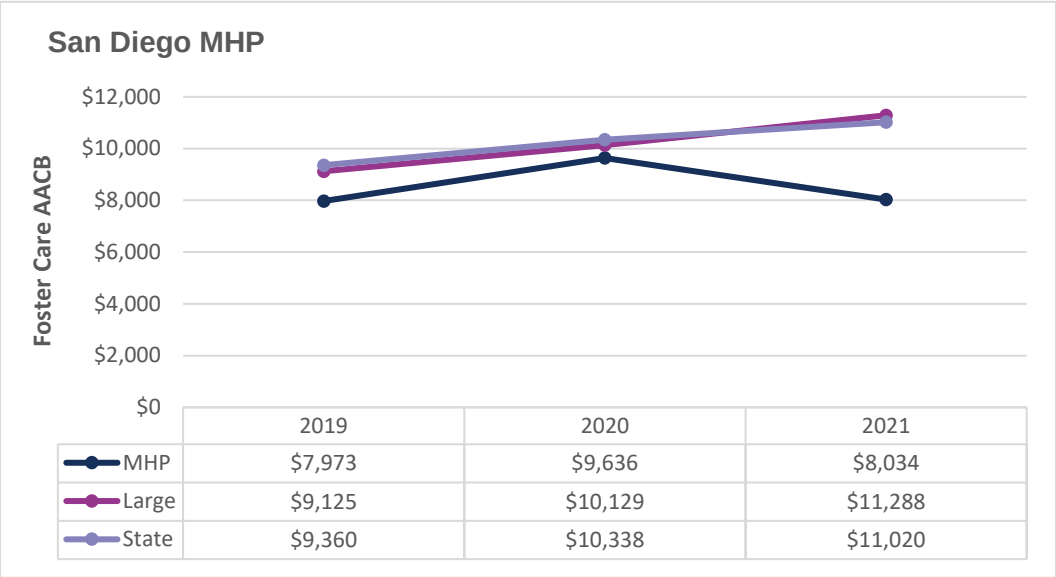
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	46.91%	48.18%	42.17%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

- The foster care PR has decreased slightly across the state over the prior two years, and the MHP previously was consistent with the similar size county average until CY 2021, as it fell below similar size counties and the statewide average. The MHP FC PR declined 14 percent from CY 2020 to CY 2021.

Figure 11: Foster Care AACB CY 2019-21



- The MHP foster care AACB decreased sharply in CY 2021 while the similar sized counties and the statewide average continued to increase. The MHP foster care AACB is 29 percent lower and 27 percent lower than the large MHP and statewide average AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 25,358				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	3,146	12.4%	12	6	11.6%	16	8
Inpatient Admin	<11	-	12	6	0.5%	23	7
Psychiatric Health Facility	14	0.1%	22	14	1.3%	15	7
Residential	35	0.1%	115	81	0.4%	107	79
Crisis Residential	1,370	5.4%	13	10	2.2%	21	14
Per Minute Services							
Crisis Stabilization	3,826	15.1%	1,376	1,200	13.0%	1,546	1,200
Crisis Intervention	1,060	4.2%	121	75	12.8%	248	150
Medication Support	16,724	66.0%	309	180	60.1%	311	204
Mental Health Services	19,452	76.7%	483	228	65.1%	868	353
Targeted Case Management	8,953	35.3%	405	136	36.5%	434	137

- The MHP has a notably higher percentage of adult beneficiaries accessing Crisis Residential (5.4 percent), compared to the statewide average (2.2 percent).
- Crisis intervention was notably lower in billed claims for adults in the MHP (4.2 percent), compared to the statewide average (12.8 percent). Of note, MCRT services provided by the MHP are not billed to Medi-Cal.

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

Service Category	MHP N = 1,181				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	38	3.2%	7	4	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	33	12	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	4	4	0.1%	17	12
Full Day Intensive	<11	-	592	528	0.2%	582	441
Full Day Rehab	129	10.8%	109	108	0.5%	97	78
Per Minute Services							
Crisis Stabilization	66	5.5%	1,096	1,096	3.1%	1,398	1,200
Crisis Intervention	36	3.0%	292	148	7.5%	404	198
Medication Support	395	33.4%	297	232	28.3%	394	271
TBS	66	5.5%	2,489	1,483	4.0%	4,019	2,372
Therapeutic FC	<11	-	45	45	0.1%	1,030	420
Intensive Care Coordination	637	53.9%	918	352	40.0%	1,351	472
Intensive Home Based Services	248	21.0%	810	490	20.3%	2,256	1,271
Katie-A-Like	<11	-	142	90	0.2%	640	148
Mental Health Services	1,104	93.5%	1,249	840	96.3%	1,848	1,103
Targeted Case Management	405	34.3%	175	101	35.0%	342	120

- The MHP is largely consistent with the statewide averages for service delivery to foster youth beneficiaries and in Medication Support. The MHP served 33 percent of foster youth, compared to the statewide average (28 percent). The MHP also provided Full Day Rehab to a significantly higher percentage (10.8 percent) of foster youth than the state average (0.5 percent). This is more than 20 times higher than the state average.

IMPACT OF ACCESS FINDINGS

- The MHP's lower FC PR in addition to the lower AACB compared to similarly sized MHPs and the state average, heighten this beneficiary group as an area to evaluate and monitor closely.
- The workforce challenges and reduced provider capacity are evident in lower PRs and AACBs in various overall trends and within specific groups.
- The MHP's Hispanic/Latino beneficiary group, the largest group in the MHP eligible population, also shows access declines that warrant evaluation and performance improvement,
- Review discussions indicate that access can have long waits and transitions to lower levels of service do not appear to be standardized, making it time consuming and difficult on a case-by-case basis.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Partially 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:

- For time to first appointments including psychiatry, the MHP meets its standards for the majority of the requests; goals are met for 70 percent of the appointments. The MHP works with network providers through the contract monitors to review timeliness and develop improvement plans. As noted earlier in this report, the

MHP prioritizes triage of crisis and hospital discharges reflected in the timeliness measurements. There are significant wait times for beneficiaries accessing services that are not emergent, acute or a step-down in care.

- The MHP reports meeting its standards for only 55 percent of urgent requests overall, and this appears to be an area to improve. However, the numbers of beneficiaries reported are very low for children (14) and foster youth (8), and they are similarly low for adults (219) as well. These are a considerably small number of requests for a large MHP, and thus EQR is not able to validate the reliability of the measurement given the low numbers. The monitoring system is not adequate for urgent requests.
- The MHP standard for follow-up post psychiatric hospitalization is three days rather than the HEDIS seven-day standard. The MHP provided follow-up within 30 days for 35 percent of beneficiary discharges for its entire system.
- As part of the FY 2021-22 Quality Improvement Work Plan (QIWP), the MHP reduced the no-rate in Child, Youth, and Family services by 20 percent (7.4 percent to 5.9 percent) from FY 2020-21 to FY 2021-22.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. For follow-up appointments following psychiatric hospitalization, the MHP sets a standard of within three days of discharge for existing clients, while new clients have a standard of follow-up appointments within seven days.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10.8 Days	10 Business Days*	79.3%
First Non-Urgent Service Rendered	21.5 Days	10 Days**	51.4%
First Non-Urgent Psychiatry Appointment Offered	9.7 Days	15 Business Days*	77.3%
First Non-Urgent Psychiatry Service Rendered	10.3 Days	15 Days**	77.3%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	203.1 Hours	48 Hours*	54.8%
Follow-Up Appointments after Psychiatric Hospitalization	5.8 Days	3 Days**	26.5%
No-Show Rate – Psychiatry	16.9%	20%**	n/a
No-Show Rate – Clinicians	7.2%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

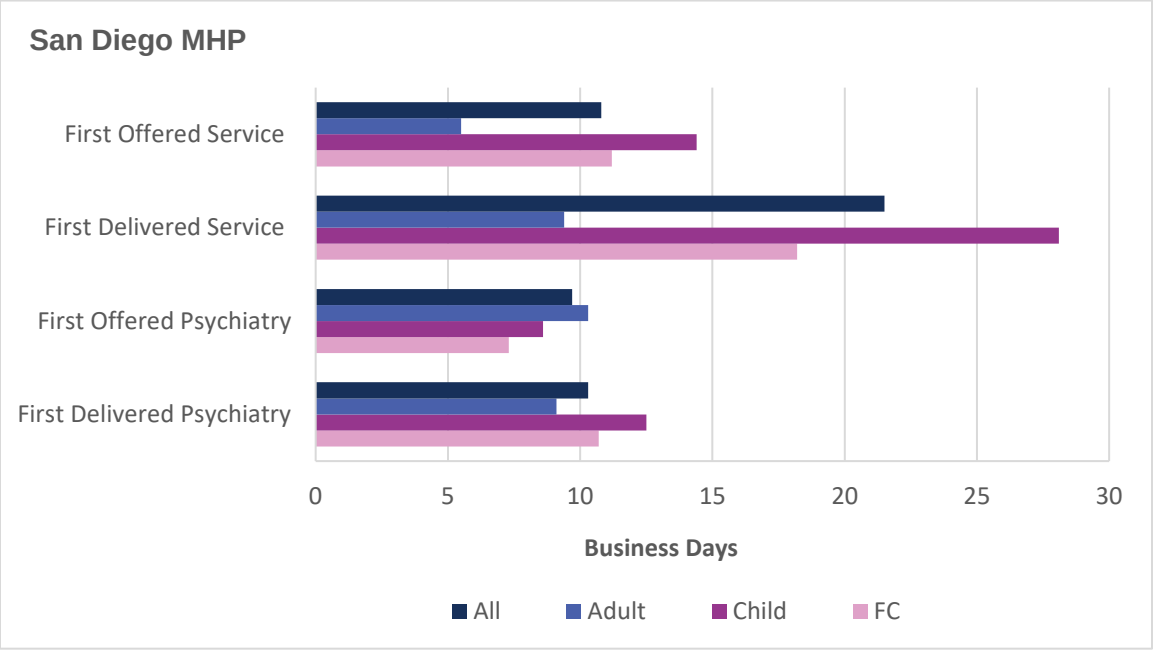


Figure 13: Wait Times for Urgent Services

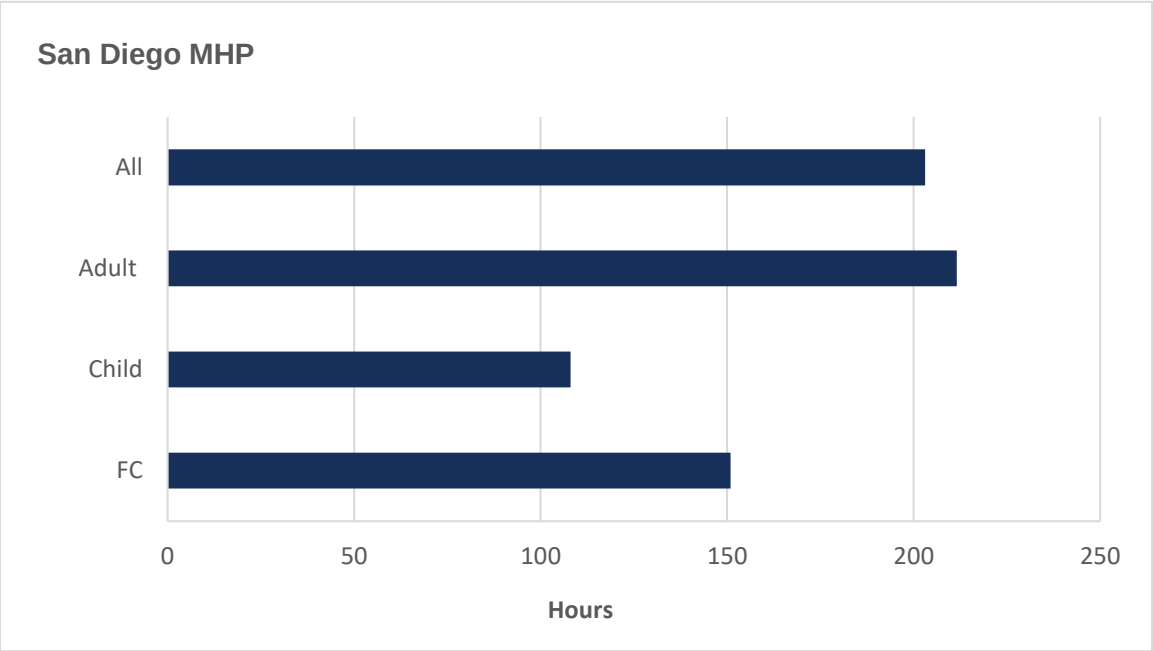
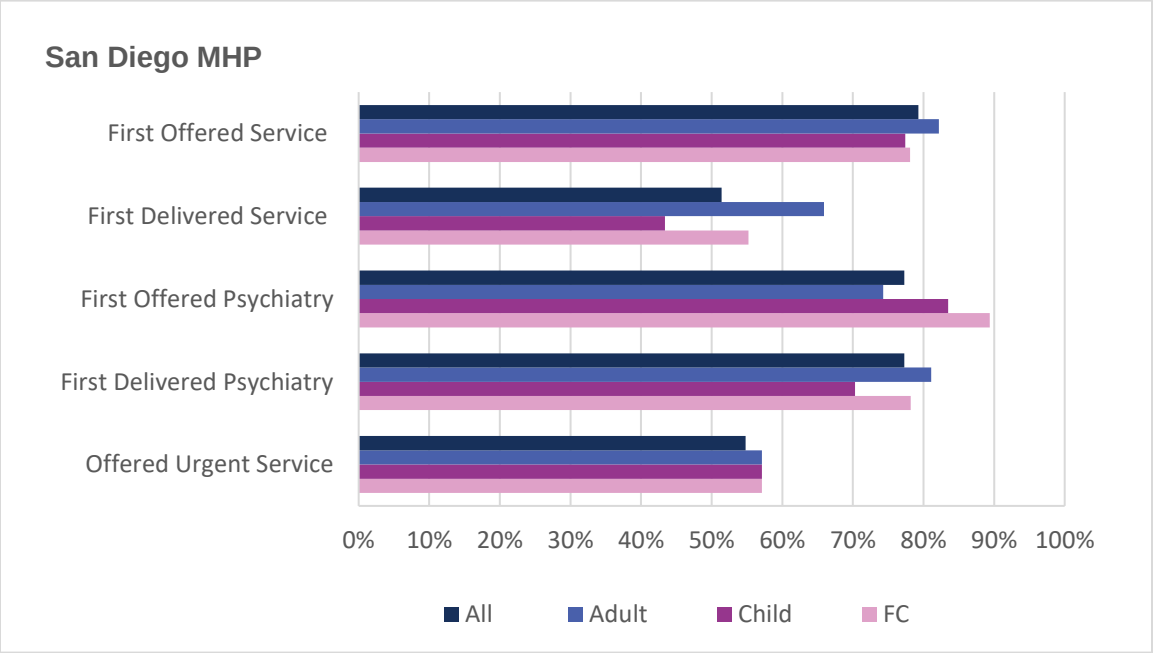


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent "the first attended appointment."

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a CSU. The MHP defined “urgent services” for purposes of the ATA as “a beneficiary 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 219 urgent service requests with a reported actual average wait time to services for the overall population of 203.1 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as the time from the beneficiary’s initial service request to the first attended appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 16.9 percent for psychiatrists and 7.2 percent for clinicians across the entire service delivery system. Average no-show rates were lower in children’s services (9.9 percent), than adult services (18.6 percent).

IMPACT OF TIMELINESS FINDINGS

- The MHP met its standard for time to first rendered service for only 50 percent of appointments. Additionally, the average is 20 days to the first delivered service which is double the MHP’s 10-day standard. This area warrants evaluation and performance improvement.
- Improving the low rate of follow-up at 7- and 30-days post hospitalization is a goal as part of the FY2022-23 QIWP.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is carried by the Executive Quality Improvement Team (EQIT). The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating QI activities. The QRC is a standing body charged with the responsibility to provide recommendations regarding the QI activities for MH and substance use disorder system and the QIWP. 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 goals, the MHP met 62 percent of goals. As reported earlier in this report, the "Quality Improvement Mental Health Services Work Plan Evaluation FY 2021-22" data and results are documented but analysis and recommendations remain routinely limited to "*San Diego County Behavioral Health Services will continue to monitor XYZ in FY 2022-23, with the intention of meeting this goal*."

The MHP uses the Milestones of Recovery Scale (MORS) as a tool to determine appropriate placement within outpatient (OP) clinics, and it uses the Level of Care Utilization System (LOCUS) for Assertive Community Treatment ACT and Strengths Based Case Management program LOC. In Children's services, the MHP uses the Child and Adolescent Needs and Strengths (CANS). The MHP produces aggregate reports in child services that include clinically significant improvement and reliable improvement indicators. The Child Outcomes Committee which includes Child Welfare Services set baselines, create standards, and examine tool completion rates. It appears that much of the activity aims to guide and ensure contract providers use tools consistently.

The MHP utilizes the following outcomes tools: MORS, Pediatric Symptom Checklist, Sutter-Eyberg Student Behavior Inventory- Revised, CANS, Illness Management and

Recovery, LOCUS, Personal Experience Screening Questionnaire, and the Recovery Markers Questionnaire.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	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 Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP employs consumer and family members through contract providers and review discussions show a high level of involvement and experience of support and value. While reported to be present in the provider organizations, consumer and family member employees did not perceive peer employees to be employed at the MHP leadership level. Peer employees identified a need for continuing educational resources for peer certification training and job classifications with advancement opportunities and higher salary levels at the County. Career advancement in parent partner fields was noted to be absent.

- As reported earlier, the QI Work Plan Evaluation reports measurements but lacks follow-up analysis. There is no way to carryover information to understand the basis for the quality improvement initiatives.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5, through sampling in medication monitoring activities.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD);
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC);
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM);
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP):

QUALITY PERFORMANCE MEASURES

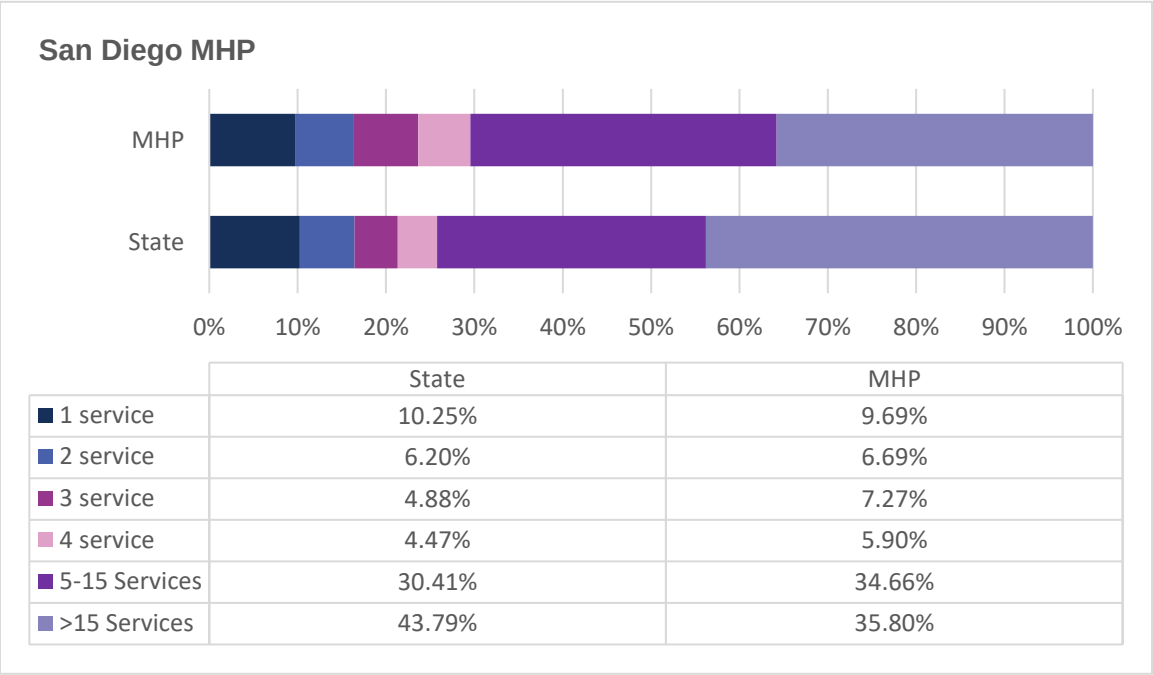
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



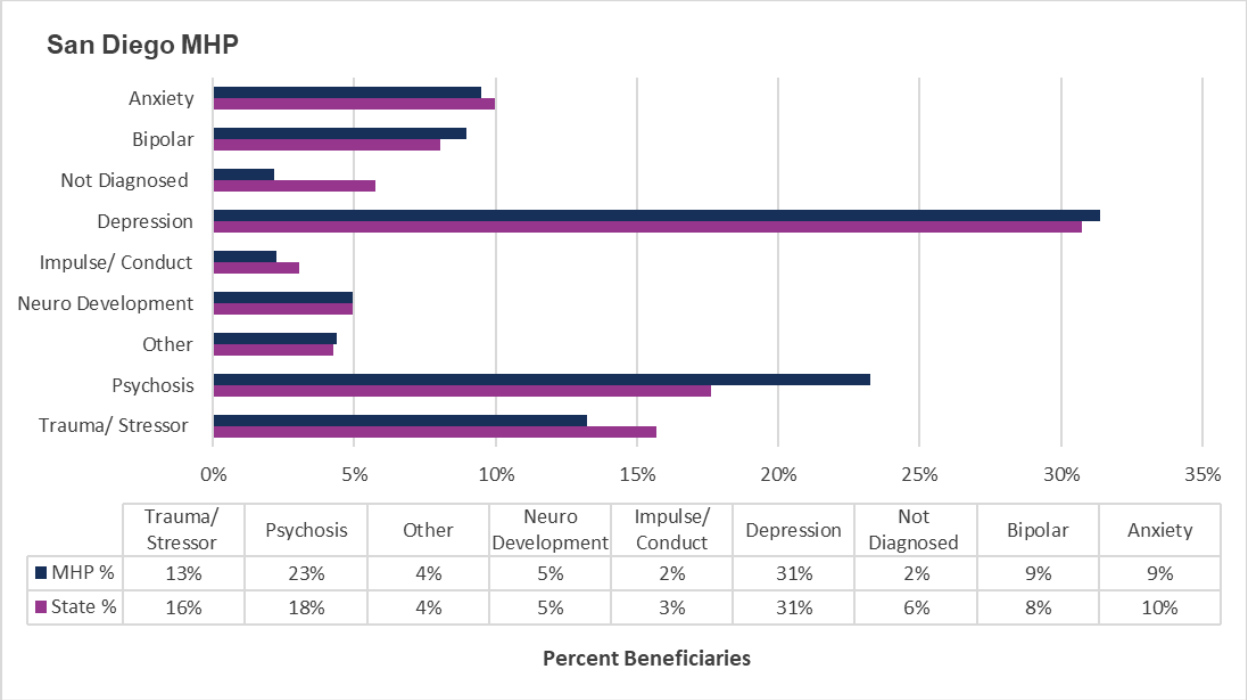
	State	MHP
1 service	10.25%	9.69%
2 service	6.20%	6.69%
3 service	4.88%	7.27%
4 service	4.47%	5.90%
5-15 Services	30.41%	34.66%
>15 Services	43.79%	35.80%

- Initial service and ongoing retention rates are generally similar to or higher than statewide averages. The exception and largest variance were for clients receiving greater than 15 services in CY 2021, where the MHP is lower at (35.80 percent), compared to the statewide averages (43.79 percent).

Diagnosis of Beneficiaries Served

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

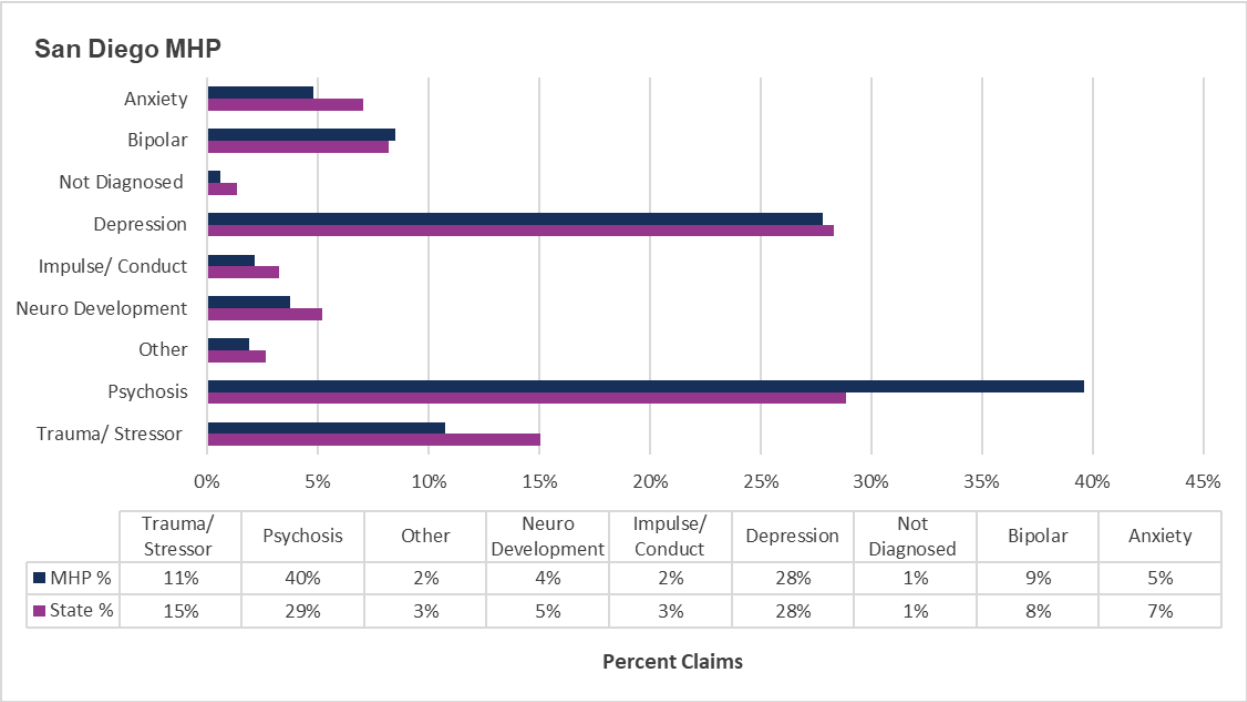
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	23%	4%	5%	2%	31%	2%	9%	9%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The diagnostic categories of beneficiaries served by the MHP largely follow the statewide proportions of diagnoses. The largest difference is a higher percentage of psychosis within the MHP, at 23 percent of beneficiaries compared to 18 percent statewide.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	40%	2%	4%	2%	28%	1%	9%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Approved claims for those diagnosed with psychosis account for 40 percent of the total MHP Medi-Cal claims, which is 38 percent higher than the statewide average of 29 percent.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	3,641	7,347	9.32	8.86	$10,384	$12,052	$37,807,296
CY 2020	3,809	9,658	8.52	8.67	$10,409	$11,814	$39,646,166
CY 2019	3,988	10,432	7.95	7.80	$9,332	$10,535	$37,216,651

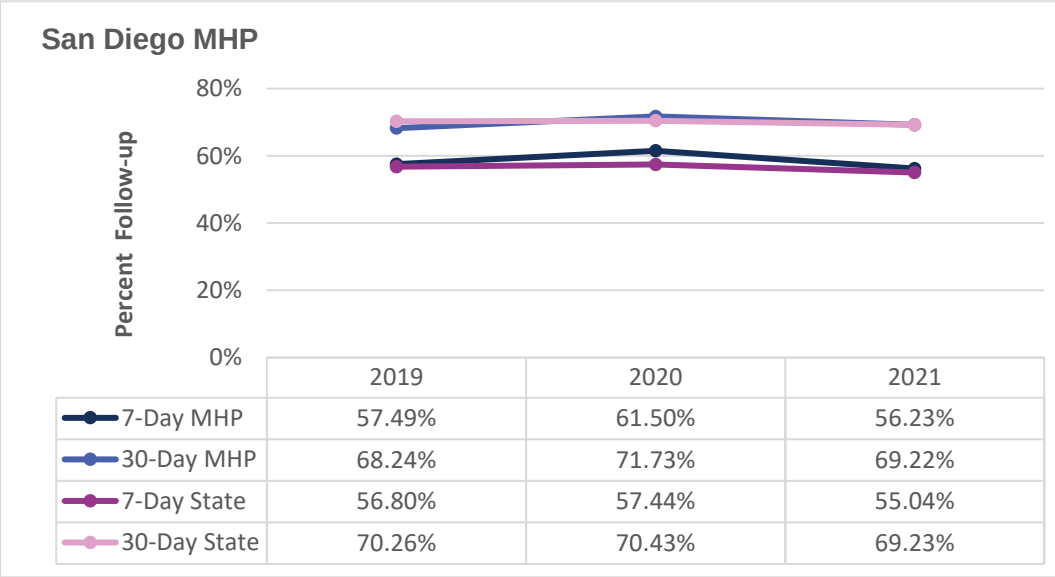
- Beneficiary admissions to psychiatric inpatient services decreased by 23.9 percent in CY 2021. The average LOS is now slightly higher than the statewide average LOS.

Follow-Up Post Hospital Discharge and Readmission Rates

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

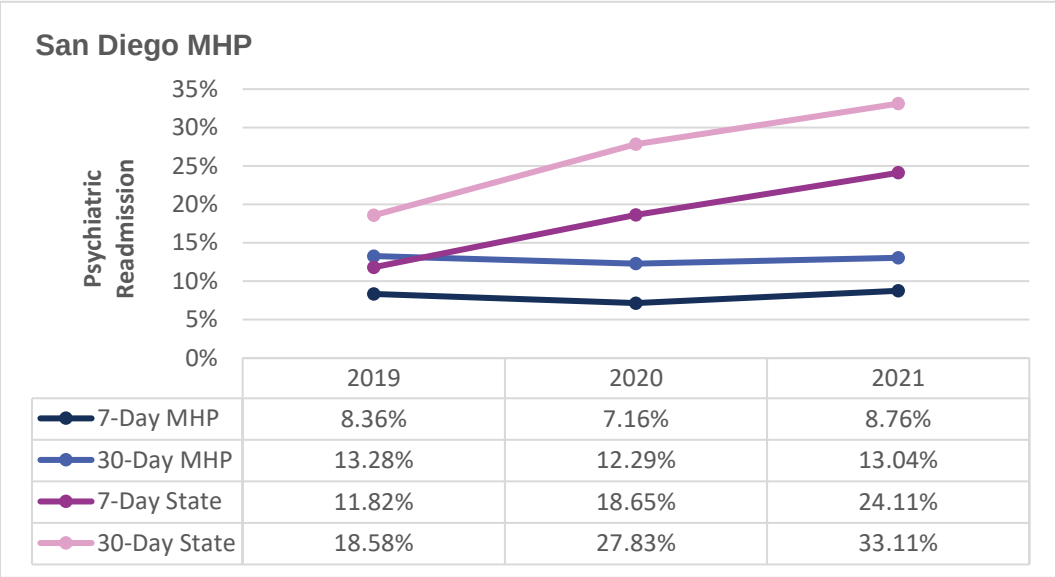
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	57.49%	61.50%	56.23%
30-Day MHP	68.24%	71.73%	69.22%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	8.36%	7.16%	8.76%
30-Day MHP	13.28%	12.29%	13.04%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The MHP psychiatric readmissions have stayed fairly consistent over the last three years in both measured time periods, compared to the statewide averages which have increased over the prior three years. Overall, the MHP had notably lower readmission rates for both measured time periods in CY 2021.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

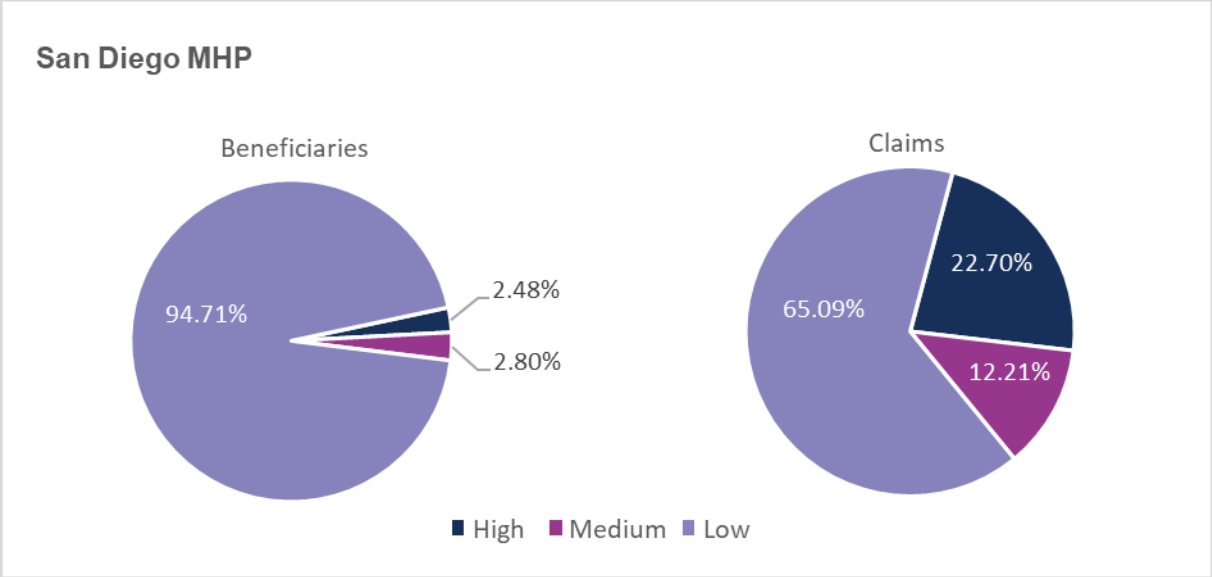
Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	885	2.48%	22.70%	$44,837,710	$50,664	$42,440
	CY 2020	1,038	2.92%	26.60%	$54,504,986	$52,510	$44,498
	CY 2019	750	2.11%	23.09%	$38,668,116	$51,557	$42,174

- The number of HCBs decreased by 153 (14.7 percent) from CY 2020 to CY 2021. The percent of HCBs in CY 2021 remains lower (2.48 percent) than the statewide average (4.50 percent), and the average approved claim amount per HCB was 8.8 percent lower than the statewide average ($50,664 vs. $55,523).

Table 15: San Diego MHP Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	999	2.80%	12.21%	$24,119,775	$24,144	$23,744
Low Cost (Less than $20K)	33,736	94.71%	65.09%	$128,577,419	$3,811	$2,290

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



IMPACT OF QUALITY FINDINGS

- The MHP's 23.9 percent decrease in inpatient admission rates likely contributes to a lower percentage of HCBs compared to the state.
- There is a lack of bi-directional communication with provider staff across all levels and contract provider systems.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

Validation tools for each PIP are 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 Beneficiaries who Identify as LGBTQ+

Date Started: 01/2022

Aim Statement: Will the increased utilization of the revised It's Up to Us website's LGBTQ+ resource page result in a lower proportion of youth ages 13 and above across the Child, Youth, and Family Behavioral Health Services (CYFBHS) system who identify LGBTQ+ reporting the need for additional services, increase reports of receiving affirming MH treatment (e.g., clinicians asking about sexual orientation and gender identity, providing LGBTQ+-specific information), and increase general satisfaction measured by the Spring 2023 Youth Services Survey (YSS) Supplemental Questionnaire for LGBTQ+ clients?

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

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

Target Population: Youth age 13 and above served by the MHP and who identify as LGBTQ+

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

Summary

Twenty-six percent of beneficiaries age 13 and older in the MHP identified as LGBTQ+. Aligned with national patterns, the MHP review of 2022 data found that this beneficiary group has a 23.5 percent higher rate of depression disorder as a primary diagnosis than cisgender/heterosexual peers. The MHP also found that this group had double the rate of inpatient services and emergency psychiatry services. Interventions planned include providing a resource webpage that aggregates local and national LGBTQ+ resources and in year two, providing clinical staff LGBTQ+ specific training.

Outcome goals include increased beneficiary satisfaction, decreased inpatient and emergency services use, and decreased rehospitalizations. Indicators include webpage usage, beneficiary satisfaction, and acute service use rates.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: it is not clear that the selected interventions address the barriers or problems identified. The first year of the PIP intervention is limited to the website resource page. The MHP review of satisfaction surveys revealed dissatisfaction related to clinical providers and services. Of note, surveys show 75 percent beneficiaries age 13+ who identify as LGBTQ+ report satisfaction. While a resource page and online supports would increase resources, improving satisfaction with services is not clear. Staff training planned in year two have promise to address these problems. In addition, the MHP did not conduct a barrier analysis to understand the significantly higher rates of acute service use. Service patterns of beneficiaries who used acute services such as service engagement, diagnosis, service patterns (retention, timeliness, follow-up care, level of care) were not examined. Understanding the root cause that may contribute to the higher hospitalization, crisis, and rehospitalization rates is needed to select interventions that could reduce identified barriers.

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

- Analyze potential factors for the higher rate of acute services in beneficiaries who identify as LGBTQ+, and select and implement interventions that address identified barriers.
- Additional suggestions follow in the validation tool at the end of this report.

NON-CLINICAL PIP

General Information

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

Date Started: 04/2022

Aim Statement: Will training and informational support increase older adult client's utilization of telehealth services by 5%. Improved utilization of telehealth services will be measured in the following ways: 1) increased number of billed telehealth services for older adult clients (Cerner Community Behavioral Health system data), 2) improved self-report of knowledge on how to access telehealth services for older adult clients (client pre- and -post intervention self-report data), and 3) improved self-report of comfort with the security and privacy while utilizing telehealth services for older adult clients (client pre- and -post intervention self-report data).

Target Population: Adults age 60 or older who are eligible for services at the MHP

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

Summary

The MHP developed this PIP after examining a number of its evaluation findings and utilization data. The MHP found that older adults were less likely to use video-based services compared to other age groups, thus limiting access. Older adult beneficiary members of a workgroup reported that lack of technology and information, in addition to lack of trust, contributed to low comfort and knowledge using telehealth care. Review of utilization data and Mental Health Statistical Improvement Program survey results showed that even when beneficiaries had access to technology, older adult consumers used the services at a lower rate than other groups. Additional surveys showed that a large majority of older adult consumers reported wanting to learn how to use devices and a majority of providers identified telehealth training for older beneficiaries may improve access.

Interventions planned include providing beneficiaries video and in-person training, and informational materials. Intervention tools will be translated into threshold languages. Indicators include rate of telehealth utilization, and levels of beneficiary knowledge and trust regarding telehealth services.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase. Baselines have not been reported for the performance measures. The design and plans to provide interventions to the eligible population appear sound thus far and have the potential to improve access and outcomes.

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

- Include process plans and measures to ensure that interventions are provided to the eligible population. As started, consider sustainability and ensure consistency in providing interventions, especially given staffing shortages and turnover. Consider including peer staff.
- Additional suggestions follow in the validation tool at the end of this report.

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 Cerner Community Behavioral Health, which has been in use for 14 years. Currently, the MHP is actively implementing a new system (Cerner Millennium), which requires heavy staff involvement to fully develop.

Approximately 6.9 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 4,545 named users with log-on authority to the EHR, including approximately 660 county staff and 3,885 contractor staff. Support for the users is provided by 62 full-time equivalent (FTE) IS technology positions. Currently there are eleven vacant positions.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
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	%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Beneficiary Personal Health Record

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

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 the following departments/agencies/organizations: 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 beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- Investment in IT infrastructure and resources is notably strong with dedicated IS support, embedded IT staffing, as well as contracted support through the ASO, Optum, for system development and reporting.
- Related to the integrity of data collection and processing, the MHP does not currently have a data warehouse to support data analytics, however implementation is an active process in tandem with the new EHR.
- The transition to Cerner Millennium had a target go-live of July 2023. The transition for contracted outpatient programs has been impacted by staffing resources pushing the go-live date to late CY 2023.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

This chart appears to reflect a largely complete claims data set for the time frame claimed.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	56,769	$13,345,677	$20,376	0.15%	$13,030,603
Feb	55,668	$13,307,985	$19,289	0.14%	$13,061,473
Mar	64,172	$15,572,895	$28,835	0.19%	$15,243,981
April	60,071	$14,814,844	$17,959	0.12%	$14,528,870
May	53,611	$13,873,718	$16,468	0.12%	$13,602,083
June	55,518	$14,033,926	$11,568	0.08%	$13,755,896
July	50,259	$14,344,623	$191,013	1.33%	$14,022,214
Aug	49,762	$14,295,763	$175,539	1.23%	$14,006,696
Sept	49,860	$14,286,174	$160,962	1.13%	$13,999,120
Oct	48,069	$14,285,984	$146,149	1.02%	$14,037,613
Nov	44,950	$13,529,034	$169,871	1.26%	$13,277,390
Dec	43,755	$12,937,235	$187,588	1.45%	$12,665,646
Total	**632,464**	**$168,627,858**	**$1,145,617**	**0.68%**	**$165,231,585**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible	1,174	$400,785	34.98%
Other healthcare coverage must be billed first	901	$360,130	31.44%
Medicare must be billed first	796	$342,414	29.89%
Late claim	42	$20,005	1.75%
Duplicate service	37	$8,964	0.78%
Deactivated NPI	27	$4,958	0.43%
Other	32	$4,671	0.41%
Place of service incomplete or invalid	1	$2,240	0.20%
Service location NPI issue	5	$1,452	0.13%
Total Denied Claims	**3,015**	**$1,145,619**	**100.00%**
Overall Denied Claims Rate	**0.68%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The top three denial reasons account for $1.1 million and 96 percent of the denied claims.
- The MHP denied claim percentage is less than half the statewide average.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The base of 62 FTEs supporting the overall IS functionality will provide a solid foundation during the EHR transition. The strategic partnership with Optum as the ASO provides needed supplemental support for system development and reporting. It is notable that the MHP anticipates posting the ASO contract for competitive solicitation prior to the current contract ending in CY 2024.
- The resource and staffing impacts to the EHR transition project have delayed needed system updates which are anticipated to provide multiple functional improvements to support the system of care. The MHP reports over 60 projects requiring IS support that are being prioritized. Many of the projects build off the EHR implementation, so consistency of development support is vital to moving the system forward.
- The MHP Medi-Cal claiming process is very consistent with a notably low denied claims rate, which reflects a well-managed billing process and supports the MHP in retaining revenue.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP produces reports and analyzes its CPS results including performance improvement projects. The QIWP includes goals related to treatment planning based on the CPS data for adults and youth.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of transitional aged youth consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight participants.

Most participants had started services in the last year. Services received include therapy, case management and medication service. Time to an initial appoint ranged one week to two months. Most waited one month which they felt "too long." Participants received services at two different contract programs. Access was quicker for those coming from a homeless shelter or juvenile hall.

Participants report that in person or telehealth appointments are offered; many received services in both methods and receive services the way they prefer. Most participants received therapy weekly, but some participants had been waiting for a therapist for over one year after former therapists left. There is inconsistent therapist, psychiatrist availability and connection services. The beneficiary had a case manager but felt that there was "no one to speak to" and felt a lack of support or "care."

Most participants felt their providers gave them a sense of hope. Participants valued peer staff. All participants perceived that their clinicians had “too many patients” and access to them was possible but limited. Some felt that clinicians “did not care” or understand the MH conditions they had.

Most received medication services and while one participant received a medication appointment monthly, most received a psychiatry appointment every two to three months which most “felt too long.” Many received appointment reminders; rescheduling appointments was not difficult. Most beneficiaries felt comfortable asking for a provider change if they needed one. Case managers are most utilized and leaned on for services and information.

Recommendations from focus group participants included:

- Hire more staff so staff can be “more available.”
- Provide more training to staff to have specific knowledge of disorders.
- Decrease the long wait times to appointments.
- Help with a transitional plan and during the process.
- Provide better transportation assistance.
- Improve treatment in locked psychiatric facilities and eliminate “over drugging” beneficiaries.
- Provide short-term trade school.

Consumer Family Member Focus Group Two

CalEQRO requested family members or caregivers of children who initiated services in the preceding 12 months. The focus group was held at virtually and included four participants. All family members participating have a child, or youth family member who receives clinical services from the MHP.

Most participants described initial access as lengthy and “complicated.” Participants received a first appointment between a month and up to several months after a request. Parents whose children were transitioning from Child Protective Services (CPS) or residential care, the experience was difficult and requires one to “start over.” Participants reported wait lists to psychiatry services is 6 months to one year.

Beneficiaries received appointment reminders, and there were no barriers to rescheduling appointments when needed. Their children received therapy weekly or biweekly, and psychiatry appointments monthly. Some saw a nurse practitioner for medication refills. Some had received transportation help; all were aware of available help.

Participants felt understood and involved in treatment and felt comfortable communicating with any feedback or request for changes with their programs. All

endorsed feeling hope for recovery from providers. For urgent needs, most call the sheriff and psychiatric emergency response team unit. They were also aware of the Emergency Screening Unit.

Recommendations from focus group participants included:

- Provide more supports and timely services including for children coming from CPS.
- Extend the length of time counseling is provided. Three to six months is not long enough.
- Decrease wait times to services and simplify transitions in care.

Consumer Family Member Focus Group Three

CalEQRO requested adult and older adult consumers who initiated services in the preceding 12 months. The focus group was held at virtually and included 11 participants. All consumers participating receive clinical services from the MHP.

Many participants received initial services within one week; access to initial psychiatry services was longer with some waiting to see a psychiatrist. Some participants report also still waiting to receive a therapist. Most participants receive therapy biweekly and psychiatry appointments monthly. For urgent needs, clear knowledge of available resources or a plan was not evident.

Most shared they feel comfortable sharing input to their programs and gain a sense of hope and recovery from services. However, participants were not aware of opportunities to provide input or any wellness centers. Consumers were also mixed in experiencing their cultural needs as understood.

Most participants received information from their case manager or fliers. A need for more transitional and housing supports was common recommendation.

Recommendations from focus group participants included:

- Provide transitional supports.
- Increase support services at housing programs.
- Reduce the wait time to psychiatry services.
- Provide motivational speakers as part of programs.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiaries value the services received and report obtaining hope for recovery from providers and programs. Overall access experience is difficult and have long wait times to initial service, and between psychiatry appointments. Beneficiaries also report

dissatisfaction with service quality areas such at clinician knowledge, change in therapists, lack of therapists, and need for assistance between program transitions or level of care changes. Some of the areas are consistent with the MHP's analysis of CPS results used to develop the Clinical PIP.

CONCLUSIONS

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

STRENGTHS

1. The MHP continues to build its network driven by a public health approach to service delivery with a focus on population health, epidemiology, behavioral and physical health integration, and health equity. (Quality, Access)
2. The MHP has implemented MCRT county-wide which increases access to beneficiaries with acute needs. (IS, Quality)
3. Peer employees within contracted services provide a breadth of in-depth experience and are dedicated to supporting beneficiaries. They are an integral component within contracted programs and bring optimism and vision for the future of the peer workforce in San Diego. (Quality)
4. The MHP has a strong strategic partnership in place with Optum that provides IS support, access support, and contracted support with fee-for-service providers. (Access, IS)
5. The MHP continues to expand data sources and data access pertinent to longer term system planning and current quality improvement areas. This access includes contract organizations and partner agencies. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Timeliness to services have wide ranges with abnormally high wait times to first-offered appointment, first delivered service, and urgent appointments offered. Beneficiary engagement and satisfaction are negatively impacted by long waits to access.(Timeliness)
2. The continues to be a need for collaborative approaches with the CBOs in system planning, service delivery, and contract formation and monitoring. There appear to be opportunities to strengthen workforce hiring and retention, and program sustainability areas with increased partnership with CBOs. (Quality)
3. Transitions for beneficiaries between LOC and general access to programs is significantly impacted due to lack of staffing which has impacted capacity within programs. This also impacts timeliness to care with many beneficiaries experiencing wait times of multiple months to access care. (Access, Timeliness)

4. The MHP continues to have a lower Hispanic/Latino PR than the large MHP and statewide Hispanic/Latino average PR. The Hispanic/Latino AACB decreased in CY 2021, counter to the state and large MHP change. (Access)
5. The MHP has many significant IS-related changes and initiatives that are priorities, including but not limited to: the Cerner Millennium EHR implementation, development of comprehensive access timeliness reports, and CalAIM and payment reform. (IS)

RECOMMENDATIONS

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

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 a carry-over from FY 2021-22.)
2. Increase collaboration with contract providers. Increase MHP knowledge of contract provider challenges in current service delivery, workforce, contracts, and sustainability strategies. Use inputs from contract providers to address current challenges. (Quality)
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. (Access, Timeliness, Quality)
4. Evaluate barriers or address barriers identified in existing assessments to increase access for Hispanic/Latino beneficiaries. As planned in the Cultural Competence Plan, examine access times by client language to determine if there are barriers. Conduct performance improvement. (Access)
5. Develop detailed testing, training, data conversion, integration, support and risk-management plans to support the outpatient cutover to the CM EHR. Ensure that all providers (CBO, 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. (IS)

   (This recommendation is a carry-over from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, 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
Access to Care
Timeliness of Services
Quality of Care
ISCA
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation of Network Adequacy
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Beneficiary Satisfaction and Other Surveys
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 Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision

CalEQRO Review Sessions – San Diego MHP
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Bill Walker, Quality Reviewer
Joel Chain, Information Systems Reviewer
Valerie Garcia, Consumer Family Member Reviewer

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

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
Arnwhine-Williams	Heirrieze	Housing Supervisor	Catalyst
Ball	Alex	Technology Development Lead	NAMI – Community Advocacy
Bergmann	Luke	Director	San Diego County Behavioral Health Services (SDCBHS)
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum
Britton	Ronnie	Family Youth Partner	Harmonium
Brown	Tammy	Peer and Family Support Specialist	NAMI Next Steps
Carrasco	Bernard	Director	NHA/UPAC – Promise Wellness Center
Carreon	Jesenia	Peer Specialist	CRF – South Bay Guidance Center
Cooper	Fran	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families SOC
Crume	Henry	Research Associate	UC San Diego Child and Adolescent Services Research Center (CASRC)
David	Nora	Assistant Medical Services Administrator, Harm Reduction/Quality Improvement	SDCBHS – Population Health Office
Dean	Robert	CEO	Vista Hill Foundation
DeVoss	Angie	Program Coordinator	SDCBHS – Management Information Systems
Esposito	Nicole	Chief Population Health Officer, Medical Director	SDCBHS – Population Health Office

Last Name	First Name	Position	County or Contracted Agency
Estrada	Juan	Family Youth Partner	Harmonium
Evans Murray	Cara	Deputy Director	SDCBHS – Adult and Older Adult SOC
Flores	Monica	Parent Partner	Center for Children Foster Family Agency Stabilization and Treatment (FFAST0
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	SDCBHS – Adult and Older Adult SOC
Garret	Michael	Licensed FEP Clinician & Clinical Supervisor	Pathways Kickstart
Gitari	Velia	Clinician	UPAC – Elder Multicultural Access and Support Services
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
Guevara	Christopher	Program Coordinator	SDCBHS – Strategy & Finance
Guingab	Amelia	Department Budget Manager	SDCBHS – Budget & Fiscal
Hammond	Linda	President	Community Research Foundation
Hansen	Stephanie	Administrative Analyst III	SDCBHS – Management Information Systems
Hayes	Skylar	Reporting and Application Development Manager	Optum

Last Name	First Name	Position	County or Contracted Agency
Hempstead	Karen	VP of Adult Outpatient Services	CRF
Higgins	Alan	Data Analytics Manager	Optum
Jackson	Sharon	Supervisor	Optum Access and Crisis Line
Johnson	Rosalyn	Employment Specialist	Community Research Foundation – East Corner Clubhouse
Justice	Linda	Clinical Supervisor	UPAC - New Leaf Recovery Center
Kelly	Channa	Assistant Medical Services Administrator	SDCBHS – Adult and Older Adult SOC
Kemble	Derek	Principal Administrative Analyst	SDCBHS – Programs & Services
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS – Operations
Klotz	Tina	VP of San Diego Operations	Exodus Recovery
Kneeshaw	Stacey	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Koenig	Yael	Deputy Director, Children, Youth and Families System of Care	SDCBHS – Children, Youth, and Families SOC
Krelstein	Michael	Chief Medical Officer, Clinical Director	SDCBHS – Healthcare Oversight
Lagare	Tiffany	Research Associate	UC San Diego Child and Adolescent Services Research Center (CASRC)
Lance Sexton	Amanda	Assistant Medical Services Administrator	SDCBHS – Children, Youth, and Families SOC

Last Name	First Name	Position	County or Contracted Agency
Lang	Tabatha	Administrator	SDCBHS –
Leone	Joanne	Clinical Supervisor	Counseling and Treatment Center-Union of Pan Asian Communities (UPAC)
Lockhart	Jack	Peer Specialist	Community Research Foundation (CRF)– Douglas Young Adult OP
Lopez	Katrina	Assistant Program Director	Pathways – Kickstart
Loyo-Rodriguez	Raul	Department Revenue & Budget Manager	SDCBHS – Strategy & Finance
Lucas	Lavonne	Medical Claims Manager	SDCBHS – Strategy & Finance
Madison	Janet	Family Youth Partner	Harmonium
Marquez	Samantha	Administrative Analyst I	SDCBHS – Health Plan Administration
McDonald	Kate	Senior Mental Health Researcher	UC San Diego Child and Adolescent Services Research Center (CASRC)
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement
Montes Mora	Stephanie	Peer Specialist	CRF – Areta Crowell Adult OP
Morgan	Tiffany	Supervisor	Optum Access and Crisis Line
Miles	Liz	Program Coordinator, Quality Improvement	SDCBHS – Population Health Office
Murguia	Krystle	Principal Administrative Analyst	SDCBHS – Children, Youth, and Families System of Care

Last Name	First Name	Position	County or Contracted Agency
Musso	Stacey	Department Director	SBCS
Nava	Alejandrina	Clinical Psychologist	SDCBHS Stabilization, Treatment, Assessment, and Transition Team
Nelson	Kandice	Therapist/Fidelity Specialist	SDCC Wrapworks
Nelson	Leah	Clinician	SDCBHS
Nembhard	Adia	Assistant Director/Clinical Supervisor	SDCC Wrapworks
Nunez	Antonia	Provider Liaison	UC San Diego Health Services Research Center (HSRC)
Oestreicher	Jeannie	Manager OP Services	Center for Children FFAST
Oktavec	Tarrah	Therapeutic Behavioral Services (TBS) Case Manager	New Alternatives TBS
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
Pauly	Kimberly	Assistant Medical Services Administrator	SDCBHS – Programs & Services
Penfold	William (Bill)	Senior MIS Manager	Optum
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
Rhinesmith	Danielle	Utilization Review QI Supervisor	SDCBHS – Health Plan Operations, Quality Assurance MH

Last Name	First Name	Position	County or Contracted Agency
Rodriguez	Theresa	VP	MHS (TURN BHS)
Rodvill	Kacie	Peer Support Specialist	NAMI – Community Advocacy
Rose	Yolanda	Psychiatric Nurse	SDCBHS
Rusit	Jennifer	Administrative Analyst III	SDCBHS – Healthcare Oversight, Workforce Education and Training
Sanvictores	Erwin	Family Education Trainer	NAMI – Family Education
Sarkin	Andrew	Director of Evaluation Research	UC San Diego Health Services Research Center (HSRC)
Shapira	Erin	Program Coordinator	SDCBHS – Quality Assurance
Smith	Alisha	Skills Coach	Fred Finch Youth and Family Services
Smylie	Bobbi	Program Director	SBCS Children's Mental Health
Strout	Elizabeth	Director of Operations	Telecare
Tally	Steve	Assistant Director of Evaluation Research	UC San Diego Health Services Research Center (HSRC)
Tran	Vihn	Clinical Psychologist	SDCBHS Stabilization, Treatment, Assessment, and Transition Team
Thornton-Stearns	Cecily	Assistant Director and Chief Program Officer	SDCBHS – Programs & Services
Valenzuela	Leslie	Peer Support Specialist	CRF – Downtown Intensive Mobile Psychosocial Assertive Community Treatment
Velasquez Trask	Emily	Senior Mental Health Consultant	UC San Diego Child and Adolescent Services Research Center (CASRC)

Last Name	First Name	Position	County or Contracted Agency
Vernice	Angie	Parent Partner	San Diego Center for Children – Wrapworks
Villarin	Shellane	Research Analyst	UC San Diego Health Services Research Center (HSRC)
Vleugels	Laura	Supervising Psychiatrist	SDCBHS – Children, Youth, and Families SOC
Wallenberg	Randall	Embedded IT Contractor	SDCBHS
Wan	Katherine	Project Manager	UC San Diego Health Services Research Center (HSRC)
White-Voth	Charity	Deputy Director	SDCBHS – Adult and Older Adult SOC
Zimmerman	Hannah	Clinician	SBCS Children's Mental Health
Ziogas	Kayla	Clinician	SBCS Children's Mental Health

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	This PIP is in the planning phase.

General PIP Information
MHP/DMC-ODS Name: San Diego MHP
PIP Title: Improved Therapeutic Support for Youth Beneficiaries who Identify as LGBTQ+
PIP Aim Statement: Will the increased utilization of the revised *It's Up to Us* website's LGBTQ+ resource page result in a lower proportion of youth ages 13 and above across the CYFBHS system who identify LGBTQ+ reporting the need for additional services, increase reports of receiving affirming MH treatment (e.g., clinicians asking about sexual orientation and gender identity, providing LGBTQ+-specific information), and increase general satisfaction measured by the Spring 2023 Youth Services Survey (YSS) Supplemental Questionnaire for LGBTQ+ clients?
Date Started: 01/2022
Date Completed: n/a
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☒ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): The study sample includes all youth ages 13 and above 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): • Enhance the It's Up to Us LGBTQ+ Resource page and increase access to the page through promotion • The Community Advisory committee will develop a LGBTQ+-specific training for clinicians
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Enhance the It's Up to Us LGBTQ+ Resource page and increase access to the page through promotion • The Community Advisory committee will develop a LGBTQ+-specific training for clinicians
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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
Increased website pageviews. The number of page visits to the *It's Up to Us* LGBTQ+ Resource Page https://up2sd.org/resources?list=lgbtq	No other data for this table was provided by the MHP.	n/a	☐ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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
Percentage of LGBTQ+ youth enrollees who reported that their providers asked about their sexual orientation and gender identity.	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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.	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth enrollees who reported that they desired additional LGBTQ+ specific resources	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth enrollees who rated their General Satisfaction as *Strongly Agree* or *Agree*	n/a	n/a	☐ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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
Percentage of LGBTQ+ youth admitted to emergency/crisis levels of care	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

This TA was provided at the review.

Worksheet 1: PIP Topic

- Specific baseline data is presented in this worksheet but not in later worksheets. Recommend inserting the baseline data as applicable in worksheet 5 Table 5.1 and Worksheet 8 Table 8.1.
- 1.4: Rehospitalization is specifically identified as a goal for reduction in worksheet 1 but not in later worksheets. Recommend that the crisis goals, baselines, and measure of improvement are clarified and aligned throughout the PIP.
- 1.5: Were LGTBQ+ involved in the intervention determinations?

PIP Validation Information

- 1.6:
    - In this Worksheet section the interventions are presented as year 1 and year 2. Recommend that the following Worksheets also present as year 1 and year 2.
    - Year 1: Is there any plan to target market to youth that identify as LGBTQ+ directly?
    - Year 2: It seems backwards to promote first and train staff second since Root Cause 1 is listed as a "Lack of affirming services and spaces in MH settings" (p.12).

Worksheet 2: Aim Statement

- Recommend more specificity of the target improvement as identified for year 1 and year 2.
- Recommend clarifying the age ceiling for the target population here and in other worksheets.
- Again, note that the goal of receiving more affirming services is prior to the training to improve those services.
- The AIM statement is not aligned with Worksheet 1. Worksheet one calls for reduced re-hospitalization rates. Recommend that all Worksheet references to goals; interventions; baselines; variables; and Target Improvement Rates align and use the same language so that they reduce drift and maintain systematic redundancy.

Worksheet 3: PIP Study Population

- Recommend clarifying the age ceiling for the target population here and in other worksheets.

Worksheet 4: Sampling Plan – no recommendations

Worksheet 5: PIP Variables and Performance Measures

- 5.2: Worksheet 2.1 lists receiving affirming care as a variable in year 1 and Worksheet 5.2 lists it as a performance measure in year 2. Table 5.1 does not differentiate year 1 and year 2. Recommend that all Worksheet references to goals; interventions; baselines; variables; and Target Improvement Rates align and use the same language so that they reduce drift and maintain systematic redundancy.
- 5.2.3 drifts rehospitalization from earlier Worksheets to "A decrease in percentage of LGBTQ+ youth receiving Emergency/Crisis services who are ages 13+ served in CYFBHS**"** and "Percentage of LGBTQ+ inpatient and emergency/crisis services usage."
- Table 5.1:

○ Recommend reviewing Worksheet 1, Worksheet 5.1 and 5.2 in the context of Table 5.1 and align accordingly.

- Recommend consider reducing the number of Goals and as they are replicated in the PMs.
    - Suggest that the MHP determine the specific crisis areas to measure (emergency department, inpatient , Recidivism; or ???) and determine national, local baseline and align the crisis areas across the PIP Worksheets, especially 1 and 5.
    - Recommend consider adding a question(s) to the survey asking if they have used the website in the last year, and their satisfaction.
- Training intervention:
    - Recommend consider including other direct service staff, supervisors and administration in the trainings.

PIP Validation Information
▪ Consider a systematic approach to training and monitoring/supporting change management: an internal campaign. ▪ Consider training all youth services direct service staff and leadership and not just clinicians. ▪ Consider medias for LGBTQ+ youth to draw to the website intervention. ▪ Consider a Toolkit to be provide to LGTBQ+ youth. o Target Improvement Rates ▪ Use baseline data and specify specific “to – from” in addition to the percentage of change. **Worksheet 6: Improvement Strategy (Intervention) and Implementation Plan** • Please complete. **Worksheet 7: Data Collection Procedures** • Recommend having a process that measures satisfaction more frequently that annually for 2-6. • Cite the baseline and what the actual improvement would be. **Worksheet 8: Data Analysis and Interpretation of Results** • Please complete columns 1-4 of Table 8.1. **Worksheet 9: Likelihood of Significant and Sustained Improvement through The PIP** Please complete

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 PIP Development tool indicates that the PIP began 4/2022. • There is substantial review and preparation to validate the PIP. • The interventions have not been developed (Table 6.1), the Target Improvement Rates do not have baseline data included (Table 5.1 and Table 8.1) • There is no evidence that the PIP has moved past the development phase. See recommendations listed at the end of this Validation tool.

General PIP Information
MHP/DMC-ODS Name: San Diego MHP
PIP Title: Improving the Experience of Teletherapy for Older Adults
PIP Aim Statement: Will training and informational support increase older adult client's utilization of telehealth services by 5%. Improved utilization of telehealth services will be measured in the following ways: 1) increased number of billed telehealth services for older adult clients (Cerner Community Behavioral Health system data), 2) improved self-report of knowledge on how to access telehealth services for older adult clients (client pre- and -post intervention self-report data), and 3) improved self-report of comfort with the security and privacy while utilizing telehealth services for older adult clients (client pre- and -post intervention self-report data).
Date Started: 04/2022
Date Completed: n/a
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): Older adults ages 60 or older who are eligible for services through SDCBHS
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): Providing trainings and providing easy to follow informational material on telehealth services
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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 MHP did not complete this section.	n/a	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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
n/a	n/a	n/a	☐ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
n/a	n/a	n/a	☐ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
n/a	n/a	n/a	☐ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information

EQRO recommendations for improvement of PIP:

Worksheet 1: PIP Topic

- The Worksheet indicates that the PIP began 4/2022. Recommend that the start of the PIP be recalibrated to when the interventions are implemented.
- Specific baseline data is presented in this worksheet but not in later worksheets. Recommend inserting the baseline data as applicable in worksheet 5 Table 5.1 and Worksheet 8 Table 8.1.
- Information Systems Capabilities Assessment data indicates that telehealth use has reduced for all age populations in the last year, 45 percent for Older Adults. Staff sessions indicate an intentional effort to use telehealth secondary to in-person care.

Worksheet 2: Aim Statement

- Recommend more specificity of the target improvement as identified for year 1 and year 2.
- Recommend specifying the baseline and a 5 percent "from – to" statement that clarifies the "by" statement.

Worksheet 3: PIP Study Population- no recommendations

Worksheet 4: Sampling Plan – no recommendations

- **Worksheets 5 and 6: (5) PIP Variables and Performance Measures and (6) Improvement Strategy (Intervention) and Implementation Plan**
  - Goals
    - Recommend goal 3 align with the positive goal statement in the Worksheet 5 narrative and prior worksheets.
  - Interventions
    - Industry standard provides tech support- consider how active support is incorporated in the intervention.
    - Training seems separated from use. Recommend considering intentionally setting up telehealth appointments and using the training specifically with a learning experience. Learning inclusive of experience to crate successful telehealth experience: practice makes perfect.
    - Table 6.1 appears to indicate that the PIP interventions have not been implemented, thus the PIP has not actually started.
  - Target Improvement Rate
    - Recommend specifying the baseline, 5 percent, and "from – to".

Worksheet 7: Data Collection Procedures

- 7.3 surveying directly after the training but not after telehealth use would seem to produce false positive feedback as it measures the training experience and not the telehealth experience. See Worksheets 5&6 recommendation bullet #2 and consider setting up telehealth use and measuring after telehealth use.

Worksheet 8: Data Analysis and Interpretation of Results

- If the PIP is active it would be expected to see 8.1-8.6 completed.
- The assumption is that the PIP is not yet implemented.

PIP Validation Information
○ Please complete the first 4 columns of Table 8.1. ○ If the PIP is implemented and there are measurements, please complete the Table 8.1 accordingly. • **Worksheet 9: Likelihood of Significant and Sustained Improvement through The PIP- no comments** If the PIP has been implemented, please complete this section accordingly.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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