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FY 2020-21 MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SAN JOAQUIN MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 27 – 28, 2020

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INTRODUCTION

The United States Department of Health and Human Services (HHS), 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). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO 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 Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the San Joaquin MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Medium

MHP Region — Central

MHP Location — Stockton

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 11,360

MHP Threshold Language(s) — Spanish, Cambodian

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09. The MHP adheres to more recent Medi-Cal

eligibility data, consistent with DHCS Behavioral Health Information Notice 20-070, wherein Cambodian is no longer identified as a threshold language.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for the EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

(AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met 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 Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

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

Status: Met

- By June 2020 the MHP had a clinical and non-clinical PIP designed and in implementation.

Recommendation 2: The MHP is encouraged to make generous use of EQRO technical assistance in thinking through both new PIPs.

Status: Met

- The MHP consulted with the EQRO on multiple occasions in the development of each PIP, including inviting written comments and spending at least 90 minutes on the phone each time reviewing the PIP design and tool completion.

Access Recommendations

Recommendation 3: The MHP should investigate the possibility of opening a wellness center in Lodi and/or Tracy.

Status: Met

- The MHP investigated the possibility of using MHSA funds to open one or two additional wellness centers, including having a discussion with beneficiaries in the MHSA planning session in January. The beneficiaries were very interested.
- COVID-19 budget constraints have hampered continuing planning; however, the option remains if/when finances allow.
- Dignity Health funded a wellness center in Manteca, the location being their choice.

Timeliness Recommendations

Recommendation 4: Develop and implement a methodology for tracking timeliness of assessment follow-up and routine appointments.

Status: Met

- The MHP has the data to track these timeliness measures; however, they are no longer included in the MHP Assessment of Timely Access (MATA).

Recommendation 5: Ensure that definitions of timeliness measures are clearly articulated and built into the data collection procedures in the new Timeliness Application.

Status: Met

- The MHP built clear definitions, based on required standards, into the new Timeliness Application and provided reports reflecting extraction of those data.

Quality Recommendations

Recommendation 6: Review claims cost trends for the last two years to understand the significantly lower costs relative to those of the state and similar

size MHPs for Overall, Hispanic/Latino, and Foster Care (FC). Analysis of utilization rates may be a fruitful place to start.

Status: Met

- The MHP described a variety of activities, in various departments, aimed at understanding these numbers and is in the process of ensuring that all services are claimed in addition to gathering more specific data on the use of crisis services.
- The MHP developed separate reporting units for FC services and Children and Youth Services (CYS) Division so that it can analyze utilization data for all foster youth separately.
- The MHP Director is directly involved in these analyses.

Beneficiary Outcomes Recommendations

Recommendation 7: Continued exploration of options for development of a more robust peer career ladder should remain a priority. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Partially Met

- The MHP reported that they continue to explore the establishment of supervisory peer positions that will require lived experience as consumer or family member.
- Due to the COVID-19 pandemic, the County maintained a status quo budget for FY 2020-21, and no new positions were established.
- The MHP has engaged the County Human Resources department on the need for additional peer positions, which they hope to establish once the budget and staff workload allow.
- Trainee positions are available as the first step to become a Peer Specialist in some programs.

Recommendation 8: Ensure that the results of the Consumer Perception Survey (CPS) are analyzed, trended, and used to identify quality improvement (QI) opportunities that would lead to improved outcomes. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Met

- The MHP has taken steps to configure CPS data in a way that makes it useful for stakeholder review and has initiated steps to compare the

results with other counties as well as to identify opportunities for QI activity.

Recommendation 9: Ensure discussion of results in multiple forums, i.e., (Quality Improvement Committee (QIC), Cultural Competence Committee (CCC), and Behavioral Health Board (BHB), with detailed documentation of follow-up activity and evidence of continued tracking of that activity. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Partially Met

- The MHP provided evidence of reporting on survey results to a broad array of stakeholders as well as having engaged the Quality Assurance/Performance Improvement (QAPI) Council in further analysis activity.
- The reports and results are not shared with the Behavioral Health Advisory Board, and beneficiaries reported having no knowledge of these reports.

Recommendation 10: Refine the QI goal regarding positive responses to the Consumer Perception Survey (CPS) to be more specific, related to activity that would define a possible improvement effort.

Status: Partially Met

- The MHP dropped the goal regarding positive responses and instead included one related to analyzing grievances and appeals and providing recommendations to prevent future occurrences.
- This recommendation was discussed in the site review and will not be carried over this review year.

Foster Care Recommendations

Recommendation 11: Closely track FC timeliness for first request to first offered psychiatry appointment for the entire system and assess and address any identified performance problems.

Status: Met

- The MHP provided a dashboard that displays monthly detail and annual averages of timeliness performance for this measure.
- The MHP implemented improvements in scheduling psychiatry appointments for foster youth coming in as presumptive transfers, which reportedly expedited scheduling.

- The current non-clinical PIP addresses psychiatry timeliness for the children's system of care, evaluating two strategies intended to improve performance on this measure.
- Because this recommendation is now being addressed in a PIP, it will not be carried over to next year.

Recommendation 12: Ensure that timeliness for first offered psychiatry appointment for foster youth meets the standard.

Status: Partially Met

- The FC Dashboard reflects improving timeliness to first offered psychiatry appointments, starting in February 2020, from no appointments meeting the standard to 100 percent meeting it in June.
- Based on implementation of a Timeliness PIP, this recommendation will not be carried forward to next year.

Information Systems Recommendations

Recommendation 13: Review and analyze claim denials for July through December 2018, to establish the cause of the increased claim denial rates.

Status: Met

- The MHP identified multiple reasons for denials, finding incorrect mapping schema within the billing setup of ShareCare.
- Unclaimed services have been methodically examined to understand the impediments and then resolve the set-up problems.

Recommendation 14: Identify and refine business practices to reduce denial rates.

Status: Met

- The MHP has refined its business practices and taken steps to reduce denial rates by correcting system setup errors, changing workflow processes, and educating staff on the use of modifier and service indicators.

Recommendation 15: Ensure that all forms are available to the providers in the electronic library. *(This is a carry-over recommendation from FY 2017-18, 2018-19.)*

Status: Partially Met

- While forms are available on the website, stakeholders reported that they are not always informed when new forms or versions are posted.
- Based on the number of times this issue has been addressed, the recommendation will no longer be carried forward.

Structure and Operations Recommendations

None noted

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
  - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

San Joaquin MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	48,114	16.7%	3,364	29.6%
Latino/Hispanic	132,150	45.9%	3,843	33.8%
African-American	27,776	9.6%	1,602	14.1%
Asian/Pacific Islander	42,503	14.8%	1,083	9.5%
Native American	795	0.3%	51	0.4%
Other	36,551	12.7%	1,417	12.5%
Total	**287,887**	**100%**	**11,360**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language as per DHCS Mental Health Services Division IN 13-09. The MHP follows more recent Medi-Cal eligibility data, consistent with DHCS Behavioral Health Information Notice 20-070, wherein Cambodian is no longer identified as a threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

San Joaquin MHP		
Threshold Language	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
Spanish	948	8.3%
Cambodian	210	1.8%
Other Languages	10,202	89.8%
Total	**11,360**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

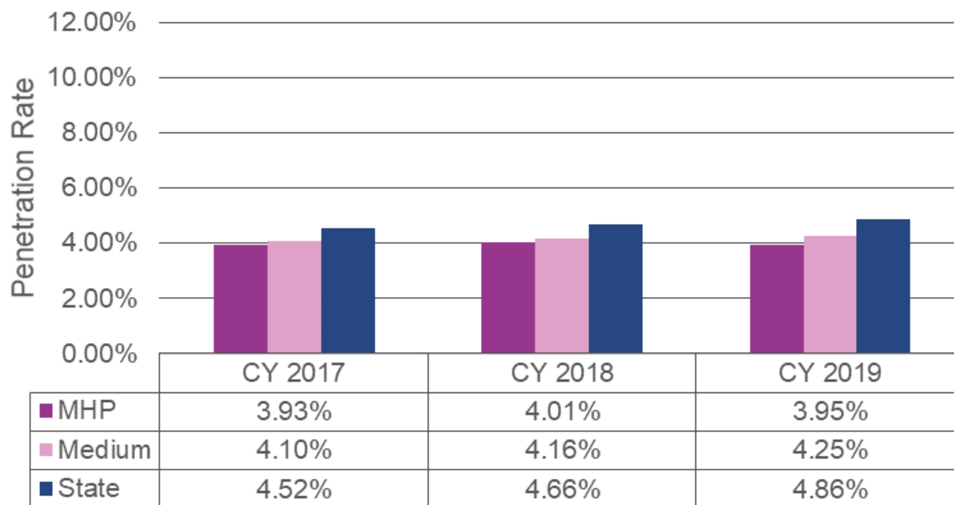
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the San Joaquin MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19

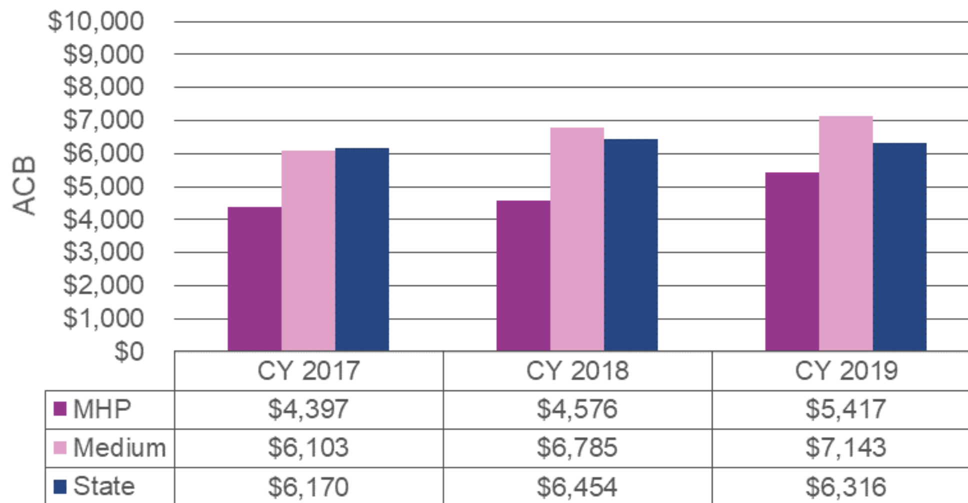
San Joaquin MHP



	CY 2017	CY 2018	CY 2019
MHP	3.93%	4.01%	3.95%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

Figure 2: Overall ACB CY 2017-19

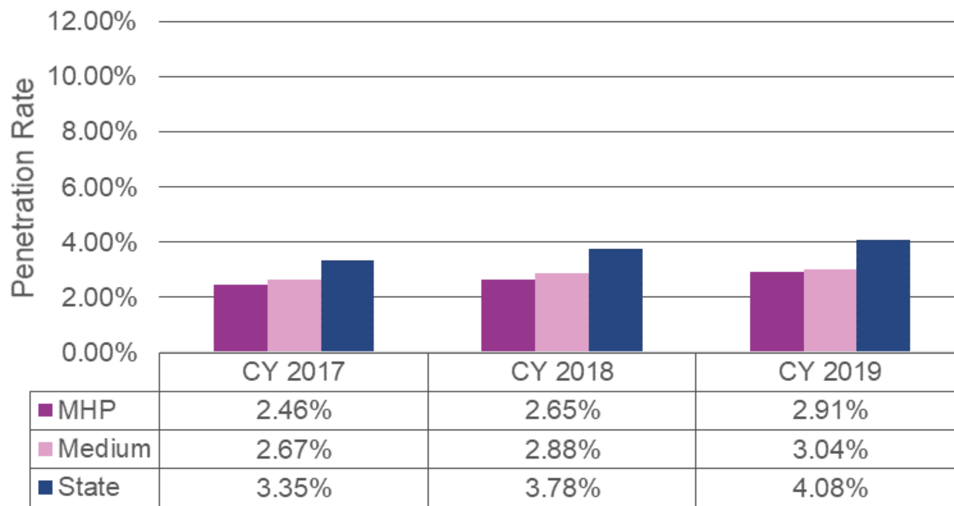
San Joaquin MHP



	CY 2017	CY 2018	CY 2019
MHP	$4,397	$4,576	$5,417
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

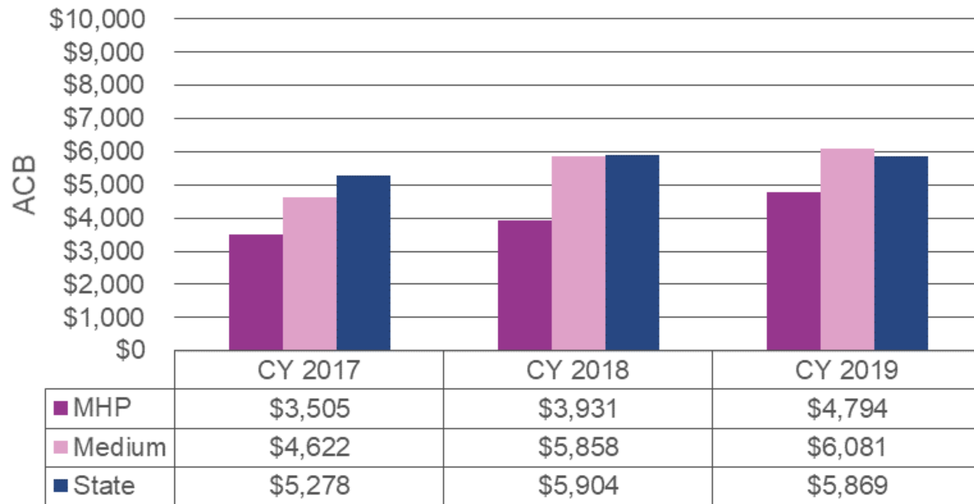
Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	2.46%	2.65%	2.91%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

Figure 4: Latino/Hispanic ACB CY 2017-19

San Joaquin MHP



	CY 2017	CY 2018	CY 2019
MHP	$3,505	$3,931	$4,794
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19

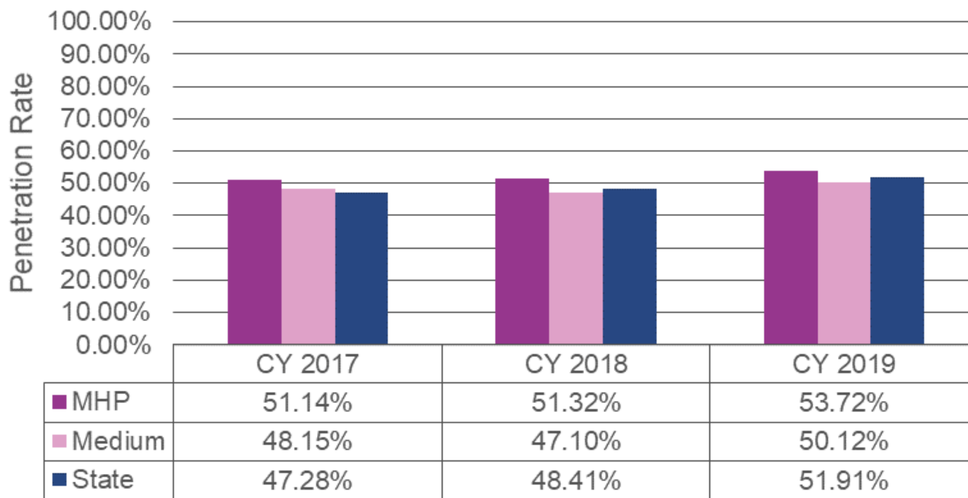
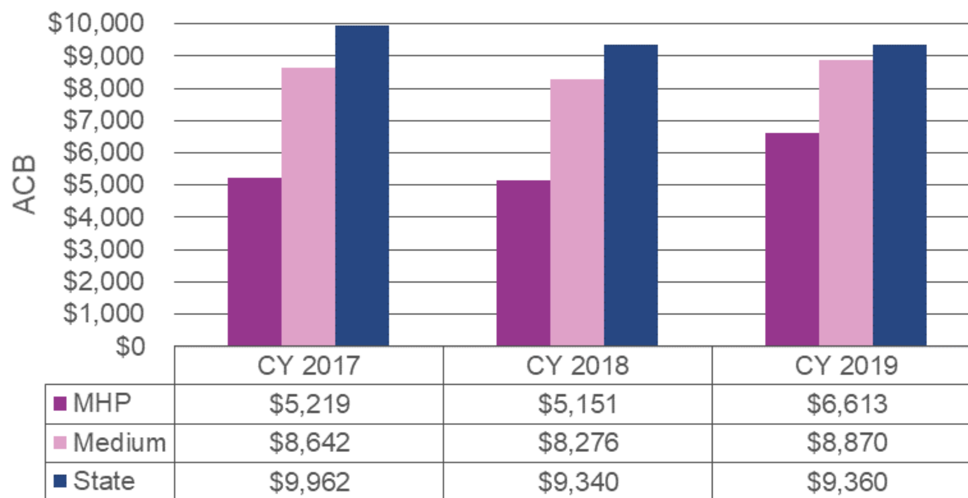


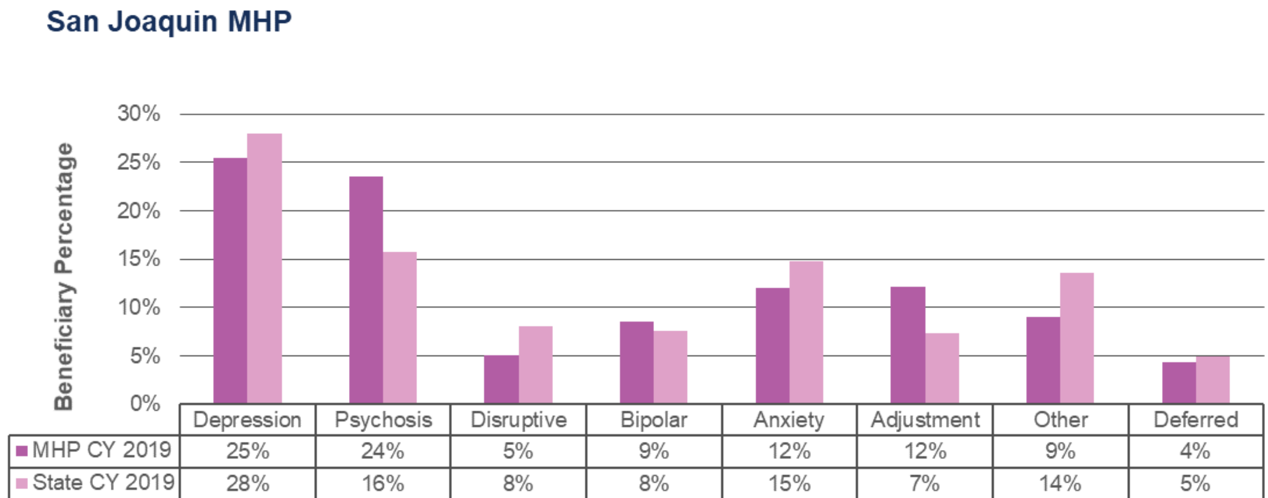
Figure 6: FC ACB CY 2017-19



Diagnostic Categories

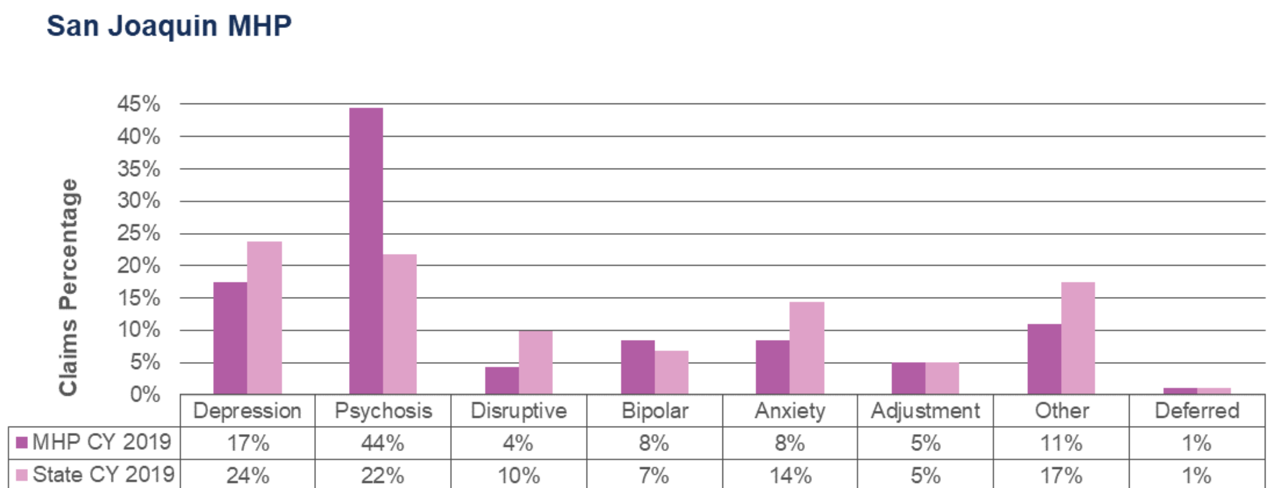
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	25%	24%	5%	9%	12%	12%	9%	4%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	17%	44%	4%	8%	8%	5%	11%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

San Joaquin MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	319	11,360	2.81%	$61,359	$19,573,385	31.81%
	CY 2018	277	11,888	2.33%	$58,706	$16,261,425	29.89%
	CY 2017	256	11,835	2.16%	$58,606	$15,003,056	28.83%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

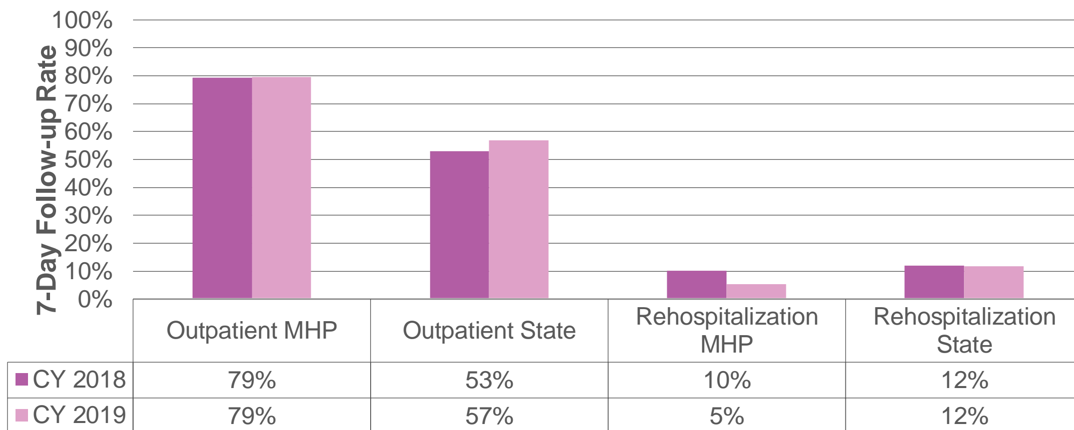
Table 4: Psychiatric Inpatient Utilization CY 2017-19

San Joaquin MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	670	1,228	11.28	7.80	$16,726	$10,535	$11,206,347
CY 2018	657	1,289	9.70	7.63	$15,486	$9,772	$10,174,071
CY 2017	595	1,242	10.03	7.36	$14,526	$9,737	$8,643,245

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

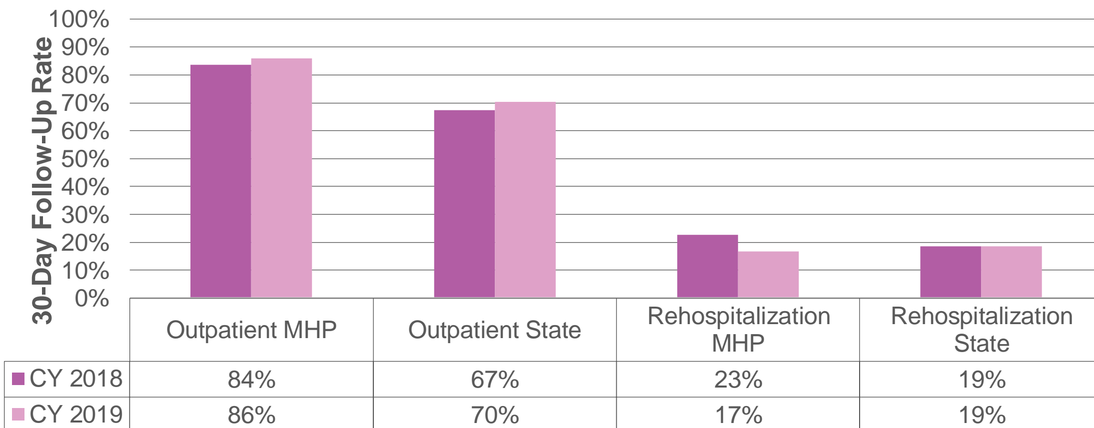
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	79%	53%	10%	12%
CY 2019	79%	57%	5%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	84%	67%	23%	19%
CY 2019	86%	70%	17%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

San Joaquin MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated two PIPs as shown below.

Table 5 : PIPs Submitted by San Joaquin MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Timely Rehabilitation Services Post CSU and Hospital Discharge
Non-Clinical	1	Children's Psychiatric Timeliness

Clinical PIP

Table 6: General PIP Information – Clinical PIP

	San Joaquin MHP
PIP Title	Timely Rehabilitation Services Post CSU and Hospital Discharge
PIP Aim Statement	"Can SJCBHS reduce adult FSP 30-day Crisis Stabilization Unit readmission rate from 38% to 28% and 30-day psychiatric rehospitalization rate from 27% to 20% by actively engaging FSP consumers in psychosocial rehabilitation services within 3 days of discharge?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply)	

	San Joaquin MHP
☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP includes all Transition Age Youth (TAY) and adult beneficiaries being served at Stockton's Community Adult Treatment Services (CATS) Clinic who are discharged from either a hospital or the Crisis Stabilization Unit (CSU). This clinic provides intensive services for TAY and adults who meet criteria for Full Service Partnership (FSP) level of care. Included indicators for this level of care are involvement in the criminal justice system, homeless or at risk of homelessness, frequent use of emergency services, or risk of institutionalization.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Case managers will establish contact with anyone on their caseload who is discharged from a hospital or the CSU within three business days of discharge and provide at least one psychosocial rehabilitation counseling session.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS

PIP Interventions (Changes tested in the PIP)
operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): None

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of FSP clients who readmit to psychiatric hospitals within 30 days of hospital discharge	FY 2018-19	100 FSP clients Rate = 27%	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of FSP clients who readmit to the CSU within 30 days of CSU discharge	FY 2018-19	234 FSP clients Rate = 37.6%	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of FSP clients who receive psychosocial rehabilitation services within three business	FY 2018-19	Rate = 24%	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
days of psychiatric hospital discharge						Other (specify):
Percent of FSP clients who receive psychosocial rehabilitation services within three business days of CSU discharge	FY 2018-19	Rate = 20.3%	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☐ 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.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
The intervention started on September 1, 2020, and by the time of the onsite review (six weeks later), the numbers of discharges were too low to evaluate. Therefore, none of the validation ratings above were applicable. The PIP is well-constructed, however, and has a strong chance of yielding the intended results.						
EQRO recommendations for improvement of PIP: • Ensure that definitions related to the intervention are specific so they can be clearly evaluated for fidelity.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Discussed details of implementing the intervention to confirm that the new process is a significant change and that there are specific metrics to reflect implementation.						

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

	San Joaquin MHP
PIP Title	Children’s Psychiatric Timeliness
PIP Aim Statement	Can SJCBHS increase the proportion of children who are *offered* an initial psychiatric appointment within 15 days of parent/caregiver request from a baseline of 58% in FY 19/20, to 70% by January 2021, and 80% by March 2021, by: • Scheduling a psychiatric appointment on the same day as parent/guardian request; and • Offering the first available opening at a different clinic, if there is an earlier time slot available.
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases)	

	San Joaquin MHP
☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study population is all children/youth (<18), who meet medical necessity for Specialty Mental Health (SMHS) services, whose parent or guardian request an initial psychiatric evaluation. Initial requests for psychiatric evaluations may occur during a clinical intake assessment or any period following and are often made through consultation with the clinical team and after non-psychiatric interventions are attempted without clinical progress.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The MHP is changing its scheduling practices as follows: 1. Rather than wait for supervisor approval (which was taking up to two weeks) to schedule a psychiatric appointment, at the time of determination of need/appropriateness the clinician will initiate a time-sensitive referral to the front desk for scheduling, which is expected to occur within one business day. 2. The family will be offered an appointment at the other county clinic if one is available sooner and the family is agreeable.
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):

PIP Interventions (Changes tested in the PIP)
None

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of children who are offered an initial psychiatric evaluation appointment within 15 business days of parent/guardian request	FY 2019 -20	Baseline: 304 Rate: 58.2%	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Number of first requests offered an earlier appointment at a different clinic		NA	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Number of first requests who accept earlier appointment at a different clinic		NA	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of offered appointments scheduled within 24 hours of initial request		NA	☒ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	

Validation phase:

☐ 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.

<table>
<tr><th>Performance Measures</th><th>Baseline Year</th><th>Baseline Sample Size and Rate</th><th>Most Recent Remeasurement Year</th><th>Most Recent Remeasurement Sample Size and Rate (if applicable)</th><th>Demonstrated Performance Improvement</th><th>Statistically Significant Change in Performance</th></tr>
<tr><td colspan="7">Interventions for this PIP began August 3, 2020, and at the time of this submission, the MHP did not have measurement data that would allow for a validation rating.</td></tr>
<tr><td colspan="7">EQRO recommendations for improvement of PIP:
• Ensure that Tracy and Manteca clinics are not adversely affected by including them in the new scheduling strategy.
• Make clear that the PIP includes foster youth, and establish performance targets for that population.</td></tr>
<tr><td colspan="7">The technical assistance (TA) provided to the MHP by CalEQRO consisted of:
• Discussed Phase II scheduling plan and possible impact on timely scheduling at Tracy and Manteca clinics.
• Phase II interventions aimed at developing a scheduling system and agreements with Tracy and Manteca clinics are actually administrative tasks associated with expanding the reach of the primary interventions.</td></tr>
</table>

*PIP is in planning and implementation phase if NA is checked.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
San Joaquin	1.50%	3.00%	3.00%	3.00%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

- The current percent of budget devoted to IT is half what it was in the three preceding years and is less than half of the statewide average for FY 2019-20. This level of funding is inadequate for the management of the combination of Clinician's Gateway/ShareCare systems.

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another county department
☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☒ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The MHP has prioritized IT plans for a more robust and hardened cyber security setup and is currently implementing Thyotic privileged account management solutions and Spirion data privacy manager.
- Although MHP IT staff are assigned to the superagency, Health Care Services, the MHP does have its own IS Security Officer.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	64.83%
Contract providers	35.07%
Network providers	0.1%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

- The MHP increased the use of community-based organizations by 17.07 percent from last year.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	9.1	0	1.4	1.4
2019-20	13	1	1	0
2018-19	13	1	1	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0.60	0	0	0
2019-20	0.60	0	0	0
2018-19	10	0	0	0

The following should be noted with regard to the above information:

- The MHP reported that data analytic capacity has not changed over the past three years. A prior report of ten staff in 2018 was referring to the management team and not specifically to data analytic staff.
- In Table 15, data reported for FY 2018-19 and FY 2019-20 reflected IT capacity for the MHP and DMC-ODS combined. Total combined technology staffing for the MHP has not changed over the past three years. The MH IT staff are now segregated from the DMC-ODS.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	157	34	191
Clinical Healthcare Professional	579	347	926
Clinical Peer Specialist	5	1	6
Quality Improvement	7	1	8
Total	748	383	1,131

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	9.10	7.87
Total EHR Users Supported by IT (Source: Table 17)	1,131.00	572.00
Ratio of IT Staff to EHR Users	1:124	1:73

- A ratio of 1:124 versus the medium MHP average of 1:73 is consistent with the low IT budget noted in Table 12. The MHP is deficient in IT resources compared to its peers, resulting in a negative impact on its ability to achieve its goals.
- The support ratio for IT is underrepresented, as there are a number of external users from CBOs who utilize the EHR and require assistance. There are approximately 130 contract providers from 12 organizations.

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☐	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	54
Number of county-operated telehealth sites	31
Number of contract providers' telehealth sites	23

Telehealth Services	Count
Total number of beneficiaries served via telehealth during the last 12 months	9961
• Adults	4,875
• Children/Youth	3,989
• Older Adults	1,097
Total Number of telehealth encounters (services) provided during the last 12 months:	86,445

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☒ For linguistic capacity or expansion
☒ To serve outlying areas within the county
☒ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e. children/youth or older adult)
☒ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- The MHP has directed a proportion of staff to provide services remotely and/or work adjusted schedules to reduce the spread of COVID-19.
- Wearing a face mask and undergoing a temperature check are mandatory for all staff and visitors to facilities. Beneficiaries are educated and encouraged to wear masks as well.
- The MHP is able to offer an increased number of mental health services via telehealth, thus reducing the time between requests for services to first offered appointments by providing phone assessments.

- The agency's Nurse Manager and Assistant Manager work directly with San Joaquin County Public Health Services on COVID-19 initiatives and testing.
- The 24-Hour Services division holds court hearings and 5150 certification hearings via teleconference.
- The Crisis Stabilization Unit and Psychiatric Health Facility restricted visitors and student interns (medical, nursing, and psychiatric technician students).

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☒	Arabic	☐	Armenian	☒	Cambodian
☒	Cantonese	☒	Farsi	☒	Hmong
☐	Korean	☒	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
ASPIRAnet	1
University of Pacific Community Behavioral Intervention Services	1
Children's Home of Stockton	1
Community Re-Entry Program, ILS	1
Cottages	5
Latino Behavioral Health & Recovery Services	1
Parents By Choice	1
Reentry Drug Court	1
SJC Child Abuse Prevention Council	1
Telecare	3
Turning Point	2
Victor Community Support Services Inc.	2
Valley Community Counseling Services	3

Current MHP Operations

- The MHP employs a combination of ShareCare (from the Echo Group) for practice management and Clinician's Gateway (from Krassons, Inc) as the EHR. They are also the contract providers' EHR.
- In response to COVID-19, the MHP bought 50 laptops for staff to use in their residences and promoted the flexibility of allowing the use of personal equipment.
- The MHP has 12 contract providers using telehealth at 23 sites.
- The MHP is a participant in the Health Information Exchange (HIE), Manifest Medx.
- IT support of line staff has seen a dramatic increase now that staff provide services from their residences with their personal equipment.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
ShareCare	Practice Management	The Echo Group	2	MHP
Clinicians Gateway	EHR	Krasson, Inc.	12	MHP

The MHP's Priorities for the Coming Year

- Timeliness data collection project
- ShareCare MCO implementation
- Voice over Internet Protocol (VoIP) implementation (outlier clinics)
- ShareCare Utilization Control implementation
- Client Treatment Plan for Mental Health Services
- Behavioral Health Services reporting tools update (continue development)
- Check Point Firewall – add more features
- Thycotic secret server roll out (service account manager)
- Thycotic integration with Securelink
- Network Access Control implementation
- Spirion (HIPAA catalog)
- Quest Lab online order
- Quest Lab result and result processing workflow

Major Changes since Prior Year

- ShareCare implementation project

- VoIP phone implementation
- Check Point Firewall upgrade
- Backup Air Conditioning for DataCenter
- Uninterruptible power supply system upgrade
- Nutanix Update – storage

Other Areas for Improvement

- The MHP's organizational chart indicates that the IS Director reports to the Health Care Services Corporate Information Officer. This limits identification of IS issues in MHP meetings and is not conducive to strategy discussions and decision-making.
- The MHP loses a valuable perspective when they do not have contract providers' voices in committees, especially in the Data Committee group.
- The MHP's IT budget as a percentage of the total MHP budget is less than half that of other medium counties. The ratio of IT employees to systems users is almost half that of other medium counties. The MHP's IT team is under-funded and under-staffed.

Plans for Information Systems Change

- Although the MHP has been using Clinicians' Gateway since 2008, they implemented ShareCare in 2018 and are continuing to work at utilizing its complete billing capabilities.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Clinician's Gateway	☒	☐	☐	☐
Assessments	Clinician's Gateway	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Clinician's Gateway	☐	☒	☐	☐
Electronic Signature—MHP Beneficiary	Clinician's Gateway	☒	☐	☐	☐
Laboratory results (eLab)	Clinician's Gateway	☒	☐	☐	☐
Level of Care/Level of Service	Clinician's Gateway	☒	☐	☐	☐
Outcomes	Clinician's Gateway	☒	☐	☐	☐
Prescriptions (eRx)	RxNT	☒	☐	☐	☐
Progress Notes	Clinician's Gateway	☒	☐	☐	☐
Referral Management	Clinician's Gateway	☒	☐	☐	☐
Treatment Plans	Clinician's Gateway	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		10	1	1	0
FY 2019-20 Summary Totals for EHR Functionality:		9	0	3	0
FY 2018-19 Summary Totals for EHR Functionality:		9	0	3	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- The MHP implemented eLab last year.
- The MHP is standing-up Document Imaging/Storage functionality.
- The MHP's official Chart of Record continues to be a hybrid as Primary Care Coordination, Hospital Release Documents, and Lab Results remain on paper.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	100%	Daily

Type of Input Method	Percent Used	Frequency
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Not Applicable		

- The contract providers have full access to the MHP's EHR using direct data entry.

Personal Health Record (PHR)

The beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Not Applicable

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

- The following section is not applicable.

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure Text Messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

☐ Dimension Reports application
☐ Web-based application, including your EHR system, supported by Vendor or ASP Staff
☐ Web-based application, supported by MHP or DMC staff
☐ Local SQL Database, supported by MHP/Health/County staff
☒ Local Excel Worksheet or Access Database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

San Joaquin MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**230,140**	**$70,146,510**	**11,285**	**$3,250,262**	**4.43%**	**$66,896,248**	**$57,900,653**
JAN19	19,410	$5,750,650	1,033	$239,712	4.00%	$5,510,938	$4,652,199
FEB19	19,317	$5,521,370	700	$194,715	3.41%	$5,326,655	$4,539,512
MAR19	21,179	$6,010,492	622	$173,646	2.81%	$5,836,846	$4,984,194
APR19	22,505	$6,357,860	659	$182,028	2.78%	$6,175,832	$5,263,798
MAY19	21,316	$6,369,548	1,294	$401,707	5.93%	$5,967,841	$4,915,304
JUN19	17,893	$5,495,391	1,548	$445,206	7.49%	$5,050,185	$4,061,587
JUL19	18,836	$6,010,796	750	$222,521	3.57%	$5,788,275	$5,187,581
AUG19	18,980	$6,137,807	878	$246,270	3.86%	$5,891,537	$5,299,544
SEP19	18,193	$5,799,900	799	$223,782	3.72%	$5,576,118	$5,031,215
OCT19	19,256	$5,958,941	708	$196,164	3.19%	$5,762,777	$5,231,876
NOV19	16,838	$5,166,998	692	$190,783	3.56%	$4,976,215	$4,512,791
DEC19	16,417	$5,566,758	1,602	$533,729	8.75%	$5,033,029	$4,221,052

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments by Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

- The MHP's denied claims rate of 4.43 percent is an increase from last year's rate of 3.41 percent and is above the 2.99 percent statewide average.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

San Joaquin MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible or non-covered charges.	3,137	$1,174,500	36%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	2,919	$788,366	24%
Medicare or Other Health Coverage must be billed before submission of claim.	2,508	$574,230	18%
Beneficiary not eligible.	1,314	$400,508	12%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	813	$171,380	5%
Total	11,285	$3,250,262	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with reasons “Medicare or Other Health Coverage must be billed before submission of claim.” and “NPI, Type 2 credentialing data missing, incomplete, or invalid.” are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Joaquin, the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted two consumer and family member focus groups, no stakeholder interviews, seven staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries. In addition, the MHP reported that:

- Transportation services are available upon request, primarily provided by the MHP and some by the health plan.
- Hearing-impaired beneficiaries have access to a video interpreting machine, and the MHP has a contract with the Nor Cal Center for Deafness to provide ASL services.
- Provision of telehealth services has increased since COVID-19 restrictions limited routine face-to-face psychiatry appointments.
- Four mobile crisis response teams operate throughout the county, including a team that collaborates with Law Enforcement to respond all hours of the day and night.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	1
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	58
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	4

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The 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 the CFMs for their participation.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group consisted of three parents of adolescent and adult beneficiaries, one of whom started services within the past year. The focus group was held on Zoom.
Total number of participants	Three
Number of participants who initiated services during the previous 12 months	One
Interpreter used	No
Summary of the main findings of the focus group: While the EQRO conducted the group with the three participants, because there were so few participants, summarizing and using their responses would not contribute meaningfully to this report.	

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adults who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group consisted of Latino/Hispanic and Caucasian men and women who are both English and Spanish-speaking, three of whom began services within the last 12 months. Participants reflected enrollment in both MH and SUD services. The focus group was held virtually on Zoom.
Total number of participants	Six
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group:	
Access - new beneficiaries	None noted
Access – overall	Law enforcement played a role in connecting several participants to mental health services. All participants agreed that transportation is readily available and that everyone can get into the clinics.
Timeliness	Participants reported mixed experiences in timely access to initial service, ranging from same day to two months. Those on medication reported satisfactory access to their prescribers and to refills on their medication.
Urgent care and resource support	All participants reported having resources for urgent care, mostly relying on their case managers.
Quality	All participants agreed they are involved in their treatment planning; some have Wellness Recovery Action Plans (WRAP) and reported that the wellness center and Gipson

Topic	Description
	Center provide information and support for their WRAP plans. Those participants who use the wellness center or Gipson reported high satisfaction, particularly with employment support activities such as resume development as well as independent living skills.
Peer employment	Some participants at one time worked at the wellness center; however, most had little knowledge of available positions.
Structure and operations	None noted.
Recommendations from this focus group	• Additional groups through the MHP (rather than wellness center), such as anger management, time management. • Improved support for people with dual diagnoses (MH/SUD): housing, treatment in particular.
Any best practices or innovations (optional)	None noted

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 34 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 34: Access to Care Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>1A</td><td>Service Access and Availability</td><td>14</td><td>14</td></tr>
<tr><td colspan="4">The MHP has moved to virtual service delivery for a high proportion of both psychiatry and MH clinical and case management services. They have increased the use of telepsychiatry, phone sessions, and Zoom as vehicles to address the restrictions related to the COVID-19 virus.

The access line is now combined with DMC-ODS; the caller is linked to a BH specialist for screening for level of care (LOC), and a warm connection is made with an appropriate provider. The MHP (along with DMC-ODS) is in the process of selecting a call management system that will track wait times, dropped calls, and referrals to mental health services.

The website has been updated and is more user-friendly, including easier access to information in other languages. The MHP anticipates full translation of the website to be completed in early 2021.</td></tr>
<tr><td>1B</td><td>Capacity Management</td><td>10</td><td>9</td></tr>
</table>

Component		Maximum Possible	MHP Score
The MHP has developed a "500" report that details service delivery of all enrollees and can be customized and analyzed by multiple variables. Stakeholders reported good communication regarding capacity management, including regular meetings focused on caseload distribution across the network. Stakeholders reported that the psychiatric health facility (PHF) length of stay (LOS) is increasing, in part because of a decrease in the number of board and care beds in the county and competition for those beds from other counties. Despite having made significant progress on filling large numbers of vacancies on the CYS team, stakeholders from multiple program areas reported ongoing staffing shortages, resulting in over-burdened caseloads and supervisors doing more direct service than supervising.			
1C	Integration and Collaboration	24	21
The MHP reported they are working to improve the referral process between MH and SUD providers. The LEAD (jail diversion) program, a BH partnership with the Public Defender's office that started a few years ago, continues to be successful.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
The MHP follows the state standards for all timeliness tracking and reporting. A timeliness application developed by the MHP captures all required data elements and is now used directly by all contract providers. Average times for this metric were within the target standard except for foster care, which averaged 19 days. At the time of the review, the MHP submitted dashboards that show dramatic improvement in this metric over the last four months and			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">discussed steps they had taken to investigate the problems and implement resolutions.</td></tr>
<tr><td>2B</td><td>First Offered Psychiatry Appointment</td><td>12</td><td>10</td></tr>
<tr><td colspan="4">Sixty-eight percent of all appointments met the 15-day standard for this metric, with children and foster care at 56.5 and 56.6 percent respectively. Of note is that the children and youth and foster care performance is almost twice that of FY 2019-20, while adult timeliness has decreased from 88.4 percent to 71.3 percent.

The MHP is currently recruiting for two new psychiatrists and does have potential candidates.

The process for scheduling appointments for both adults and youth includes a daily, highly intensive review of ongoing and urgent need as well as new beneficiaries requiring assessments.</td></tr>
<tr><td>2C</td><td>Timely Appointments for Urgent Conditions</td><td>18</td><td>18</td></tr>
<tr><td colspan="4">Overall, 95.3 percent of appointments met the MHP’s standard of 120 minutes to respond. The longest wait was 67 minutes.</td></tr>
<tr><td>2D</td><td>Timely Access to Follow-up Appointments after Hospitalization</td><td>10</td><td>10</td></tr>
<tr><td colspan="4">Adult follow-up met the seven-day standard 89 percent of the time; children’s appointments met it 70 percent of the time, and foster care, 80 percent.

More recent dashboards reflect considerable improvement for all youth since July 2020, with foster care averaging 1.8 days and all children 2.7 days. The MHP reflected during the review that this improvement is likely attributable to their success in replacing CYS staff who had left in significant numbers last year.

Follow-up procedures for all populations include discharge planning and appointments scheduled prior to discharge, with transportation provided.</td></tr>
<tr><td>2E</td><td>Psychiatric Inpatient Rehospitalizations</td><td>6</td><td>6</td></tr>
<tr><td colspan="4">The readmission rate overall was 13 percent, with adults at 14 percent (the highest), and children at nine percent (the lowest).</td></tr>
<tr><td>2F</td><td>Tracks and Trends No-Shows</td><td>10</td><td>10</td></tr>
</table>

Component	Maximum Possible	MHP Score
No-show rates for non-psychiatry clinicians are exceptionally low, overall at 2.17 percent and foster care at 1.92 percent. The MHP reported that they had investigated the foster care rate and discovered that one contract agency had been under-referring; that has now been addressed. In addition, they are tracking the psychiatry rate, which overall is 14.27 percent, to see if they need to initiate a performance improvement activity.		

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contribute to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	10
The MHP's Cultural Competence Committee did not meet for five about months due to COVID-19; however, it has resumed, and they are working on the evaluation of last year's plan. The primary task in 2020-21 has been the integration of SUD elements into the plan to create one integrated plan. The MHSA Plan includes a detailed analysis of the prevalence of underserved populations and strategies to address low penetrations rates. The MHP does not currently use a data-driven methodology to identify improvement needs, set goals, and evaluate the impact of strategies devised to achieve the goals. They recognize the need and are working on developing this methodology.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	10
The MHP uses a variety of strategies to determine LOC needs and transition beneficiaries across service intensity levels, including frequent review of the CANSA in partnership with the beneficiary. Stakeholders reported that the health plans are receptive to requested transfers to mild/moderate services.			

Component		Maximum Possible	MHP Score
3C	Quality Improvement Plan	10	10
The QI Plan reflects all elements of the EQRO's Key Components as well as all state-required monitoring activity. It also includes some goals established by the MHP based on their QI discussions. Measurable goals or targets are usually established, and performance is documented and reported in various QI committees.			
3D	Quality Management Structure	14	12
The MHP is recruiting additional staff for its QI unit.			
3E	QM Reports Act as a Change Agent in the System	10	10
Minutes of various QI-related committees reflect review of reports and discussion of results. Ongoing development of dashboards that effectively track key performance indicators (KPIs) has enhanced reporting effectiveness.			
3F	Medication Management	12	9
The Pharmacy and Therapeutics (P&T) Committee meets monthly and reviews a variety of issues, including such reports as targeted medication reviews, pharmacy interventions, and PHF review. They discuss metabolic monitoring and ADHD practices, among other topics. Most information is contained in text reports that do not lend themselves to tracking and trending for QI purposes, although they do act on any information in a report that may be problematic. The committee reports monthly to the QI Council (QIC). Prescribers attend weekly team meetings CYS staff; adult coordination is more individual. Program-level problem-solving is done at a monthly meeting with adult program managers and twice monthly with all deputy directors. SB1291 reviews include contractor charts, and all MD notes are seen by the interim Medical Director.			

Beneficiary Progress/Outcomes

In Table 37, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as

capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	13
The MHP uses the Child, Adolescent and Adult Needs and Strengths Assessment (CANSA) for adult and youth treatment planning and outcomes. Contractors produce quarterly aggregated reports as well as sample individual client reports, and all data is contained in Clinician's Gateway, accessible at any time by anyone so-authorized. Current MHP use of this information is not well-defined; they are working with Objective Arts to finalize system-wide aggregated reports.			
4B	Beneficiary Perceptions	10	4
The MHP administers the CPS twice annually and reviews results in QI meetings. They are developing a way to track and trend data and compare their results with those of other counties in order to understand where they might have improvement opportunities. Minutes from the Behavioral Health Board do not reflect discussion of these results.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	11
The MHP contracts for the operation of a peer-run wellness center in Stockton and a medical center-funded one in Manteca; there is also a drop-in center in Stockton run by the University of the Pacific (UOP). Consideration of additional centers in population centers of Lodi and Tracy has stalled in light of current budget concerns.			

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26
The MHP offers all required services other than Day Treatment Intensive and Day Rehabilitation; however, they reported that if needed, they would contract for them.			
5B	Network Enhancements	18	14
The MHP does not have a health homes program and relies on the school system for psychological testing. If necessary, they would contract with a community provider for the testing.			
5C	Subcontracts/Contract Providers	16	16
Subcontractors participate in a wide array of QI and CC committees, and the MHP provided evidence of meetings to discuss access to services, caseloads, and care transitions, among other administrative and clinical issues.			
5D	Stakeholder Engagement	12	11
Family members/parent partners are involved in QI and CC committees as well as in MHSA planning and sit on the MHP Grievance Committee. Minutes from the BH Advisory Board reflect provision of timely and important MHP policy and process changes as well as discussion and information exchange among the MHP staff and stakeholders in attendance. The board meets monthly.			
5E	Peer Employment	8	6
The MHP has 38 budgeted Mental Health Outreach Worker positions, 30 of which are currently filled. There are a few training positions; however, there is no career ladder for peer employees. Contract providers also have peer positions, e.g., in the wellness center as peer recovery coach. The wellness center offers a training program for those with lived experience who are interested in becoming employed or in advancing in their organizations.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of San Joaquin MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The MHP has moved to virtual service delivery for a high proportion of both psychiatry and MH clinical and case management services. They have increased the use of telepsychiatry, phone sessions, and Zoom as vehicles to address the restrictions related to the COVID-19 virus.
- Court hearings and 5150 certification hearings are held via teleconference.
- The MHP contracted for the creation of a High Risk Transition Team to wrap services around individuals discharged from acute care facilities to outpatient services.
- The MHP opened a new FSP for children and youth, providing Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) for eligible non-dependents.
- The MHP contracted for recovery-focused peer navigation services for people moving from crisis services to outpatient.
- Two of the cultural clinics moved into the Stockton outpatient building, improving collaboration and clinical coordination for those beneficiaries.

Strengths:

- A focus on supporting high risk beneficiaries as they move between levels of care should improve their ongoing retention in care that can have a positive impact on their recovery.

- The MHP manages capacity by using data and holding frequent meetings with service providers in which beneficiary needs are discussed, caseloads are reviewed, and referrals are distributed (sometimes traded).
- The “500 Report” is a flexible tool, available for all levels of staff to use for a variety of capacity management and treatment planning purposes.

Opportunities for Improvement:

- None noted

Timeliness of Services

Changes within the Past Year:

- While still significantly below standard, the percent of first offered appointments for psychiatry meeting the 15-day standard almost doubled over FY 2020-21.
- Timeliness for foster care youth accessing initial assessments improved significantly during the last quarter of FY 2019-20 and continues to do so since then. Multiple solutions were implemented to achieve this improvement, including filling a significant number of vacancies, working with a provider to reduce bottlenecks, and increasing expectations of administrative staff.

Strengths:

- The MHP operates an interim care clinic for outpatient beneficiaries who have urgent needs for psychiatry appointments; the clinic can accommodate 12 appointments per day.
- Daily nurses’ meetings focus on immediate beneficiary needs and scheduling changes required to ensure that highest priorities are addressed.
- Contract providers enter timeliness data directly into the MHP’s Timeliness App.
- The MHP tracks timeliness metrics monthly using dashboards that track and trend performance against baselines, allowing them to easily identify looming problems and start to investigate and problem-solve before too much time has elapsed.

Opportunities for Improvement:

- Continued attention to recruiting psychiatrists will be necessary to bring timeliness for psychiatric appointments up to standard.

Quality of Care

Changes within the Past Year:

- The MHP contracted with a new agency to manage crisis residential services; there are two homes, each with 15 or 16 beds. Stakeholders reported improved relationships between the MHP and the service provider, particularly regarding coordination of services.
- The MHP is now doing 5150 training for the whole county, including law enforcement, and has incorporated a more intensive training process and certification procedure.
- The MHP has been working with the DMC-ODS system to incorporate cultural competence planning and activity, particularly related to inclusion of the Culturally and Linguistically Appropriate Services (CLAS) standards.

Strengths:

- The MHP uses a variety of strategies to determine LOC needs and transition beneficiaries across service intensity levels, including frequent review of the CANSA in partnership with the beneficiary.
- Minutes of various QI-related committees reflect review of reports and discussion of results. Ongoing development of dashboards that effectively track key performance indicators (KPIs) has enhanced reporting effectiveness.
- The MHP recognizes the importance of QI and the work involved to both ensure compliance and conduct effective improvement activities and is recruiting for two additional staff for the QI unit.
- The Pharmacy and Therapeutics Committee (P&T) meets monthly and reviews a variety of reports and issues, including tracking metabolic monitoring and ADHD prescribing practices.
- The Interim Medical Director reviews all MHP and contractor MD notes.

Opportunities for Improvement:

- At the time of the review, the Cultural Competence Committee was just back up and running after about five months' hiatus during the early period of COVID-19 operational changes. It is important for this committee to catch up and evaluate its accomplishments and needs and goals in a more data-driven manner.
- The data reviewed by P&T would be much more useful for QI purposes if it were documented in a spreadsheet and/or on a dashboard that allowed for tracking and trending key indicator performance over time.

Beneficiary Outcomes

Changes within the Past Year:

- None noted

Strengths:

- Contractors produce annual aggregated reports of CANSA scores that are reviewed by the QAPI Council.
- The MHP has taken steps to work with the CPS, reviewing the results with multiple levels of staff and contractors and initiating a comparison with other MHPs.

Opportunities for Improvement:

- Information about the results of the CPS is not shared with the Behavioral Health Board, and stakeholders reported having no knowledge of these reports.
- As finances and resources allow, continued planning for wellness centers in Lodi and Tracy would be very beneficial for those communities.

Foster Care

Changes within the Past Year:

- The MHP now has five certified Therapeutic Foster Care (TFC) parents (with one youth placed) and an additional three in the certification process. TFC is managed by a Foster Family Agency with which the MHP subcontracts.
- The MHP and CW did a joint training on Child and Family Team processes during the summer 2020, resulting in better working relationships between the two agencies.

- The MHP improved administrative processes and reports to better track timeliness, service schedules, and presumptive transfers.
- The MHP set up joint, ongoing meetings with CW to address process improvement and best practices related to CFTs.
- An updated memorandum of understanding with the San Joaquin County Probation Department, County Social Services Agency, and the County Office of Education now allows the MHP to share CANS information and fully participate in CFT meetings.

Strengths:

- SB1291 reviews, conducted quarterly, include contractor charts. All required indicators are captured in the review.
- Stakeholders expressed appreciation of the MHP's leadership in developing a more robust FC process.

Opportunities for Improvement:

- Finalizing the Objective Arts reports that aggregate CANS and PSC-35 data will yield valuable information for the MHP, both clinical and administrative/financial.

Information Systems

Changes within the Past Year:

- The MHP continues to harden its IT system by ensuring backup air conditioning for the data center, providing an uninterruptible power supply, and upgrading the firewall.
- The addition of communication features available through the implementation of VoIP increases the productivity and effectiveness of staff.

Strengths:

- The MHP supports a twice monthly Data Committee that includes ambassadors from each program along with QI and IT staff. They invite subject matter experts to attend as needed.
- The MHP produces the '500 Report' which provides detailed client management information. Individualized reports, based on criteria selected as appropriate for various levels of staff, are also produced and regularly accessed.

- The MHP has prioritized refining their billing functionality, including validating that insurance priorities and modalities conform to state regulations, thereby decreasing the number of services being denied.

Opportunities for Improvement:

- The perspective of contract providers on IS functionality is valuable and is currently missing, as they are not included in the Data Committee group.
- The MHP's IS operation is under-funded and under-staffed. The IT budget, as a percentage of the MHP budget is 1.50 percent which is less than half the average of other medium counties which was 3.28 percent in FY 2019-20. Its number of system users supported by each IT employee is currently one IT staff for 124 users which is almost twice the number of system users supported in other medium counties which were one IT staff supporting 73 users in FY 2019-20.
- The EHR is a vital strategic tool for the MHP; however, the present organizational structure of the IS Director reporting to the Health Care Services superagency is not conducive to focused strategy discussions and decisions.

Structure and Operations

Changes within the Past Year:

- Several senior leadership positions turned over, including the Medical Director. At the time of the review, the MHP had identified two qualified candidates.

Strengths:

- Stakeholders reported that with the MHP taking over responsibility for training on 5150s, there has been an increase in the quality and quantity of information contained in the certifications.
- Family members/parent partners participate regularly in a wide array of QI, CC, and MHSA planning committees
- Contract providers consistently praised the MHP for being a valued and active partner. There were multiple comments about the continuing improvement in communication and transparency.
- Contractors participate in a wide array of QI and CC committees; the MHP provided evidence of meetings to discuss access to services, caseloads, and care transitions, among other administrative and clinical issues.

Opportunities for Improvement:

- The Finance Division would benefit from the development of desk manuals for each of its procedures to pass working knowledge from one generation of staff to the next.
- Staff reported continuing morale problems, in part due to feeling that senior management does not recognize nor acknowledge the burden of their work (in general, given vacancies, and with COVID-19, increased pressures related to schedules, risk, beneficiary need).
- Other than a few training-level positions, there continues to be no career ladder for peer employees within the MHP. Continued exploration of the possibilities, as the budget allows, should be pursued.

FY 2020-21 Recommendations

PIP Status

- **None noted**

Access to Care

- **None noted**

Timeliness of Services

Recommendation 1: Ensure that timeliness for first psychiatry appointments meets the 15-business day standard for all populations.

Quality of Care

Recommendation 2: Include measurable goals for increasing services to underserved populations in the Cultural Competence (CC) Plan, and track performance throughout the year using reliable data.

Recommendation 3: Develop and implement a method to track and trend the results of medication monitoring activity; report results at the Pharmacy and Therapeutics Committee (P&T) and identify quality improvement (QI) opportunities based on the data.

Beneficiary Outcomes

Recommendation 4: Ensure that consumers receive information related to the results of the Consumer Perception Survey (CPS) and any quality QI activity that is generated from those outcomes. The Behavioral Health Advisory Board agenda should include this information as it becomes available. *(This is a carry-over recommendation from FYs 2018-19 and 2020-21.)*

Recommendation 5: Finalize Objective Arts' aggregated CANS and PSC-35 reports and define and operationalize an analysis plan.

Foster Care

- **None noted**

Information Systems

Recommendation 6: Work with the Health Care Services Agency to ensure that there is a high-level MHP IT Director who reports to the MHP Director or Deputy.

Recommendation 7: Add contract providers to the Data Committee group in order to incorporate their experience and input into problem-solving and decision-making.

Structure and Operations

Recommendation 8: Continue exploration of options for development of a more robust peer career ladder. *(This is a follow-up recommendation from FYs 2018-19 and 2020-21.)*

Recommendation 9: Develop a process and formalized work product to effectively pass on working knowledge from one generation of staff to the next.

Recommendation 10: Assess and address staff morale issues, including giving consideration to creating a representative committee to identify problem areas and generate and help implement solutions.

SITE REVIEW PROCESS BARRIERS

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

- Due to ongoing restrictions on face-to-face gatherings due to the COVID-19 pandemic, all sessions were conducted virtually, on Zoom. In particular, beneficiary focus groups were difficult to conduct as participants were wearing masks and sitting at a distance from each other and the microphone/speaker.
- For the above reason, the EQRO was not able to visit contractor sites or wellness centers, nor participate in any in-person sessions.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

San Joaquin MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Harriet Markell, Lead Quality Reviewer
Olivia Kozarev, Quality Reviewer
Lamar Brandysky, Information Technology Reviewer
Deb Strong, Consumer/Family Member Consultant

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

Sites of MHP Review

All sessions were held virtually on ZOOM

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Akeem Lewis	Marsha	Executive Director	Victor Community Support Services
Alcantar	Ezequiel	Mental Health Outreach Worker	BHS/CYS
Amador	Keith	Mental Health Clinician III	BHS/Adult
Anderson	Vanessa	Deputy Director	BHS/Finance
Ansari	Shaukat	Lead Child Psychiatrist	BHS/CYS
Balmaceda	Angelo	Management Analyst/Ethnic Services Manager	BHS/Admin
Barclay	Jacob	Office Supervisor	BHS/CYS
Bickham	Donna	Deputy Director	BHS/QAPI
Black	Tracey	Case Management Director	God Love Outreach
Borillo	Giselle	Chief Mental Health Clinician	BHS/24-Hour Services
Brocco	Ben	Mental Health Specialist III	BHS/Adult
Camello	Bena	Mental Health Clinician III	BHS/24-Hour Services
Cassettari	Donna	Chief Mental Health Clinician	BHS/CYS
Castleman	Raksmey	Program Administrator	Telecare
Chavez	April	Mental Health Clinician III	BHS/Adults
Chukwuka	Ogiram	Chief Mental Health Clinician	BHS/Adults
Cross	Robin	Senior Office Assistant	BHS/Adult/Older Adult
DeWitte	Tiffany	Deputy Director	BHS/Adults/Older Adults
Dunn	Cara	Deputy Director	BHS/Admin

Last Name	First Name	Position	Agency
Elias	Stephen	Mental Health Clinician I	BHS/CYS
Fabian	Todd	Program Manager	Gipson Center
Fenner	Kendra	Office Secretary	BHS/CYS
Flores	Courtney	Interim Deputy Director	BHS/CYS
Garcia	Julio	Mental Health Clinician III	BHS/JDD
Gordon	Yvonne	Chief Mental Health Clinician	BHS/24-Hour Services
Gutierrez	Antonio	MH Clinician III	Children's
Hannah	Kathy	Deputy Director	BHS/24-hour Services
Hart	Robert	Interim Medical Director	BHS
Helsby	Sherri	Chief Mental Health Clinician	BHS/Adults
Hernandez	Alfredo	Senior Office Assistant	BHS/Adult
Herrick	Kara	Chief Mental Health Clinician	BHS/Adult
Hollowell	Shirley	Nurse Department Management	BHS/Outpatient
Hood	Keturah	Clinical Director	God Love Outreach
Howell	Yvette	Mental Health Outreach Worker	BHS/24 Hour Services
Hudson	Dana	Mental Health Clinician III	BHS/Adults
Hutchins	Frances	Associate Director	BHS/Admin
Johnson	Curtis	Peer Employee	The Wellness Center
Kavanagh	Priscilla	Mental Health Clinician II	BHS/Adult
Kooger	Giana	Executive Director	Victor Community Support Services
Lambert	Rehka	Mental Health Clinician II	BHS/24-Hour Services

Last Name	First Name	Position	Agency
Lowe	Cassie	Program Director	Child Abuse Prevention Council
McClary	Mark	Peer Employee	The Wellness Center
McHenry	Heidi	Sr. Psychiatric Technician	BHS/Adult
Molina	Rico	Chief Mental Health Clinician	BHS/JDD
Morales	Leonardo	Mental Health Clinician II	BHS/24-Hour Services
Morris	Robert	Application Analyst IV	BHS/IS
Nunez	Jaime	Chief Mental Health Clinician	BHS/CYS
Owen	Jessica	Program Director	God Love Outreach
Pollock	Leora	Mental Health Clinician III	BHS/CYS
Poulos	Cynthia	Staff Nurse IV	BHS/QAPI
Roberts	Sharmaine	Chief Mental Health Clinician	BHS/Adults
Rose	Betsey	Deputy Director	BHS/SUD/Justice Decriminalization Division (JDD)
Saelee	Cindy	Mental Health Clinician III	BHS/Adult
San Miguel	Carmella	Mental Health Specialist II	BHS/CYS
Santos	Marc	Sr. Psychiatric Technician	BHS/QAPI
Spruill	Jennifer	Chief Mental Health Clinician	BHS/JDD
Stanley	Anastacia	Mental Health Clinician III	BHS/CYS
Stendardo	Chantal	Compliance Officer/Chief Mental Health Clinician	BHS/Admin
Susskind	Jennifer	Consultant	Praxis Associates

Last Name	First Name	Position	Agency
Tutupalli	Lohit	Pharmacy Manager	BHS/Pharmacy
Vartan	Tony	Director	BHS/Admin
Vieira	Fay	Chief Mental Health Clinician	BHS/CYS
Viles-Reed	Theresa	Program Manager	Valley Community Counseling Services
Williams	Wendy	Mental Health Clinician III	BHS/24-Hour Services
Wilson-Parish	Kathleen	Chief Mental Health Clinician	BHS/Adults
Wright	Denisha	Mental Health Clinician III	BHS/CYS
Yim	Donna	IS Manager	BHS/IS
Yocham	Amanda	Chief Mental Health Clinician	BHS/CYS
	Jerima	Mental Health Outreach Worker	BHS
	Matthew	Mental Health Outreach Worker	BHS/CYS
	Debbie	Mental Health Outreach Worker	BHS/CYS

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

San Joaquin MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	70,332	2,814	4.00%	$12,460,887	$4,428

Table C2 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

San Joaquin MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	10,773	94.83%	93.31%	$35,477,923	$3,293	$3,998	57.65%	59.06%
>$20K - $30K	268	2.36%	3.20%	$6,489,473	$24,214	$24,251	10.54%	12.29%
>$30K	319	2.81%	3.49%	$19,573,385	$61,359	$51,883	31.81%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
n/a (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version