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

SAN LUIS OBISPO MHP DRAFT REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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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 Luis Obispo 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 — Southern

MHP Location — San Luis Obispo

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 3,694

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS MHSD Information Notice (IN) 13-09.

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 EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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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 2. 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.

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 review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 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: For the clinical PIP, include a measure of beneficiary anxiety prior to the start of the intervention as well as after.

Status: Not Met

- The purpose of the clinical PIP is to improve the attendance or show rate for post-psychiatric health facility (PHF) follow-up appointments. The MHP posits that anxiety is a barrier to attending those appointments, particularly for individuals who are homeless and not already linked to outpatient services.
- The PIP team did not provide (1) data suggesting that anxiety is a cause of the problem or (2) data on current levels of anxiety for the study population or a control group.

Recommendation 2: For the non-clinical PIP, revise the study population to be beneficiaries who missed outpatient appointments and provide relevant data.

Status: Met

- The MHP has shifted the topic of its non-clinical PIP from the previous year. The PIP now focuses on utilizing several interventions to reduce the no-show rates for initial assessments from 28 percent to 22 percent from January 2021 to December 2021.
- The study population for the current project are adult Medi-Cal beneficiaries requesting SMHS, with a special focus on high-risk beneficiaries, defined as those referred by their primary care providers, forensic or other health agencies, and have co-occurring disorders or are homeless.
- Having revised the non-clinical PIP, the MHP now has an appropriate study population that matches the focus of the project.

Recommendation 3: Collect and review data monthly.

Status: Not Met

- The MHP did not present data on the clinical project, although the project has been underway for six months.
- The team cited improper or incomplete documentation as the reason for the delay in data collection. With monthly data collection, the MHP would have identified the data collection issues sooner.

Access Recommendations

Recommendation 4: Monitor and present to the MCP provider that is responsible for non-emergency medical transport transportation incidents regarding beneficiary access and resolve. Maintain written documentation of the incidents and resolution.

Status: Met

- San Luis Obispo Behavioral Health Department (SLOBHD) has bi-monthly meetings with CenCal, the MCP provider, to resolve non-emergency medical transportation barriers.
- The MHP implemented a problem resolution process that involves email communication between CenCal and SLOBHD managers when a transportation issue occurs.

- Because of the shift to telehealth and telephonic services prompted by Corona Virus 2019 (COVID-19), transportation issues have been infrequent as of late. Nevertheless, they do occur. They often involving CenCal's subcontractors and new/different drivers, and may require a more proactive approach to preventing.

Recommendation 5: Work with the information technology (IT) division to modify the MHP's web page so that the suicide hotline number is on the MHP's banner.

Status: Met

- The MHP added a link to the banner at the top of the SLOBHD home page that displays hotline phone numbers.

Recommendation 6: Survey beneficiaries on their awareness of various supportive services (e.g., the warm line, crisis, support groups, transportation, etc.) that are available to them.

Status: Partially Met

- The MHP did not conduct this survey, but the MHP reports a variety of ways of regularly informing beneficiaries of offered services. The majority of the focus group participants endorsed receiving written information on services. The Hispanic focus group participants indicated a need for more information to the Latino community.

- During the EQR focus groups, participants reported varying levels of knowledge of the supportive services offered by the MHP. They reported that they received most of the information about supportive services from their individual therapists or case managers.

- Participants were aware of numbers to call (e.g., a warm line or crisis) and available support groups, but not aware of transportation resources available.

Timeliness Recommendations

Recommendation 7: Conduct an analysis of access by language, focused particularly on time to various services for Hispanic beneficiaries compared to English-speaking beneficiaries.

Status: Met

- The MHP tracks data related to timely access to services for Spanish-speaking beneficiaries separately from timeliness data for English-speaking beneficiaries.

- The MHP is able to provide services to Hispanic beneficiaries in the same amount of time as English-speaking beneficiaries and sometimes with shorter latency. CalEQRO notes, however, that for some variables and years (e.g., inpatient follow-up FY 2019-20) the MHP did not have data for Hispanic beneficiaries, but did have data for English-speaking (or other) beneficiaries.

Recommendation 8: Conduct an audit on the frequency and time to routine appointments for a representative sample of beneficiaries receiving ongoing services. *(This is a follow-up recommendation from FY 2017-18.)*

Status: Not Met

- The MHP did not conduct a focused audit on the frequency and time to routine appointments for ongoing services for established beneficiaries.
- The MHP reports developing a plan to track time to ongoing services. For now, the MHP is tracking the time to first routine appointment following the intake assessment.
- This recommendation will not be carried forward.

Recommendation 9: Include clinical line staff or supervisors on the committee to conduct this audit.

Status: Not Met

- As the MHP did not conduct the audit (above), there was no opportunity to involve clinical staff.
- This recommendation will not be carried forward.

Recommendation 10: Initiate improvement activities to decrease the no-show rate for adult psychiatry from 30 percent, and document the changes made.

Status: Met

- The MHP reported a no-show rate for psychiatry appointments for adult beneficiaries of 20.83 percent, a decrease from the previous year.
- The MHP points to an increase in telehealth services to assist with physical distancing as having a positive impact on the attendance rate for psychiatry appointments.
- The MHP examined factors related to pre-pandemic no-show rates. The MHP implemented improvement activities: reminder calls, back-filling cancelled appointments, and improvements in transportation options.

- The MHP has yet to set a benchmark for psychiatry no-shows, which would help in monitoring and maintaining tighter oversight of this limited resource.

Quality Recommendations

Recommendation 11: Increase the number of clinical staff to better meet the demand for services.

Status: Met

- Prior to COVID-19 and the reduction in state funds, SLOBHD hired three behavioral health specialists, one health information technician, and three school-based family advocate positions through a Mental Health Services Act (MHSA) grant. Adult case manager positions were also hired at 40 Prado, the 24/7 homeless services center.

- The County has implemented a hiring freeze to protect existing employees from layoffs. As the County is expecting state budget cuts as a result of the pandemic, SLO Board of Supervisors will be reviewing BHD budget for cuts.

- The MHP is only able to add additional positions that are fully funded by grants or contracts.

Recommendation 12: Reduce line staff's clinical caseloads and determine and adhere to a maximum caseload number.

Status: Not Met

- There has been no appreciable reduction in staff caseload numbers and with COVID-19—and the decrease in staffing and a hiring freeze—caseloads for some positions have increased. Caseloads for licensed psychiatric technicians (LPTs) were purportedly at 120 and higher and for case managers at 200.

- The review of caseloads rests with program supervisors. There was a plan to evaluate caseloads and develop standards; however, this plan was delayed and deferred with the onset of COVID-19. For now, caseload assignments are as before, based on medical necessity determination. Clinic supervisors strive for a balanced distribution of number of cases and acuity.

- Given the current hiring freeze, there will likely continue to be elevated caseload numbers. This recommendation will not be continued until the MHP is able to hire staff.

Recommendation 13: Monitor (i.e., gather from staff) issues related to the transfer of beneficiaries to MCP providers.

Status: Met

- The MHP received and addressed feedback from staff regarding issues related to transfers of beneficiaries to the MCP provider, the Holman Group.
- The MHP has a standing, weekly consultation to review open referrals with the Holman Group. The MHP maintains a tracking spreadsheet of all referrals to the Holman Group and during the weekly meetings, the status of referrals and access barriers are identified and resolved.
- The MHP recently developed a process to expedite transfer of beneficiaries to the MCP. Beneficiaries that are medication-only and who have already been screened by the MHP no longer require a new assessment by Holman Group, thus decreasing the time to MCP services.

Recommendation 14: Compare the transfer process to the established 'continuity of care' procedure and resolve the issues.

Status: Not Met

- In the previous year, the MHP identified a collaborative 'continuity of care' process with the MCP provider. This process was to facilitate the coordination of care for beneficiaries. The MHP did not expound on this process and if its current approach (above) reflects the continuity of care that was developed.
- Ostensibly, the MHP also has a 'continuity of care' process that it uses to review requests from beneficiaries who want to maintain the same mental health provider after it is determined that they require a higher level of care.

Recommendation 15: Develop and implement a protocol for integrating minors back to services in-county after they have received services out-of-county.

Status: Met

- The MHP has a process to integrate youth served out of the county back to services in county. The process is the similar for both FC and non-FC youth.
- For youth in FC, a designated case manager coordinates with the Department of Social Services (DSS) social worker and the staff of the out-of-county provider, often a Short-Term Residential Therapeutic Program (STRTP).

- For non-FC youth, the PHF transfer coordinator informs the minor's clinic of the out-of-county placement and return. The PHF transfer coordinator contacts the county clinic with the relevant information and clinic staff then work directly with the hospital and the minor's family on the return to MHP-based services.

Recommendation 16: Include the findings from the monthly medical peer review committee and other medication related issues as part of the morbidity and mortality report in the Quality Support Team (QST) committee meetings.

Status: Partially Met

- Morbidity and mortality review are a regular topic of the QST meetings, occurring at least every other month. However, the findings from the monthly medical peer review committee did not appear to be part of this review, per QST meeting minutes.
- Otherwise, in response to some findings from peer review committee on medication errors, the MHP has a plan to train staff who administer medications, beginning in 2021.
- Beyond medication errors, the medical peer review committee ought to discuss utilization of services, trends in beneficiary care, best practices, and other areas that improve the quality of care.

Beneficiary Outcomes Recommendations

Recommendation 17: Conduct an analysis or quality improvement study on case closures and the reasons for closure.

Status: Not Met

- The MHP reported that this analysis was not completed.
- While the formal analysis or study of case closures systemically was not implemented, the MHP tracks and reports on progress and closures of FSP beneficiaries.
- The MHP reports two trends from the FSP data: there has been a slight reduction in beneficiaries who have met their goals upon case closure and there have been more clients moving out of the area resulting in case closure.
- The MHP intends to investigate these trends further, though there are more pressing priorities for the MHP.

Recommendation 18: Monitor referrals to MCP, track time from referral to enrollment/acceptance, and meet with MCP providers at least quarterly to review the process.

Status: Met

- The MHP monitors referrals to the Holman Group. As part of the weekly consultation with the Holman Group, the MHP raises concerns regarding acceptance of referrals and timeliness of service provision to beneficiaries.

Recommendation 19: Engage MCP's primary care physicians and provide training and periodic consultation to facilitate transfer of beneficiaries to lower level of care. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Met

- Primary care providers that serve former SMHS beneficiaries are often located at the Community Health Centers (CHC). SLOBHD medical director has reached out to the CHCs to establish a standing monthly meeting with CHC medical directors, a forum for consultation and addressing concerns regarding transfer and care. No meetings have been established or confirmed, but this remains a focus of the medical director.
- In the meantime, the MHP meets quarterly with the four local hospital emergency department representatives, to include the emergency department doctors and directors, medical directors, and nursing supervisors.

Recommendation 20: As part of the process to increase the hiring of peers, consult with other MHPs that have job classifications for peer employees or positions which specifying lived experience.

Status: Met

- The MHP has collected examples from other MHP's of their county job classifications/job descriptions. It is working with the county Human Resources Department to add peer-specific jobs classifications and descriptions.
- The MHP reports that some case managers identify as having lived experience. The peer job classification will ensure continuation of those positions by requiring lived experience.

Foster Care Recommendations

Recommendation 21: Track and review monthly rehospitalization for children, including those in FC, and follow-up post-hospitalization.

Status: Not Met

- The MHP's tracking of follow-up appointments post-hospitalization for youth in FC is limited to children that are new to services and not established beneficiaries. Thus, the MHP did not report on follow-ups for youth in FC in FY 2019-20.
- The MHP did not provide rehospitalization information for any beneficiary, citing that this metric is not tracked. The MHP only tracks rehospitalization to the (adult) PHF, but did not report this information as it did in the previous year.

Recommendation 22: Track and report on all timeliness metrics for children in FC separately. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Not Met

- The MHP is building its capacity to provide separate timeliness results for youth in FC; however, for this review, the MHP was not able to the following timeliness metrics: first offered psychiatry appointment; follow-up appointments post-hospitalization; 30-day inpatient readmission rate; and no-shows.

Information Systems Recommendations

Recommendation 23: Evaluate the type and level of IT and analytical resources dedicated to MHP service needs for daily operations, improved reporting capabilities, and the delivery of significant initiatives, which will move the organization forward.

Status: Met

- The MHP has experienced fiscal impacts from the pandemic, which has impeded the hiring of analytic staff; however, the MHP has obtained permission to hire a new Administrative Services Officer to provide EHR support and address ongoing reporting needs.
- The MHP states that several IT staff, including the EHR Program Manager, have been reassigned to positions in the Emergency Operations Center to respond to the public health crisis.

Recommendation 24: Conduct an analysis of the low rate of co-occurring disorders and implement solutions to obtain accurate beneficiary diagnoses.

Status: Met

- The MHP provided trainings to outpatient clinic staff on consistently and accurately including co-occurring disorders in the diagnostic reviews.

Recommendation 25: Begin the process of using one common EHR by including the requirements to use the MHP's EHR in the contracts with contract providers.

Status: Not Met

- The MHP states that it will not consider requiring the contract providers to use one common EHR.
- The recommendation will not be carried forward.

Structure and Operations Recommendations

Recommendation 26: Increase the number of clinicians to better meet demand for services.

Status: Met

- During FY 2019-20, the MHP was awarded an MHSA grant that funded one clinician, four behavioral health specialists, and one health information technician to expand school-based services.
- The County has implemented a hiring freeze to protect existing employees from layoffs. The MHP is only able to add additional positions that are fully funded by grants or contracts.

Recommendation 27: Further increase telehealth services to expand capacity for psychiatry. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Met

- As a result of the pandemic, the MHP has shifted to more telehealth services. The MHP offers psychiatric evaluations and medication support services to all beneficiaries via telehealth and in-person when necessary.
- Telehealth services are available both in the outpatient clinics and staff homes to facilitate physical distancing.
- The MHP offered 8,985 telehealth services in the last year.

Recommendation 28: Review the scope of licensed psychiatric technicians' (LPTs) work and re-assign tasks to other staff whose positions are designated for those tasks.

Status: Partially Met

- Mental health professionals throughout SLOBHD confirmed that LPTs continue to perform a broad range of services. LPTs support psychiatric providers (e.g., lab request and lab reviews) and facilitate medication

support (e.g., communicate with the pharmacies and reconcile medications). They also perform ancillary functions (e.g., clerical work, scheduling appointments).

- The scope of LPT work does not appear to have changed; however, the MHP is looking at how some tasks can be handed-off to the case manager assigned to the adult outpatient clinic, as appropriate.
- The MHP's hiring of additional LPTs will be impeded by the county's current hiring freeze.

Recommendation 29: Hire more LPTs to better meet demand for services.

Status: Partially Met

- The MHP increased staff at one of the adult clinics and started a strategy of rotating LPTs at SLO clinics. However, these changes were short-lived. Following the onset of COVID-19, there have been increased absences due to illness or quarantine and reassignment of LPTs to throughout the department.
- The MHP is preparing for budget cuts in the upcoming year and therefore is conservative about hiring new/additional LPTs, which are not otherwise fully funded.

Recommendation 30: Employ 'floating' staff to be able to fill in when assigned staff are away due to illness or on medical leave, of which there appeared to be an increase of late.

Status: Partially Met

- Prior to COVID-19, the MHP created a temporary, floating medication manager position. The MHP was not able to fill the position due to the impact of COVID-19.
- The MHP has implemented a hiring freeze and is focused on maintaining current positions of existing employees.
- The recommendation will not be carried forward.

Recommendation 31: Review existing recruitment strategies and determine if efforts should be expanded, for example to include high schools, two- and four-year colleges, and graduating students in nursing, psychology, social work, and child development programs.

Status: Met

- The MHP started a Psychiatric Nurse Practitioner student internship program.

- The MHP was working with a career counselor at one of the local high schools so that SLOBHD staff may provide presentations and field trips for students who are on a medicine track. These plans have been put on hold because of COVID-19.

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 CFR 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 Luis Obispo MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	24,554	42.9%	1,859	50.3%
Latino/Hispanic	18,675	32.6%	607	16.4%
African-American	677	1.2%	70	1.9%
Asian/Pacific Islander	1,257	2.2%	34	0.9%
Native American	301	0.5%	23	0.6%
Other	11,751	20.5%	1,101	29.8%
Total	**57,214**	**100%**	**3,694**	**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.

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

San Luis Obispo MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	266	7.2%
Other Languages	3,428	92.8%
Total	**3,694**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

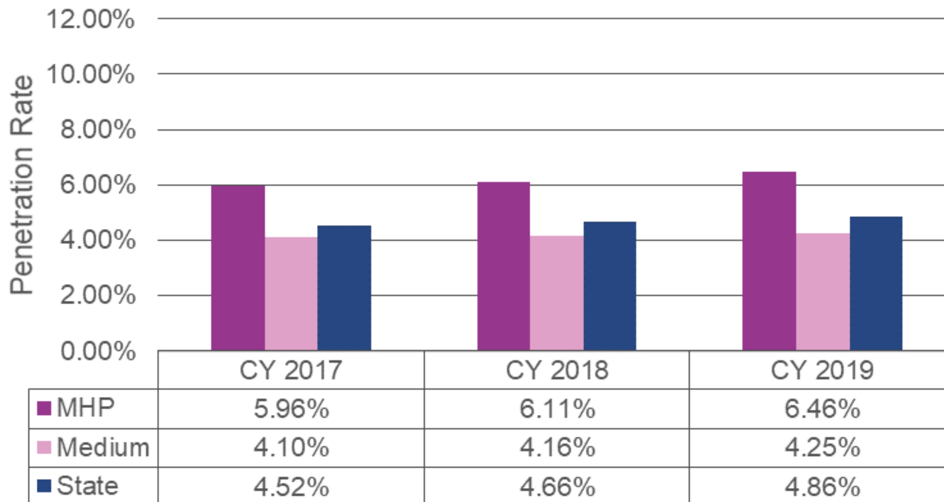
Penetration Rates and Approved Claims per Beneficiary

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 Medi-Cal Expansion (ACA) Penetration Rate and ACB.

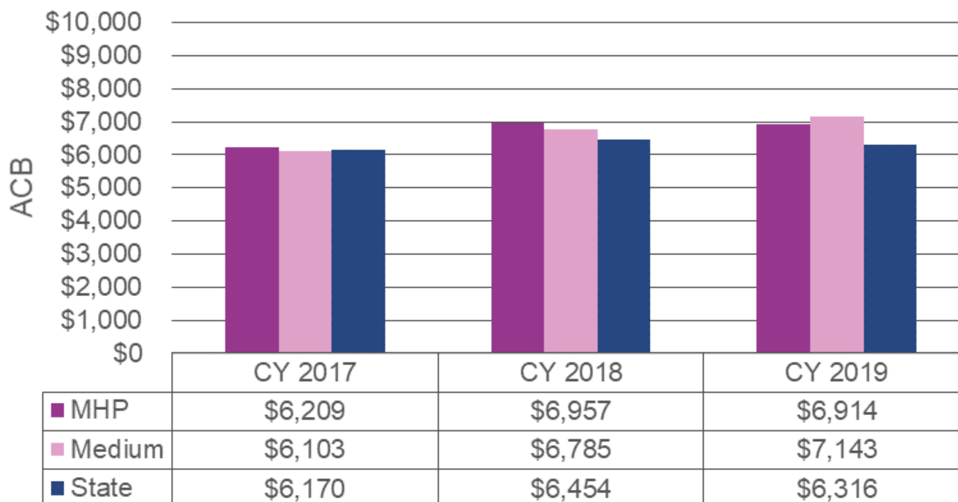
Regarding the calculation of penetration rates, the San Luis Obispo MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.96%	6.11%	6.46%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

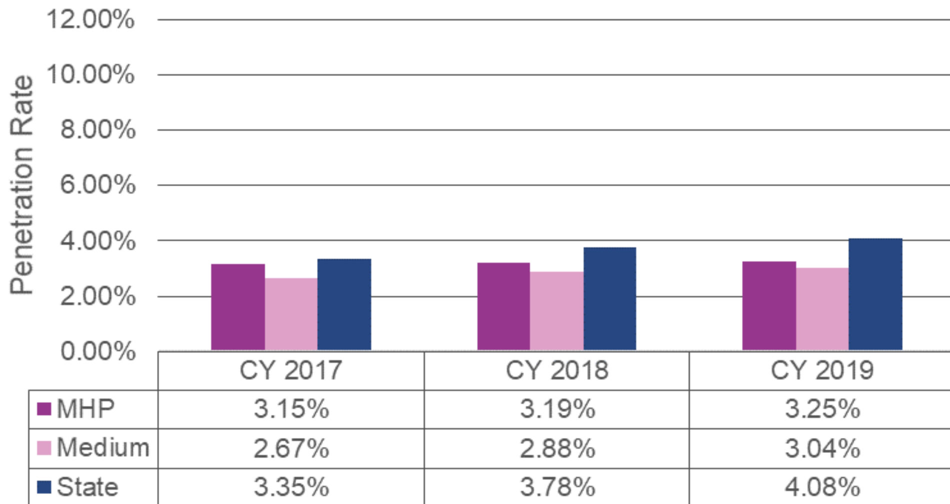
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,209	$6,957	$6,914
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

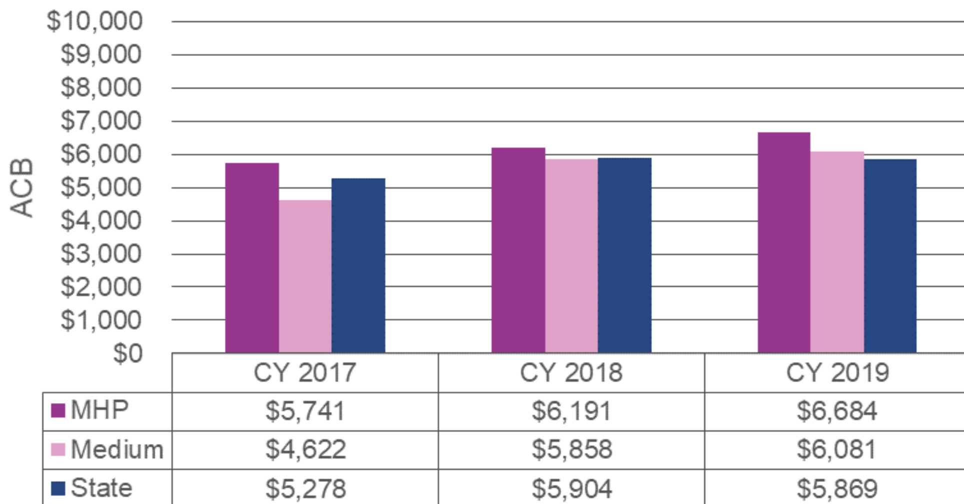
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	3.15%	3.19%	3.25%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

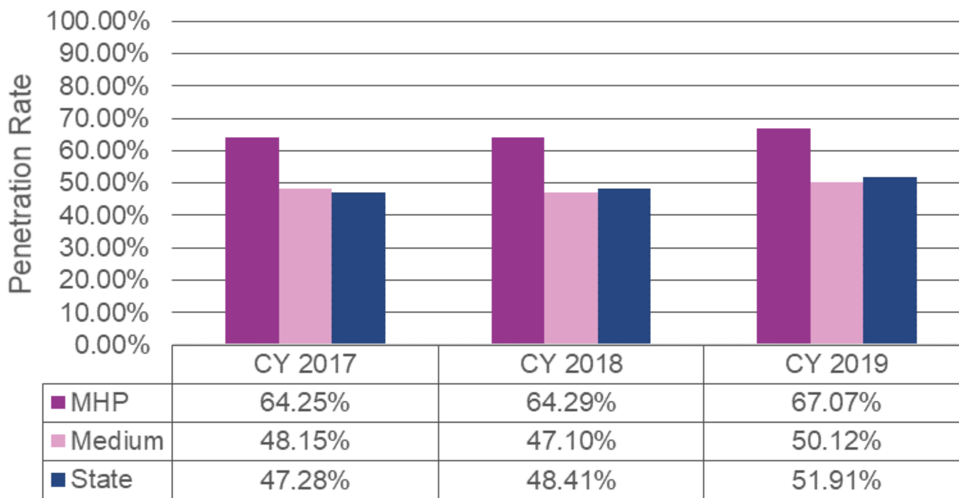
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,741	$6,191	$6,684
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

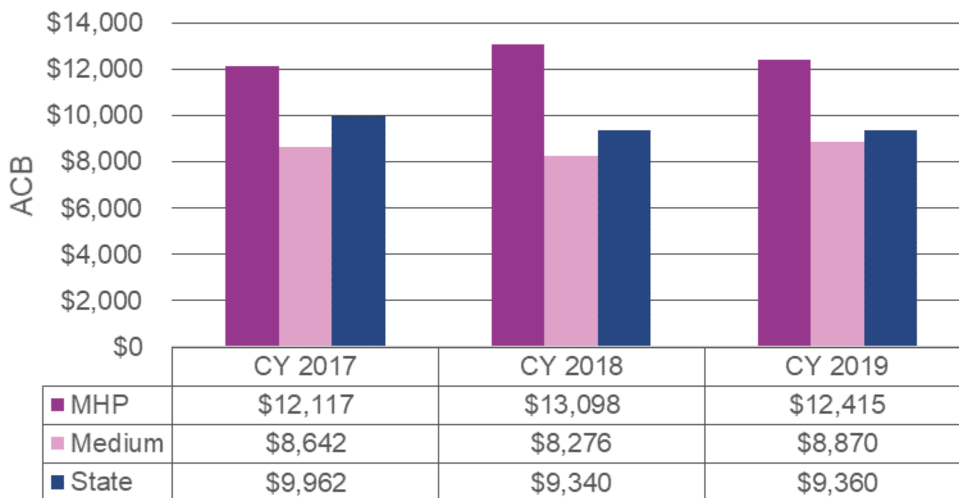
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	64.25%	64.29%	67.07%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$12,117	$13,098	$12,415
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

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

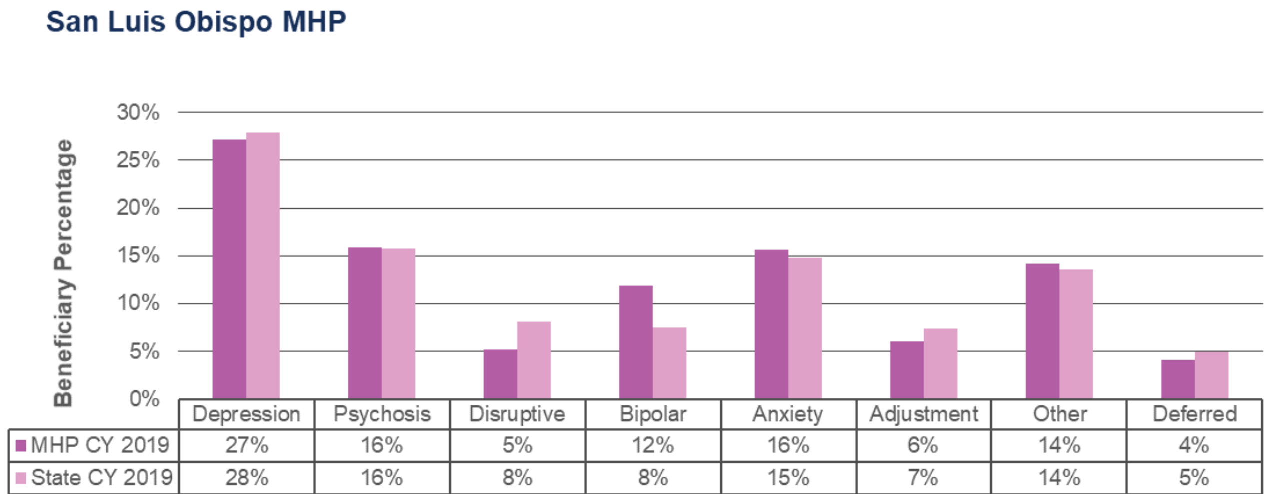
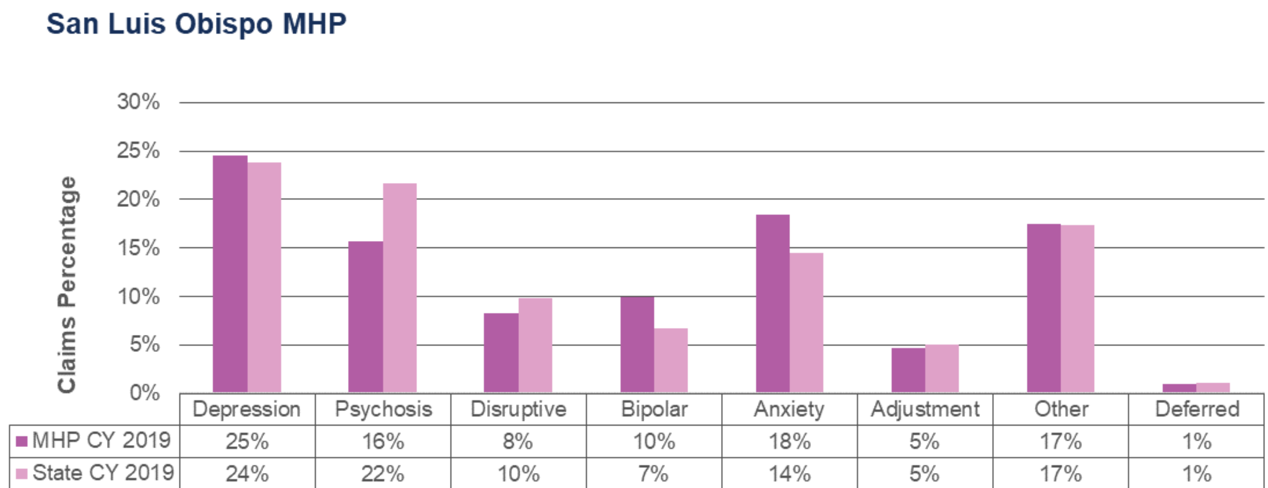


Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



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 Luis Obispo 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	181	3,694	4.90%	$46,549	$8,425,354	32.99%
	CY 2018	173	3,616	4.78%	$50,799	$8,788,295	34.93%
	CY 2017	149	3,663	4.07%	$48,788	$7,269,438	31.96%

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.

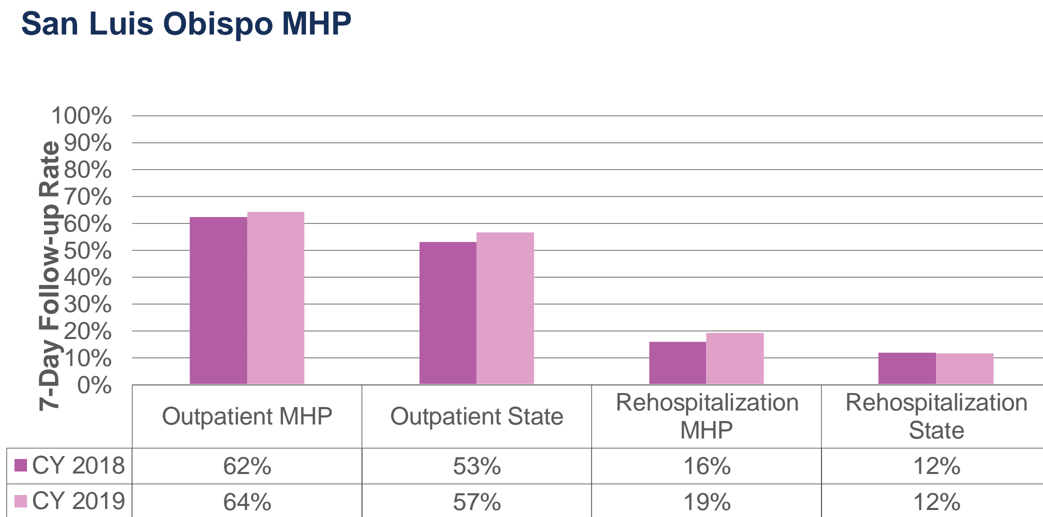
Table 4: Psychiatric Inpatient Utilization CY 2017-19

San Luis Obispo MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	385	989	6.01	7.80	$9,224	$10,535	$3,551,382
CY 2018	317	659	5.45	7.63	$10,630	$9,772	$3,369,633
CY 2017	326	807	4.97	7.36	$7,490	$9,737	$2,441,801

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

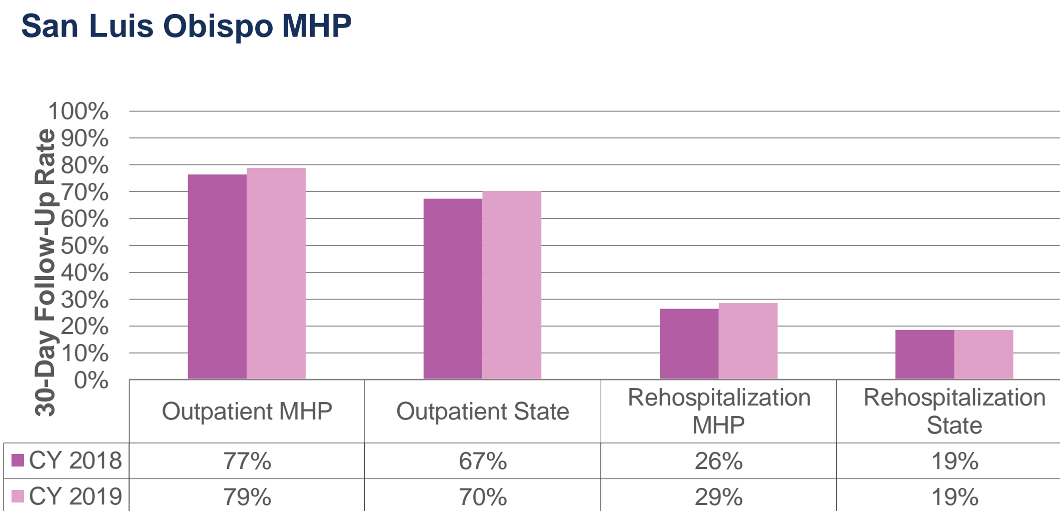
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	62%	53%	16%	12%
CY 2019	64%	57%	19%	12%

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	77%	67%	26%	19%
CY 2019	79%	70%	29%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” CMS’ EQR Protocol 1: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

San Luis Obispo 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 did not validate either of the PIPs, as shown below.

Table 5 : PIPs Submitted by San Luis Obispo MHP

PIPs for Validation	Number of PIPs	PIP Titles
ClinicalClinicalClinical	1	Improving Transition of Care of Un-engaged Homeless Individuals from the PHF to Outpatient Care
Non-ClinicalNon-ClinicalNon-Clinical	1	Same Day Access

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	San Luis Obispo
PIP Title	Improving Transition of Care of Un-engaged Homeless Individuals from the PHF to Outpatient Care
PIP Aim Statement	“Will face-to-face case management and individual rehabilitation services provided by the Homeless Outreach Team Outreach Worker during SLO PHF admission and after discharge from the SLO PHF result in improved initiation and engagement in outpatient treatment for un-engaged homeless individuals from 5/1/2020 through 5/1/2021 as measured by identifying these individuals’ anxiety assessed for while on the PHF in the electronic

MHP Name	San Luis Obispo
	health record generated by PHF staff compared to anxiety assessed for by the service providers scheduled for the post-PHF appointment documented in the electronic health record?"
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) ☒ 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 target population are adults admitted to the PHF and who are determined to be homeless and previously unlinked to outpatient mental health services.	

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): Meet with the individual prior to discharge from the PHF and provide case management and individual rehabilitation services.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Attend PHF multidisciplinary team meetings to participate in the discharge planning process
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):
n/a

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
The variable is anxiety; however, no specific performance measure was indicated.	2020	None	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Post hospitalization appointments. While there is an NQF measure for post-hospitalization follow-up (391), the MHP did not use either of them.	2020	30.4	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?					☐ Yes	☒ No
Validation phase: ☐ PIP submitted for approval ☐ Planning phase						

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
☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):						
Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence The MHP has not provided enough information to determine if reliable and valid methods were employed. A main concern is that the project is meant to be clinical, but lacks clinical measures or interventions. “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Design a project that has clear clinical outcomes for beneficiaries, which are substantiated by data, both before and after the intervention. While this was meant to be a clinical project, the clinical components are lacking. The clinical strategy is vague and cannot be differentiated from a non-clinical approach. • Collect and review data on a monthly basis. Six months into the project, the MHP had no data to present, neither on the number of participants to date nor the baseline anxiety level, or any other variables. • Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Suggestions to articulate what is new this year, compared to last year, and to clarify the scope of the project. • Feedback on where to provide more clarifying information on the project.						

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	San Luis Obispo
PIP Title	Same Day Access
PIP Aim Statement	"Will providing same-day access to assessments; adding clients to a cancellation waitlist and contacting them if assessment earlier appointments open prior to their standing appointment time; and offering to complete Authorizations to Disclose PHI for support persons (nurses, homeless services employees, family, etc.), decrease the assessment no-show rate from 28 percent to 22 percent during a one-year period from January 1, 2021 to December 31, 2021 for all Medi-Cal beneficiaries requesting mental health services."
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) ☒ 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): All adult Medi-Cal beneficiaries requesting to be assessed for SMHS, with a special focus on high-risk individuals (defined as those referred by their PCP, forensic, or other health agencies, and/or those who have co-occurring disorders and/or are homeless).	

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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP is focusing on changing initial assessment intake procedures and processes to increase rate of kept initial assessments. Interventions include: implementing authorizations for coordination of assessment appointments, offering same-day assessments, offering sooner appointments to those on the cancellation list, and sending text reminders.

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
Comprehensive assessment appointment no-show rate for all adult beneficiaries	2019-2020	28%	☒ n/a*	n/a	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☐ Yes	☒ No	

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
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 Interventions for this PIP are scheduled to start in January 2021, thus there are no results available at this time to determine a more specific confidence rating. “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Revise the aim statement to indicate the target population being adult Medi-Cal beneficiaries, instead of all Medi-Cal beneficiaries. • Consider shortening the aim statement to make it more readable and concise. • In the PIP write-up, Table 5.2 lists the third variable as “Documented count of clients sent text reminders”, which does not appear in Table 5.1. The MHP should either add this variable for tracking into Table 5.1 or remove it from Table 5.2 for consistency. • Update the start of the intervention to be 1/1/2021, instead of 1/1/2020.						

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
• Continue with starting interventions in January 2021 and following the implementation plan. • Adhere to monthly data collection and at least quarterly review.						
The TA provided to the MHP by CalEQRO consisted of: • A detailed review of the non-clinical PIP write-up was completed with feedback for the MHP in November 2020.						

*PIP is in planning and implementation phase if n/a 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 staff 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 Luis Obispo	2.42%	2.52%	2.35%	1.81%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

- The IT budget has been less than the statewide average for the last three years. Considering the MHP's plans to transition from the Cerner Community Behavioral Health (CCBH) platform to the Cerner Millennium platform, 2.42 percent is a low level of funding and may be inadequate.

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 Application Service Provider (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 HA 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 placed disaster recovery planning on the top of its priority list; however, it has been delayed as a result of COVID-19.
- The SLO Health Agency (HA) IT staff are developing a centrally located disaster recovery IT center in North County. The disaster recovery center is scheduled for completion in Spring 2021.
- The SLO HA conducts phishing exercises by sending out fake (test) emails. If staff do not pass, they are mandated to attend security trainings.
- The MHP strategically removed administrative rights from all computers to decrease the risk of malware.
- The MHP replaced the protocol of requiring strong passwords to the use of passphrases.

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	46.12%
Contract providers	52.04%
Network providers	1.84%
Total	**100%***

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

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	5	0	1	1
2019-20	9	0	1	1
2018-19	10.75	0	0	1.75

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	0	0	1
2019-20	2	2	0	0
2018-19	0	0	0	0

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

- The MHP is a branch of the SLO HA, as such, IT staff are assigned to a centralized IT department. There are no dedicated staff with behavioral health data analytical expertise.
- In prior years, IT and analytic staffing numbers included both MHP and DMC-ODS. For FY 2020-21, only MHP staff were included. There have been no changes in staffing levels.

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 the 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	28	10	38
Clinical Healthcare Professional	128	31	159
Clinical Peer Specialist	25	25	50

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
Quality Improvement	30	0	30
Total	211	66	277

While there is no standard ratio of IT staff to support EHR user's, 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)	5.00	7.87
Total EHR Users Supported by IT (Source: Table 17)	277.00	572.00
Ratio of IT Staff to EHR Users	1:55	1:73

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	11
Number of county-operated telehealth sites	5
Number of contract providers' telehealth sites	6

Telehealth Services	Count
Total number of beneficiaries served via telehealth during the last 12 months	1475
• Adults	738
• Children/Youth	719
• Older Adults	18
Total Number of telehealth encounters (services) provided during the last 12 months:	8,985

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

- The MHP's long history of telehealth service delivery provided a foundation to quickly pivot to telehealth for other services after the declaration of the health crisis in March 2020.
- Despite many staff vacancies, the SLOBHD kept all offices open for limited service and rotated staff's days in the office and at home.
- Contract providers in the focus group agreed that the MHP had effective and frequent communication so that all agencies were able to respond to state guidelines for the expanded use of telehealth.
- Contract providers deliver supplies to beneficiaries to ensure that beneficiaries have the therapeutic material in advance of the telehealth sessions (e.g., for play therapy).

- Field-based services were enhanced by the use of a mobile van so that physical distancing could be maintained while working with individuals who are homeless.

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
San Luis Obispo Child Development Center	1
Wilshire Community Services	1
Sierra Mental Wellness Group	1
Seneca Family of Agencies	1
Family Care Network Inc.	1
Transitions Mental Health Association	1

Contract Provider	Count of Sites
Kenneth Glenn Starr, MD	1
Stefan Marin Lampe, MD	1

Current MHP Operations

- The MHP's EHR has been the CCBH product suite since 2010. It is maintained by the SLO HA IT staff.
- Contract agencies in SLO use locally developed EHRs and so do not have integration with CCBH.
- Although correctional health care services are contracted out to Well Path by the Sheriff's department, the MHP uses direct EHR entry to document its limited delivery of services.
- The MHP is a participant in the One California Partnership Regional Health Information Organization health information exchange (HIE).

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
CCBH	Clinical documentation and billing	Cerner	9.4	County IT

The MHP's Priorities for the Coming Year

- Establish a disaster recovery plan with county central IT. Data Center will be located in North County and is planned for March 2021.
- Upgrades of Secure Print hardware and software will be deployed by December 2020.

- Universal Serial Bus device control.

Major Changes since Prior Year

- Contract approved for migration from CCBH to Cerner's Millennium product.
- Removal of administration rights from all desktop computers.
- Long-term EHR division manager retired.

Other Areas for Improvement

- The MHP continues to have challenges retaining analyst positions.
- Organization chart indicates IS director and managers are assigned to the SLO HA. This lack of IS representation limits identification of issues in management meetings (e.g., the readiness of Business Continuity Plan in the event of a cyber-attack, emergency, or local disaster) and is not conducive to strategy discussions and decision-making.
- The MHP would benefit from expanded use of telehealth services post-COVID-19 to support beneficiaries who live some distance from clinics.

Plans for Information Systems Change

- The MHP plans to migrate clinical documentation and management from CCBH to Cerner's Millennium Behavioral Health system beginning in 2021.
- Agency staff have noted that although Millennium is able to create agency-specific forms, it is not able to change clinical workflow protocols. In addition, access to historical beneficiary data remains a concern.

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	Cerner	☒	☐	☐	☐
Assessments	Cerner	☒	☐	☐	☐
Care Coordination	Cerner	☒	☐	☐	☐
Document Imaging/Storage	Cerner	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Cerner	☒	☐	☐	☐
Laboratory results (eLab)	Cerner	☐	☐	☒	☐
Level of Care/Level of Service	Cerner	☒	☐	☐	☐
Outcomes	Cerner	☒	☐	☐	☐
Prescriptions (eRx)	Cerner	☒	☐	☐	☐
Progress Notes	Cerner	☒	☐	☐	☐
Referral Management	Cerner	☒	☐	☐	☐
Treatment Plans	Cerner	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		11	0	1	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0

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

- The MHP has a hybrid electric/paper chart. They continue to have hard copies of Releases of Information, lab results, hospital release documents, and primary care coordination.
- Successful implementation of electronic prescribing of controlled substances.
- Paper records and releases from external sources are usually scanned into the EHR.

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
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 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	80%	Monthly
Direct data entry into MHP EHR system by contract provider staff	5%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	5%	Daily

Type of Input Method	Percent Used	Frequency
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	10%	Daily

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
n/a		

- The MHP's contract providers all use locally developed and unique EHRs.

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

n/a

Expected implementation timeline:

☐ Already in place	
☐ Within 6 months	☒ Within the next year
☐ Within the next two years	☐ Longer than 2 years

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

Table 28: PHR Functionalities

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 Structured Query Language Database, supported by MHP/Health/County staff

☐ Local Excel Worksheet or Access Database

- The MHP decided to not pursue a contract with Dimensions. It is in the process of implementing a clearing house named Ability.

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 SDMC Claims

San Luis Obispo MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**90,776**	**$27,597,996**	**3,743**	**$1,398,677**	**4.82%**	**$26,199,319**	**$24,538,694**
JAN19	8,073	$2,410,356	468	$81,725	3.28%	$2,328,631	$2,219,660
FEB19	7,564	$2,276,896	543	$113,521	4.75%	$2,163,375	$2,011,442
MAR19	8,868	$2,536,764	570	$131,154	4.92%	$2,405,610	$2,260,469
APR19	8,150	$2,537,721	228	$124,489	4.68%	$2,413,232	$2,267,042
MAY19	8,667	$2,600,812	479	$178,481	6.42%	$2,422,331	$2,232,505
JUN19	7,116	$2,165,460	331	$118,160	5.17%	$2,047,300	$1,916,233
JUL19	7,454	$2,142,405	171	$60,267	2.74%	$2,082,138	$2,010,697
AUG19	7,361	$2,378,435	202	$203,858	7.89%	$2,174,577	$1,950,729
SEP19	6,773	$2,097,380	134	$82,067	3.77%	$2,015,313	$1,916,418
OCT19	7,553	$2,414,987	195	$71,066	2.86%	$2,343,921	$2,209,347
NOV19	6,645	$2,097,282	168	$122,646	5.52%	$1,974,636	$1,838,291
DEC19	6,552	$1,939,497	254	$111,242	5.42%	$1,828,255	$1,705,860

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 other health coverage plans, or state adjustments for maximum allowed reimbursement.

- The MHP's denial rate has increased by 2.09 percentage points from last year's rate of 2.73 percent to 4.82 percent, which exceeds the state's average of 2.99 percent.

Table 30 summarizes the top five reasons for claim denial.

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

San Luis Obispo MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible.	882	$694,176	50%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	699	$358,778	26%
Beneficiary not eligible or non-covered charges.	1,300	$159,678	11%
Medicare or Other Health Coverage must be billed before submission of claim.	586	$103,424	7%
Service line is a duplicate and a repeat service procedure code modifier not present.	106	$65,746	5%
Total	3,743	$1,398,677	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 “ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid”, “Medicare or Other Health Coverage must be billed before submission of claim”, and “Service line is a duplicate and a repeat service procedure modifier is not present” 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 Luis Obispo , the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 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, six stakeholder interviews, five staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

There was one zip code that required an AAS in San Luis Obispo County. The zip code, 93453, did not meet the time and distance standards for psychiatry services for youth and adults. The other zip codes for the MHP for youth and adult psychiatry services met time and distance standards as required by DHCS.

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

To meet the required standards and enhanced beneficiary access to care, the MHP is petitioning DHCS for an exception for this zip code. The MHP contends that the zip code is in a remote, sparsely populated eastern area of the county with few, if any, Medi-Cal beneficiaries.

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	7
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	1

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number reported is associated with two or more providers	3
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	2
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	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 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 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 group of Hispanic adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Two
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group:	
Access - new beneficiaries	One participant initiated services by calling the access line and was connected to services within two weeks. The other participant experienced a delay of two months.
Access – overall	Participants were not all aware of availability of transportation assistance; most had or organized their own

Topic	Description
	transportation. There were also mixed responses to the availability of family therapy by the MHP. Hispanic participants endorsed availability of services and written information in Spanish. Changing service providers was not an easy process for a parent/caregivers of youth in FC.
Timeliness	Participants had either weekly or biweekly appointments with their therapists and monthly or twice monthly appointments with psychiatric providers. The frequency of mental health appointments was described as sufficient and meeting participant's needs. Participants received text and telephone reminders of their appointments and did not have difficulty rescheduling appointments when needed.
Urgent care and resource support	Participants endorsed a number of ways to obtain urgent care, including contacting the hotline, the crisis number, going to the emergency room, calling the warm line, a parent support number/warmline, their provider agency, and their therapist. Some participants were part of support groups and parents/givers, in particular, endorsed that the county offers several groups and classes (e.g., on trauma) and provides information that supplements the mental health services.
Quality	Participants endorsed being actively involved in the course of their treatment and care planning. Participants described responsive mental health providers, particularly the psychiatric providers. The wellness centers were frequented by adult participants, prior to COVID-19. Participants have provided their input and feedback on services via surveys, but did not recall the results of the survey being shared with them.
Peer employment	n/a
Structure and operations	Generally, participants were not aware of opportunities to be involved in system planning. One participant was a member of a committee, the Quality Parenting Initiative, and other participants expressed interest in participating in planning committees.
Recommendations from this focus group	• Provide beneficiaries with a written summary of content of session to aid in recall and practicing behaviors. • Increase outreach and dissemination of information about available mental health services. As well, provide more education to the general public on

Topic	Description
	mental illness and interacting with persons with a mental illness.
Any best practices or innovations (optional)	No particular practice was endorsed, but parents/caregivers were particularly pleased with the mental health services for their children and were resolute in the need for more.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries, including TAY youth, who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group included only two parents, and none had initiated services within the past 12 months.
Total number of participants	Two
Number of participants who initiated services during the previous 12 months	None
Interpreter used	No
Summary of the main findings of the focus group: As there were too few participants for a focus group, the participants' comments were included in the summary for CFM Focus Group One.	
Access - new beneficiaries	n/a
Access – overall	See Focus Group One
Timeliness	See Focus Group One
Urgent care and resource support	See Focus Group One
Quality	See Focus Group One
Peer employment	See Focus Group One
Structure and operations	See Focus Group One
Recommendations from this focus group	• None
Any best practices or innovations (optional)	• None

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

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	11
The MHP uses a number of means to relay information (e.g., flyers, brochures, the MHP website, meetings) about services and programs, but stakeholders expressed a need for more outreach and dissemination of information to Latino and Hispanic beneficiaries and eligibles. The MHP has updated its website to reflect service availability during COVID-19 as well to including other wellness information. The website is functional and easy to navigate. While the link to the hotline is now on the home page, it still requires several click-throughs to locate. The MHP has a system for monitoring calls, which tracks dropped calls. The MHP has an updated provider directory that is available in English and Spanish. While there has been less of a need for transportation services, transportation is reported by stakeholders as contributing to delays in beneficiary access and missed appointments.			
1B	Capacity Management	10	8
The MHP has a cultural competency plan developed in 2018 and annual updates of the Mental Health Services Act (MHSA) plan, which provide additional information on			

Component		Maximum Possible	MHP Score
the beneficiary population. The MHP also uses data from other sources (e.g., the LGBTQ+ Needs Assessment by Cal Poly) to assess beneficiary needs. The MHP monitors penetration rates by ethnicity and reviews timeliness by threshold languages. A focus of the MHP has been to increase Latino access and engagement in services. To this end, the MHP continues to work with Promotores to assist with interpretation, collaborates with the Latino Outreach Program, and most recently sponsored an advertisement in a local Latino magazine "Somos". However, stakeholders reported that there were insufficient number of Hispanic staff to meet the current demand. Other underserved populations include older adults, the LGBTQ, veterans, and persons experiencing homelessness. As in the previous year, the staff caseloads are high, at over 120 for some mental health professionals. The need for more staff was raised by many stakeholders and funding was identified as a crucial linchpin. In the face of budget cuts and no other allocation of funds, the MHP is limited in its ability to increase its capacity in this critical way.			
1C	Integration and Collaboration	24	23
The MHP collaborates with a number of community-based organizations, both private and public, to facilitate access to services. The MHP has established relationships with primary care providers, the Community Health Centers; educations systems, primary and advanced degrees; law enforcement and justice programs; housing providers; and employment support agencies. Fewer concerns were raised this year regarding the collaboration with and continuity of care between managed care providers, which was in part credited to the oversight by the new managed care supervisor. Besides the collaboration with a sober house that has a faith-based approach, partnerships with faith-based organizations were not prominent.			

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	15
The MHP uses the 10-business day standard for time to first offered appointment. The MHP's reporting includes the entire system of care, including FSP programs. The MHP met the standard overall 90.81 percent of the time, with a range of 0 to 43 days.			

Component		Maximum Possible	MHP Score
The MHP met the standard 93.5 percent of the time for adults and 88.55 percent for children. The MHP met the standard 77.42 percent of the time for youth in FC, which is a decrease in timeliness from the previous year (above 90 percent.) The MHP attributed greater delays for youth in FC to differing scheduling protocols and staffing issues at some of its youth contract providers that also provide first appointments. First offered appointments are reviewed bimonthly (every other month) at QST meetings; however, minutes do not note decline in timeliness of first appointment for youth in FC.			
2B	First Offered Psychiatry Appointment	12	9
The MHP follows a 15-business day standard for time to first offered psychiatry appointment. The MHP calculates the time to appointment following the determination of need or point of referral. The MHP tracks time to psychiatry for only county-operated appointments and not its entire system. The MHP met the standard overall 74.60 percent of the time, with a range of 0 to 56 days. The MHP met the standard 76.7 percent of the time for adults and 53.0 percent for children. The MHP did not track time to psychiatry for youth in FC. The MHP's time to psychiatry has improved from the previous year, which were attributed to increased use of telehealth services and the immediacy of appointments.			
2C	Timely Appointments for Urgent Conditions	18	11
The MHP reported on time to urgent appointments in 96 hours, which require prior authorization. Such appointments included assessments, medication support services, and post crisis stabilization unit (CSU) appointments and only included county-operated urgent response. The MHP met the standard overall 81.33 percent of the time, with a range of 0 to 11 days. The MHP met the standard 84.92 percent of the time for adults, 60 percent for children, and 50 percent of the time for children in FC. Improvement activities were needed for the MHP's responses for children, but meeting minutes did not show review or discussion of delayed response to urgent conditions. Focus group participants were well informed of how to receive urgent care and did not raise concerns about police involvement in reaching out or crisis and urgent care, as they had during the last review.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	7
The MHP uses the 7-day standard for time to follow-up appointment after hospitalization. The MHP reported on county-operated follow-up appointments. In addition, the follow-up appointments included only beneficiaries who were new to services/not previously open to services. The MHP's reporting does not capture the established beneficiary population who were hospitalized during the year. The MHP met the standard 97.47 percent of the time overall, with a 3.35-day mean. The MHP's			

Component		Maximum Possible	MHP Score
rate for adults was 97.56 percent and 96.88 percent for children. The MHP did not have any data for youth in FC; no youth in FC who were new to SMHS and were hospitalized during the year.			
2E	Psychiatric Inpatient Rehospitalizations	6	0
The MHP did not present any rehospitalization data for FY 2019-20. In previous years, the MHP has reported on 30-day rehospitalization to the adult PHF.			
2F	Tracks and Trends No-Shows	10	7
The MHP reported no-shows for intake assessments, for which it has not set a benchmark. Only no-shows for county-operated appointments were included. The MHP's psychiatry no-show rate was 17.71 percent overall, 20.83 percent for adults, and 6.43 percent for children. The MHP's no-show rate for clinician appointments was 9.9 percent overall, 11 percent for adults, and 6.77 percent for children. The MHP did not track no-show for youth in FC. The adult no-show rate has improved in the past year (from 30 percent) and was attributed to increased use of reminder calls and improved access through telehealth and decreased transportation needs.			

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 contributes 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	11
The MHP incorporates cultural competency principles in its system of delivering care. The MHP has an active and well-attended cultural competency round table. The cultural competence committee meets quarterly and guides the MHP's trainings and cultural competency initiatives. MHP uses its own and other data to assess the cultural, ethnic, racial, and linguistic needs of its beneficiary population. An example of internal data is a new MHP survey on the beneficiary experiences during the			

Component		Maximum Possible	MHP Score
pandemic. A cultural competence plan update was not provided, but the MHP had updates on MHSA plan.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	8
The MHP facilitates a range of services at various levels of intensity, 46.12 percent of which are provided by SLOBHD, 52.04 percent by contract providers, and the remaining 1.84 percent by network providers. A focus in the past year has been on improving access to FSP programs: the MHP has added more staff to programs; increased slots; and incorporated a level of care instrument, the Milestones of Recovery Scale (MORS). The MHP has formalized a process for integrating youth, both FC and non-FC youth, into services after (an out-of-county) hospitalization. The MHP has not adopted a standard instrument for level of care. Level of care decisions are made based on assessment, clinical judgement, beneficiary goals, and available programs. There was no evidence of a regular process for evaluating transitions in care.			
3C	Quality Improvement Plan	10	7
The MHP has a current QI work plan. The work plan has goals and some measurable objectives. The work plan includes planned steps (i.e., actions to achieve objectives), but does not indicate who is responsible for the goals and objectives. Some of the objectives need more specificity or closer monitoring (e.g., annual review is insufficient to monitor change in the Latino penetration rate and maximize beneficiary satisfaction requires more than increasing completion rates on the Consumer Perception Survey (CPS)). The QI work plan does not include the findings and results from the previous year's QI activities, but the MHP did conduct an evaluation of the effectiveness of QI activities.			
3D	Quality Management Structure	14	10
The MHP has a designated QM unit, the QST that interfaces with other units in the department. The QST had a few staff changes over the past year. The team includes a designated manager as well as analysts. While the transition to new QST staff was smooth, QST has not caught up with the full monitoring of the unit. QST manages QI projects, data extraction, and routine monitoring. The QST holds monthly meetings, which were often attended by BHD leadership, as well as the SLO HA Director, behavioral health board members, program supervisors, and the Peer Advisory and Advocacy Team (PAAT). However, beneficiary and family member attendance were not evident. The QST is still in the process of developing a dashboard to include key indicators that speak to service utilization, quality, and outcomes.			

Component		Maximum Possible	MHP Score
3E	QM Reports Act as a Change Agent in the System	10	7
The MHP produces a variety of reports (e.g., inpatient (PHF) daily census; outpatient timeliness reports; failure to show; incident reports; caseload reporting). The reports are more effective in monitoring access and timeliness than quality and outcomes. The medical director discussed MHP plans to improve monitoring and reporting on outcomes, which would consider the tenure of the beneficiary's status as medication only; hospitalizations; readiness for discharge). The QST minutes reference review of reports, but not further action or decisions based on the findings. The QST did not endorse use of particular QI practices or change management approaches, but a general committee brainstorming on areas for change and improvement. The MHP had two PIPs, but the clinical project had insufficient clinical approach and the plan for improvement was vague.			
3F	Medication Management	12	9
The MHP has a medical peer review committee and a morbidity and mortality review committee. Prescribing practice and specifically polypharmacy is a subject of the medical peer review committee. The medical director endorsed a holistic approach to health that includes review of somatic conditions and collaboration with primary care providers. SLOBHD had a Health Integration Program in collaboration with the CHCs; however, this program has since ended with the conclusion of the grant period. As reported last year, the MHPs medication monitoring includes some recommended HEDIS measures (e.g., diabetes screening, cardiovascular screening for children prescribed stimulants, and regular EKGs), but documentation and communication on multiple concurrent medications, review and updates to the medication list were not explicitly noted. Communication between prescribers and therapists was improving; some clinics have weekly case reviews where therapists and psychiatric providers meet. LPTs filled this roll as liaison between psychiatric providers and therapists.			

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	12
The MHP has maintained usage of the Adult Needs and Strengths Assessment (ANSA), the Child and Adolescent Needs and Strength (CANS-50), and the Pediatric Symptom Checklist-35 Item (PSC-35). The ANSA is completed at the beginning of treatment and then yearly, while the children's measures are completed every six months. Staff reported that the measures were more effective as assessment tools, rather than measures of clinical outcomes; for that, clinicians use treatment goals. Children's CANS-50 and PSC-35 are aggregated to be sent to DHCS, but not used to look at beneficiary outcomes systemically.			
4B	Beneficiary Perceptions	10	5
MHP participates in the bi-annual CPS. The MHP also administers its own surveys and is intending to conduct a survey on services during COVID-19. The focus group participants endorsed participating in these surveys and, as before, did not report being provided with the results of those surveys. Other stakeholders, including staff and mental health board members, were informed of the results of the CPS survey in meetings. A goal of the QI work plan is to maximize beneficiary satisfaction; however, the QST only measures rate of response. The findings from previous surveys and areas needing improvement were not discussed.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
The MHP has a number of peer-run and peer-driven programs, facilitated through the contract provider TMHA: Hope House, Life House, and Safe Haven. The programs are located in each of the MHP's primary geographic service areas. A stand-out peer program is Growing Grounds that provides multi-faceted training, job readiness, and employment opportunities for beneficiaries. Beneficiaries are informed of the wellness and recovery programs after the completion of their initial assessments through a presentation by the service enhancement team and behavioral health navigators. The MHP's reports and documentation did not specifically mention services and utilization of the wellness programs.			

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

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>5A</td><td>Capability and Capacity of the MHP</td><td>30</td><td>24</td></tr>
<tr><td colspan="4">The MHP continues to offer variety of specialty mental health services, including outpatient clinics, medication support services, treatment residential programs, FSP programs for adults and children, mobile crisis, a CSU, and services for children in FC or at-risk of placement. The MHP has increased FSP programs in the past year. The MHP has access to psychiatric inpatient hospitals, which serve children who require hospitalization. The MHP does not provide day treatment, day rehabilitation, and crisis residential treatment, but collaborates with neighboring counties, Santa Barbara and Monterey, for crisis residential services.</td></tr>
<tr><td>5B</td><td>Network Enhancements</td><td>18</td><td>14</td></tr>
<tr><td colspan="4">The MHP has used telehealth services for psychiatry and because of COVID-19, has expanded telehealth for other clinical appointments. Stakeholders commented that while the MHP has adapted to provide access remotely and safely (via telephone and telehealth), COVID-19 has highlighted that some of the MHP’s systems and infrastructure are outdated and in need of upgrade. The MHP has co-located staff at the DSS and has school-based staff, mobile crisis, and field-based services. The MHP has maintained in-person and field-based services throughout COVID-19. The MHP is in the preliminary stages of implementing Whole Person Care and is developing policies to guide practice and service delivery. The MHP has few network providers and its network providers were thought to be limited in their capacity to provide Spanish-language services—an area of need.</td></tr>
<tr><td>5C</td><td>Subcontracts/Contract Providers</td><td>16</td><td>14</td></tr>
<tr><td colspan="4">Contract providers reported open communication and collaboration with SLOBHD. Contract providers remarked on the SLOBHD’s response to COVID-19 and keeping its partners informed. The MHP has maintained regular, monthly meetings with contract providers. While contract providers knew whom to contact at SLOBHD to raise concerns, they did not have a designated contract liaison. Contract providers are active members of committees and attend other meetings, including Homeless Oversite, cultural competence, and QST meetings. Double service entry was characteristic of contract providers, documenting services into the SLOBHD’s EHR as well as their own systems. Contract providers appreciated the department’s</td></tr>
</table>

Component		Maximum Possible	MHP Score
transparency on the budget concerns and inclusiveness on plans to transition to Cerner's Millennium system.			
5D	Stakeholder Engagement	12	10
Stakeholder participation has improved over the past year. Particularly with COVID-19, the MHP has made a concerted effort to keep stakeholders informed. Line staff were not noted to participate in system planning meetings, likely due to limited number and high caseloads; however, they did endorse receipt of information primarily from supervisors. Some staff noted that quality of the information varied depending on one's supervisor. Supervisors' focus has been on meeting the demand for services. They report having raised concerns about understaffing, including a staff protest in December 2019, but with no appreciable change in MHP's capacity to deliver services. While members of the PAAT were present in a number of meeting and committees, beneficiaries and family members from the focus group were less aware of the opportunities to give feedback and participate in system planning. As stated previously, contract providers endorsed regular and active engagement.			
5E	Peer Employment	8	5
MHP demonstrated peer and family member integration in the system of care. Designated peer positions are through the contract provider, TMHA. The opportunities for advancement were reported as limited. Besides the occasional training of new staff, which can be a supervisory task, there were no supervisory positions. Through a cooperative agreement between TMHA and the Department of Rehabilitation in 2017, the MHP provides comprehensive employment and educational support to beneficiaries.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of San Luis Obispo 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: Concept only, not yet active (not rated)

Access to Care

Changes within the Past Year:

- The MHP has expanded the use of telehealth in order to maintain services with beneficiaries while minimizing pandemic risk factors. The MHP utilizes Zoom for its telehealth platform.

Strengths:

- The MHP has been thoughtful about the service delivery during the pandemic and to date has conducted two reviews on the appropriate means to deliver services, including face-to-face, telehealth, telephone, field-based, or clinic-based.
- Beneficiaries are now able to go to the CSU directly without requiring a health screening at the emergency department first. The CSU is able to complete the health screenings on site, improving access to services.
- The Cultural Competence Newsletter is a well-put together document that keeps the MHP's partners informed about events, trainings, and relevant information pertinent to the community.

Opportunities for Improvement:

- Staff reported not having the bandwidth to locate/track down beneficiaries. Because the MHP is short-staffed, services are focused on meeting immediate needs. Beneficiaries who are persistent or who present with emergent health care needs are prioritized. Beneficiaries who may be less inclined to reach out but still require services are at increased risk. This is consistent with concern that beneficiaries are discharged because they do not engage with services.

- Beneficiaries living some distance from clinics will benefit from the on-going use of telehealth services post COVID-19.
- Hispanic beneficiaries in the focus groups were less informed of MHP services and resources than English-speaking focus group participants.

Timeliness of Services

Changes within the Past Year:

- None.

Strengths:

- The MHP has an i-STAT device that performs a broad range of diagnostic tests. Now, the CSU is able to complete the health screenings on site, obviating the need for an emergency department assessment and improving timeliness of crisis services.

Opportunities for Improvement:

- The MHP does not provide a comprehensive account of post-hospitalization follow-ups. The MHP only tracks follow-ups for beneficiaries who are new to services. Established beneficiaries, who likely make up the majority of hospitalizations and also require post-hospitalization follow-up appointments, are not monitored.
- Other timeliness metrics were also missing from its report: readmission rates and several FC metrics.
- The MHP met the 15-day standard for time to psychiatry for children only 53.0 percent of the time in FY 2019-20.

Quality of Care

Changes within the Past Year:

- The MHP made a number of changes to its FSP programs: adding medication support services; increased staff to provide more peer support; restructured staffing to provide more case management; and adding a youth partner for the youth and TAY FSP program.

Strengths:

- Contractor providers were proactive in facilitating remote services to beneficiaries, including delivering therapeutic material (e.g., for play therapy) as well as other resources for families (e.g., supplies and food boxes).

- The MHP implemented varied outreach efforts to the Latino population in a culturally sensitive manner. Some of these strategies included: contracting with Promotores, creating bilingual social media content on YouTube and social media platforms, working with a Mixteco interpreter, plans to purchase a full page in a local magazine called Somos to provide information on accessing mental health services, distributing mental health packets on self-care, and more.

Opportunities for Improvement:

- The MHP's evaluation of previous year's QI activities, initiatives, surveys, and programs were light on detail. The MHP provided results, but not the import, need, and/or plan for further improvement.

- The MHP does not have a policy for beneficiary level of care transition.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP designated MORS as the standard outcome measure for adults in FSP programs; staff were trained on the measure in February 2020.

Strengths:

- None noted.

Opportunities for Improvement:

- Outcome monitoring and measurement is not well evidenced in the MHP. Stakeholders reported that beneficiaries are discharged from care more often because of failure to show and treatment absence rather than positive outcomes.

Foster Care

Changes within the Past Year:

- The MHP is working with contract providers to approve two STRTPs, Aarons Boys Home and Youth Treatment Program.

- More youth have been identified as needing services in CY 2020 than in CY 2019. January through December 2020, the MHP has completed 74 assessments for youth in FC compared to 65 assessments for all of CY 2019.

Strengths:

- The MHP has effective coordination of care strategies with the DSS, which has resulted in timely referrals and efficient coordination of services for youth in FC.

Opportunities for Improvement:

- The MHP does not consistently disaggregate and report on timeliness to services for youth in FC. The MHP did not provide timeliness outcomes for youth in FC for the following timeliness metrics: first offered psychiatry appointment; follow-up appointments post-hospitalization; 30-day inpatient readmission rate; and no-shows.
- The MHP indicated that its service utilization and tracking mechanisms did not permit identification of FC status.

Information Systems

Changes within the Past Year:

- The contract was approved for migration from CCBH to Cerner's Millennium product.
- SLO HA IT removed administration rights from desktop computers.

Strengths:

- The SLO HA conducts phishing test to monitor staff compliance with email communication.

Opportunities for Improvement:

- Lack of IS representation in MHP executive team limits identification of issues and is not conducive to strategy discussions and decision-making.
- The MHP's transition to a new EHR would benefit from feedback and experience of other MHPs that have undergone a similar conversion.
- Collaboration with SLO HA IT division is needed to assure that critical business functions are maintained in the event of a cyber-attack, emergency, or disaster.

Structure and Operations

Changes within the Past Year:

- None noted.

Strengths:

- SLOBHD's staff are solution-focused. Despite ongoing staffing challenges, the staff were focused on delivering services to meet beneficiary need.
- There is a strong, collaborative, and bidirectional working relationship between the MHP and contract providers. Contractor providers report feeling supported by the MHP.

Opportunities for Improvement:

- Stakeholders reported a continued lack of a sufficient network provider pool, with bilingual network providers being even more scarce.
- Beneficiaries and family members were not present in QST meetings and, generally, were not aware of how their voice could be heard. Several of the focus group beneficiaries had never heard of the QIC or other committees where they could have greater input into system operations.

FY 2020-21 Recommendations

PIP Status

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.

Recommendation 2: Include clinical measures that are tracked both before and after the implementation of an intervention. (*This is a follow-up recommendation from FY 2019-20.*)

Access to Care

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

Timeliness of Services

Recommendation 4: Provide more complete and comprehensive reporting of timeliness, to include the entire system of service providers, youth in FC (first offered psychiatry appointment; follow-up appointments post-hospitalization; 30-day inpatient readmission rate; and no-shows), and established beneficiaries as well as new beneficiaries. (*This is a follow-up recommendation from FY 2019-20 and FY 2018-19.*)

Quality of Care

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

Beneficiary Outcomes

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

Foster Care

Recommendation 7: Modify the EHR and/or other information systems to include a FC designation/status. Such a field should be compulsory to ensure that it is consistently indicated. (*This is a follow-up recommendation from FY 2019-20 and FY 2018-19.*)

Information Systems

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

Structure and Operations

Recommendation 9: None noted.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.
- All participants in the Spanish-speaking adult focus group arrived between 30 to 45 minutes after the start of the focus group. This affected the ability of the reviewers to fully gather feedback from the beneficiaries.
- Due to the small number of participants in the parents and caregivers focus group, a true focus group was not held. Their feedback was included with that of the other focus group participants.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1: EQRO Review Sessions

San Luis Obispo County
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
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lamar Brandysky, LMFT, Information Systems Reviewer
Marlene Gold, 2nd Information Systems Reviewer
Olivia Kozarev, LCSW, 2nd Quality Reviewer
Pamela Roach, MEd, Consumer/Family Member Consultant
Ewurama Shaw-Taylor, PhD, Lead Quality Reviewer

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

Sites of MHP Review

MHP Sites

None

Contract Provider Sites

None

All sessions were held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Adoptante	Dana	Drug and Alcohol Services (DAS) Health Information Technician (HIT)	San Luis Obispo Behavioral Health Department (SLOBHD)
Archer	Michele	unknown	unknown
Atwell	Angela	Quality Support Team (QST) Utilization Review Nurse	SLOBHD
Bahner	Kristin	Program Supervisor, South County Youth	SLOBHD
Bailey	Kathy	QST Administrative Services Officer (ASO)	SLOBHD
Barnett	Cyndi	Clinical Manager	Family Care Network, Inc.
Barrette	Kristy	BH Clinician	SLOBHD
Bolster-White	Jill	Executive Director	Transitions Mental Health Association (TMHA)
Byers	John	Homeless Outreach Team Peer Mentor	TMHA
Clementi	Tony	Service Enhancement Team	TMHA
Crabill	Chelsea	Peer Advisory and Advocacy Team	TMHA
Diaz	Araceli	TAY Partner	Family Care Network, Inc.
Dueck	Alicia	Program Supervisor, Managed Care	SLOBHD
Elliott	Jeffrey	QST BH Clinician	SLOBHD
Epps	Sara	QST ASO	SLOBHD
Feliciano	Katrina	DAS ASO	SLOBHD
Forgette	Gina	Program Supervisor, Youth Services	SLOBHD
Friedrich	Danielle	Behavioral Health Navigator	TMHA
George	Tony	WRAP Family Partner	Family Care Network, Inc.

Last Name	First Name	Position	Agency
Getten	Amanda	Division Manager, QST	SLOBHD
Godfrey	Mike	unknown	unknown
Goodman	Ramona	Licensed Psychiatric Technician (LPT), Adult	SLOBHD
Graber	Star	Division Manager, DAS	SLOBHD
Heintz	Molly	IT ASO	SLOBHD
Hibble	Norman	IT Supervisor	SLO HA
Hill	Michael	Health Agency Director	SLO Health Agency (HA)
Hoffman	Christine	Program Supervisor, South County SAFE	SLOBHD
Hopkins	Denise	Fiscal Department Manager	SLO HA
Ilano	Daisy	Medical Director	SLOBHD
LaChapelle	Tom	BH Clinician	SLOBHD
Lamore	Mark	Program Supervisor	TMHA
Lehman	Tina	Clinical Director	Kinship
Limon	Enrique	Accountant	SLO HA
Linn-Castro	Crystal	FSP Youth Partner	Family Care Network, Inc.
Maxwell	Kevin	LPT, Adult	SLOBHD
McGuire	Kathy	Medical Records Supervisor	SLOBHD
Mendez	Louise	Senior Account Clerk	SLO HA
Mendoza	Conrad	BH Clinician	SLOBHD
Menghrajani	Christina	Program Supervisor, QST and FSP Coordinator	SLOBHD
Michels	Dave	Compliance and Privacy Officer	SLO HA
Miranda	Daniel	LPT, Youth	SLOBHD
Newsum	Candice	BH Clinician	SLOBHD
Nibbio	Jon	Chief Operating Officer & Director of Clinical Services	Family Care Network, Inc.

Last Name	First Name	Position	Agency
Parham	Rebecca	Program Supervisor, Central Adults	SLOBHD
Patlan	Juanita	unknown	unknown
Pemberton	Teresa	Justice Services Division Manager	SLOBHD
Perez	Irma	Program Manager, DAS	SLOBHD
Peters	Josh	Program Supervisor, Prevention & Outreach	SLOBHD
Pille	Marivel	Parent Partner/Martha's Place	SLO HA
Pirruccello	Christine	Program Manager, Crisis Services	Sierra Mental Wellness Group
Parham	Rebecca	Program Supervisor, Central Adults	SLOBHD
Patlan	Juanita	unknown	unknown
Pemberton	Teresa	Justice Services Division Manager	SLOBHD
Perez	Irma	Program Manager, DAS	SLOBHD
Peters	Josh	Program Supervisor, Prevention & Outreach	SLOBHD
Pille	Marivel	Parent Partner/Martha's Place	SLO HA
Pirruccello	Christine	Program Manager, Crisis Services	Sierra Mental Wellness Group
Schmidt	Julianne	QST BH Clinician	SLOBHD
Seamen	Kimberly	unknown	unknown
Simpson	Josh	LPT, Adult	SLOBHD
Sverchek	Bill	Peer Advisory and Advocacy Team	TMHA
Twaddell	Brian	LPT, Adult	SLOBHD
Veloz-Passalacqua	Nestor	Program Manager and Ethnic Services Manager; Whole Person Care Manager	SLO HA

Last Name	First Name	Position	Agency
Ventresca	Kristin	Program Manager, Community Services and Support Program	SLOBHD
Vick	Judy	Division Manager, Adult	SLOBHD
Volk	Valentina	Service Enhancement Team	TMHA
unknown	Danni	Parent Partner	unknown
Warren	Frank	Prevention & Outreach Division Manager	SLOBHD
Weirick	Clint	Board Member	SLO Behavioral Health Board
Woodbury	Josh	Program Supervisor	SLOBHD

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 Luis Obispo 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	17,225	883	5.13%	$4,345,787	$4,922

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 Luis Obispo MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	3,374	91.34%	93.31%	$13,689,521	$4,057	$3,998	53.60%	59.06%
>$20K - $30K	139	3.76%	3.20%	$3,425,732	$24,646	$24,251	13.41%	12.29%
>$30K	181	4.90%	3.49%	$8,425,354	$46,549	$51,883	32.99%	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	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