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

SAN FRANCISCO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 14-16, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — November 14-16, 2023

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	5	1	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**19**	**7**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Adapt a level of care (LOC) tool to support clients getting to the right LOC"	Clinical	10/2023	Planning	Moderate
"Hiring Culturally Congruent Workforce"	Non-Clinical	01/2023	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	13
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	6
3	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- MHP psychiatric pharmacists work to identify prescribing treads and participate in detailed data analysis through the medication use improvement committee (MUIC).
- Members can participate and gain employment skills through an MHP sponsored vocational program in areas such as janitorial services, a café, mail room, and the Avatar helpdesk.
- With over 70 percent of billable services submitted through contracted organizations, the MHP reported a very low overall denial rate of 1.16 percent.
- The MHP has prepared extensively for the upcoming Epic Electronic Health Record (EHR) role out, creating, testing, and validating documents for upload, training, and creating a new Director of Informatics.
- The MHP created a new adult level of care (LOC) tool to identify appropriate member placement and movement within the continuum of care (COC).

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

- The current website continues to lack basic crisis service information such as 988, and easily identified services or resources the MHP offers.

- The MHP aspires to review all goals and objectives within the Quality Assessment Performance Improvement (QAPI) plan but would be better served prioritizing two to three goals with input from members.
- Contracted community based organizations (CBO) report a lack of preparation for the new EHR rollout, low capacity, and lack of communication throughout the SOC. The potential for incomplete compliance may be remedied by a collaborative learning experience.
- Internal key informants across the system of care (SOC) reported an overall lack of knowledge of the COC and being unfamiliar with available resources and referral options.
- External key informants across the SOC reported an overall lack of knowledge of the COC; being unfamiliar with available resources and are not provided with a warm hand-off when being referred to other services such as the Managed Care Plan (MCP).

Recommendations for improvement based upon this review include:

- Identify immediate updates to the department's public website, including prominent crisis and access to services phone numbers and addresses, and an updated COC flow chart; provide information in primary threshold languages.
- Expand on two to three outcome goals within the QAPI, by identifying impacts on member experience that coincide with achieved compliance goals.
- Provide presentations and training to disseminate information on department changes and expectations for all staffing levels throughout the SOC, documenting the distribution of knowledge within the CBOs.
- Create a COC flow chart for all staff throughout the SOC; provide up to date referral, location, contact information, and member qualification; and ensure members receive a warm hand-off when being referred for services.
- Provide all members, their families, or caregivers throughout the SOC a COC flow chart to identify all available services and resources; to include contact information, location, languages offered, and access qualifications.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for San Francisco County MHP by BHC, conducted as a virtual review on November 14-16, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

There was no environmental impact affecting the MHP operations.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Due to CalAIM there have been significant changes to the payment and documentation of Medi-Cal services.
- The MHP is planning for an Epic EHR launch which requires dedicated time and resources to the process.
- The MHP continues to juggle numerous initiatives occurring simultaneously, including Care Court, SB 43, infrastructure grants, and CalAIM.
- Work force recruitment and retention continue to be a challenge for both civil service and CBO positions.
- The MHP expanded critical behavioral health infrastructure such as residential treatment and street response.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: Customize Epic for maximum efficiency and accuracy in data collection to improve validity and reliability of data, minimize impacts of understaffing, make documentation more manageable for line staff, and improve worker retention. Engage contracted CBOs throughout the implementation process to assist them with the rollout and mitigate the transition's impacts on staff.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- A centralized San Francisco Department of Public Health (SFDPH) Epic EHR support team has been working to make sure the build meets the needs of Behavioral Health Services (BHS). Using the SFDPH team helps decrease the demands placed on BHS Information Technology (IT) staff. Ongoing workgroups focused on specific service modalities have been held since May 2023 to determine workflows, and a test session is scheduled for December 2023, followed by demonstrations of all workflows in January 2024.
- Training courses are open to all county and CBO staff, and there is also a public-facing webpage that includes training resources and information. The MHP reports CBO staff are involved in the planning process for the rollout of Epic and have opportunities to provide feedback and ask questions via the workgroups.

- Engagement efforts may not be transcending all levels of the workforce as key informants within the SOC do not know when the go-live date is or how the transition from Avatar will take place.
- The MHP has requested Epic "champions" to work within the SOC for ease of transition.
- The go-live date is currently set for May 2024. The MHP cannot move forward until the Epic work team has completed the build and upload of MHP specific requirements. The actual impact on staff will be unknown for some time. For this reason, the recommendation will not be carried forward.

Recommendation 2: Identify and utilize a LOC tool within the AOA and TAY SOC that provides the necessary data and facilitates conversations with beneficiaries, to impact service delivery and the ability to seamlessly transition to a lower LOC.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP established a workgroup to research and develop a LOC that will reduce documentation burden, to be a decision-making tool, and increase the percentage of reassessment to 75 percent.
- By reviewing LOC examples and working with the Praed Foundation the MHP created a LOC tool. The MHP was able to develop an algorithm and ran a qualitative review of the tool this FY to gather feedback from a clinical perspective. The MHP has plans to revise the algorithm as needed.
- The MHP will wait for rollout of the new EHR to determine the use and effectiveness of this tool in real-time. Until the roll-out of the new EHR is complete the MHP is unable to move forward with full utilization of the LOC tool, and for this reason the recommendation will not be carried forward.

Recommendation 3: Utilize feedback from internal teams, the Community Action Board (CAB), and peer contracted CBOs to identify immediate updates to the website, including crisis and access to services phone numbers and addresses, and consistent messaging of programs and resources.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP reported receiving feedback from internal teams, city, and contracted partners that requested clear and readily accessible information on how people can connect with services.
- The MHP reported waiting on website data analytics to determine the need for information to upload.
- Upon review of the new website version by the EQR team, it was noted that it is not very user friendly and there are several areas warranting attention include:
    - Lack of easily accessible crisis numbers or 988.
    - Different versions of the member handbook exist with different years.

- Child, youth and family services were found under the “Services for people age 18-25.”
- The access line and crisis information is listed on the home page, with “Learn About our Services,” shows a provider list updated 4/2020 and a PDF version dated 2023 in a separate location.
- The translation tab does not include access for all priority threshold languages.
- There is no information on the Client Perception Survey (CPS), not even to describe the lack of listing due to the low number of respondents.

- Because the website continues to lack the most basic and necessary information for the public, this recommendation will be carried forward.

Recommendation 4: Expand on outcome goals within the QIWP by identifying impact goals that coincide with achieved compliance goals. Utilize information about the beneficiary experience, including goal-specific surveys, LOC tools, and/or client perception survey results.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP plans to improve all data quality prior to deciding impact goals and engaging the members. This will be a multi-year effort and cannot be accomplished without the new EHR functioning and members engaged.
- This recommendation will be carried forward with the modification of limiting the review of data quality by identifying two to three priority goals that can be improved and engaging the members in the discussion of the mental health impact.

Recommendation 5: Enhance contract oversight to ensure contracted CBOs are consistently and accurately submitting required access, timeliness, and capacity data to improve access to services by avoiding long wait times and lack of resources within the SOC.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP meets with contracted CBOs in monthly contract meetings. This effort improved the submittal of timeliness data, however, there remain those contractors that are out of compliance.
- Key informants throughout the SOC reported the lack of capacity and members having longer wait times for services; this was due in large part to the lack of staffing and attempts to comply with new CalAIM mandates.
- Key informants report a lack of knowledge of resources available to them to move members throughout the SOC.
- The MHP offers an array of training courses throughout the year but cannot determine if those trainings are being attended by staff that are most impacted by

the changes. The lack of a COC of resources offered by the MHP has been reported to hinder the movement of members throughout the SOC, and some members are left without services when being referred to the MCP.

- The MHP has created extensive training efforts for the CalAIM mandate, testing of new documents, planning for the seamless role out of the new EHR, reviewing pay discrepancies, and yet, the CBOs are reporting these efforts are unknown, or not accessed due to lack of communication, lack of understanding and lack of capacity. For these reasons the recommendation will be carried forward with an added recommendation of creating a COC flow chart and collaborative learning opportunities.
- This recommendation is continued in similar form in this year's report.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 28.11 percent of services were delivered by county-operated/staffed clinics and sites, and 71.89 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78.66 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free behavioral health (BH) access line available to beneficiaries 24 hours, 7 days per week that is operated by MHP staff during regular business hours and through a contracted provider after hours; beneficiaries may request information regarding access to services through the access line as well as upon request through direct walk-in to clinic/program sites. A separate physical space, the BH Access Center is available on a walk in/drop-in basis 64 hours per week, into weekday evenings and on weekends. Requests for service through the Access teams are documented in Epic

[1] CMS Data Navigator Glossary of Terms

and not included as part of timeliness data reporting, which currently occurs out of Avatar only.

The access teams are constituent programs of the newly created Office of Coordinated Care (OCC) which also provides centralized care coordination services for beneficiaries needing specialized care coordination, outreach, and engagement to connect to behavioral health care. Areas of focus for OCC's care coordination services include individuals who are unhoused or experiencing homelessness with significant unmet mental health needs, individuals transitioning from higher acuity settings such as hospitals, and individuals who have had contact with crisis services. OCC's care coordination follow-up teams provide intensive and field-based outreach, engagement, and case management services.

In addition to in-person MH services (which occur in clinics and in the field), the MHP provides psychiatry and MH services via telehealth videoconferencing and phone to youth and adults. In FY 2022-2023, the MHP reports having provided telehealth services to 1,806 adults, 1,719 youth, and 228 older adults across 14 county-operated sites and 43 contractor-operated sites. Among those served, 875 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

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

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

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

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

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

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP conducted a workforce demographic study to advocate for human resource recruitment based on the cultural needs of the members.

- The MHP continues to increase their ability to address capacity issues within civil service employment. The challenges remain for the CBOs that lose staff to the jobs within the civil service sector.
- The MHP actively collaborates and coordinates with multiple governmental and community agencies.
- The MHP lacks a comprehensive guide describing all services and resources within the SOC that is easily accessible. Key informants report the lack of knowledge of wellness centers and the ability to access transportation.
- The new website lacks basic information regarding ease of access to crisis information, resources, and ability to access information in priority threshold languages.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, San Francisco demonstrates better access to care than reported statewide, with a PR of 5.53 percent.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	245,424	13,583	5.53%	$208,994,304	$15,386
CY 2021	230,892	13,866	6.01%	$194,130,063	$14,000
CY 2020	212,258	13,553	6.39%	$175,604,455	$12,957

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

- The total members eligible, number of members served, total approved claims, and average approved claims per member all show increases over the past three CYs. The total PR has been trending downwards over the past three years.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	14,666	431	2.94%	1.50%	1.82%
Ages 6-17	34,678	2,470	7.12%	5.01%	5.65%
Ages 18-20	8,871	493	5.56%	3.66%	3.97%
Ages 21-64	135,944	8,461	6.22%	3.73%	4.03%
Ages 65+	51,268	1,728	3.37%	1.64%	1.86%
Total	**245,424**	**13,583**	**5.53%**	**3.60%**	**3.96%**

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

- PRs for all age groups were higher than those in similar sized counties and statewide.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	1,510	11.41%
Cantonese	1,135	8.58%
Vietnamese	144	1.09%
Russian	142	1.07%
Mandarin	134	1.01%
Members Served in Threshold Languages	**3,065**	**23.16%**
Threshold language source: Open Data per BHIN 20-070		

- The county had five threshold languages, with the largest being Spanish with 11.41 percent, followed by Cantonese with 8.58 percent reported.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	93,011	3,764	4.05%	$47,953,360	$12,740
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This pattern held true within the MHP for the AACM and total ACA eligibles.
- The MHP PR for the ACA eligible population was lower than that of other large counties and the statewide PR for this group.

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

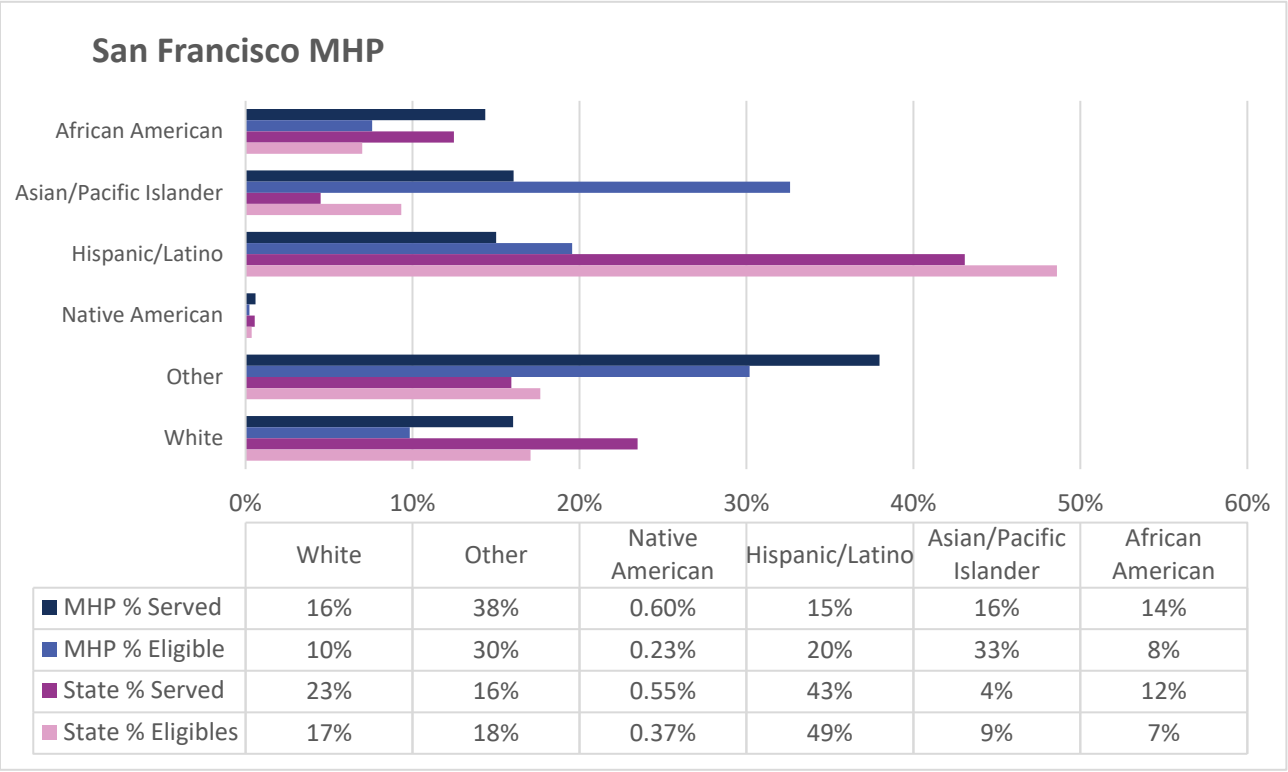
Table 7: San Francisco MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	18,616	1,950	10.47%	7.08%
Asian/Pacific Islander	80,040	2,180	2.72%	1.91%
Hispanic/Latino	48,001	2,038	4.25%	3.51%
Native American	567	81	14.29%	5.94%
Other	74,080	5,157	6.96%	3.57%
White	24,122	2,177	9.02%	5.45%
Total	**245,426**	**13,583**	**5.53%**	**3.96%**

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

- The Hispanic/Latino population makes up the second largest racial/ethnic group of eligibles in the county and has one of the lowest PRs.
- PRs were higher than the statewide PRs for all racial ethnic/groups.
- Asian/Pacific Islander members had the lowest PR of any group, whereas African American members had the highest PR, followed by Native American members.

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

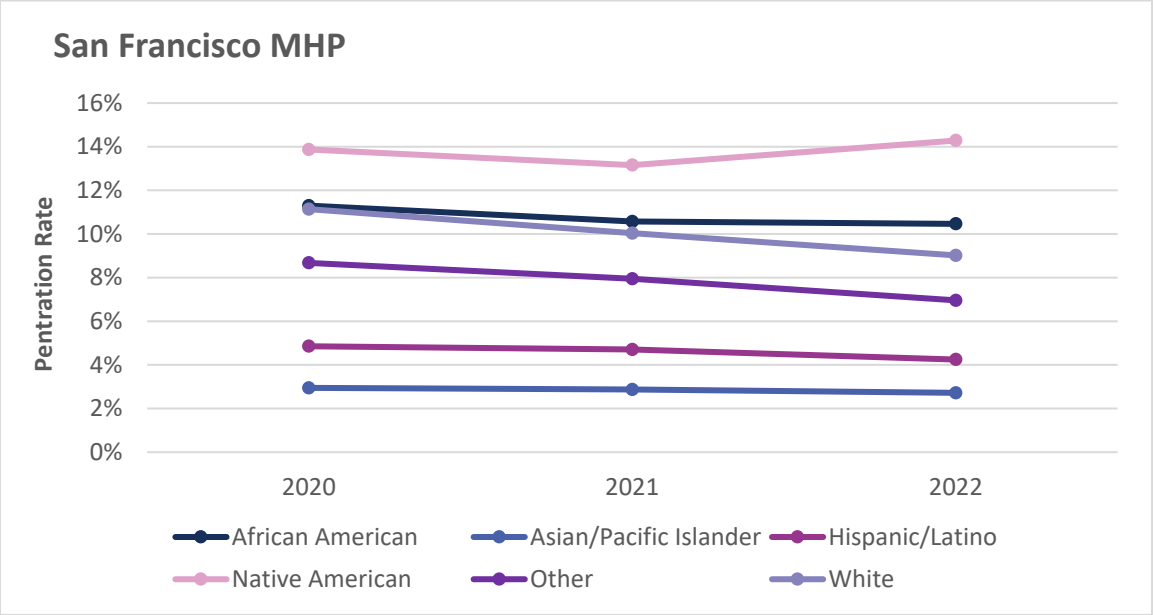


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	16%	38%	0.60%	15%	16%	14%
MHP % Eligible	10%	30%	0.23%	20%	33%	8%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- Proportionally, the most overrepresented groups in the MHP were those in the “Other” category (which includes members who select "decline to state” and those for whom data was missing, as well as those who identify as biracial or multiracial), White, and African American members. Asian/Pacific Islander members and Hispanic/Latino members served were underrepresented relative to their proportion of the eligible population.
- The largest disparity was among Asian/Pacific Islanders, who made up 33 percent of eligibles yet only 16 percent of members served.

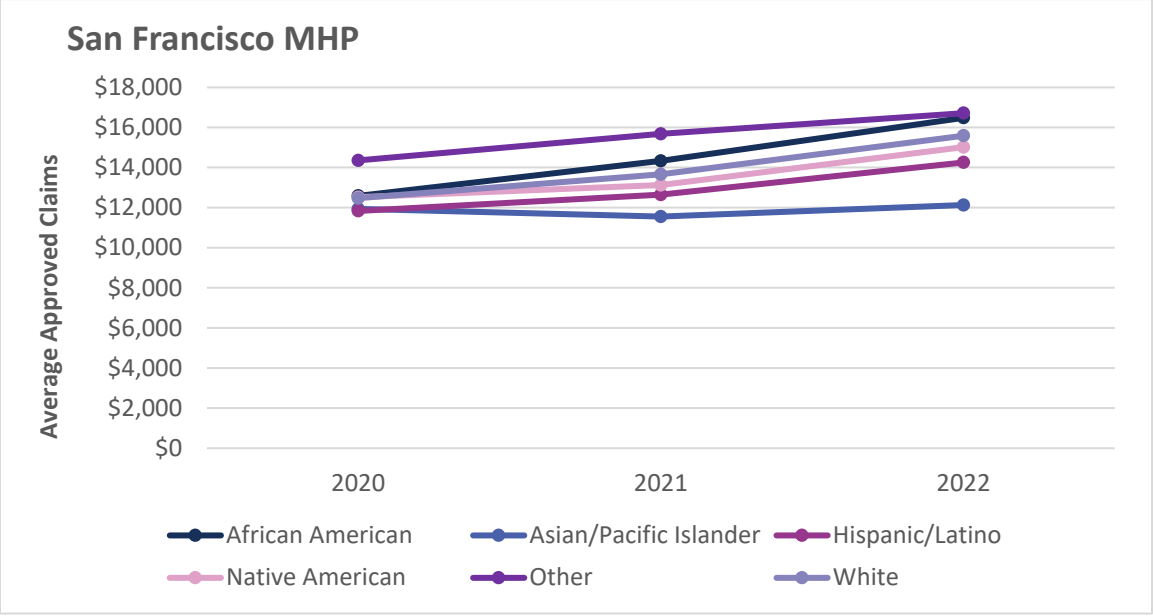
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



- Over the past three CYs, PRs for Asian/Pacific Islander and Hispanic/Latino eligibles have been consistently lower than those of other racial/ethnic groups.

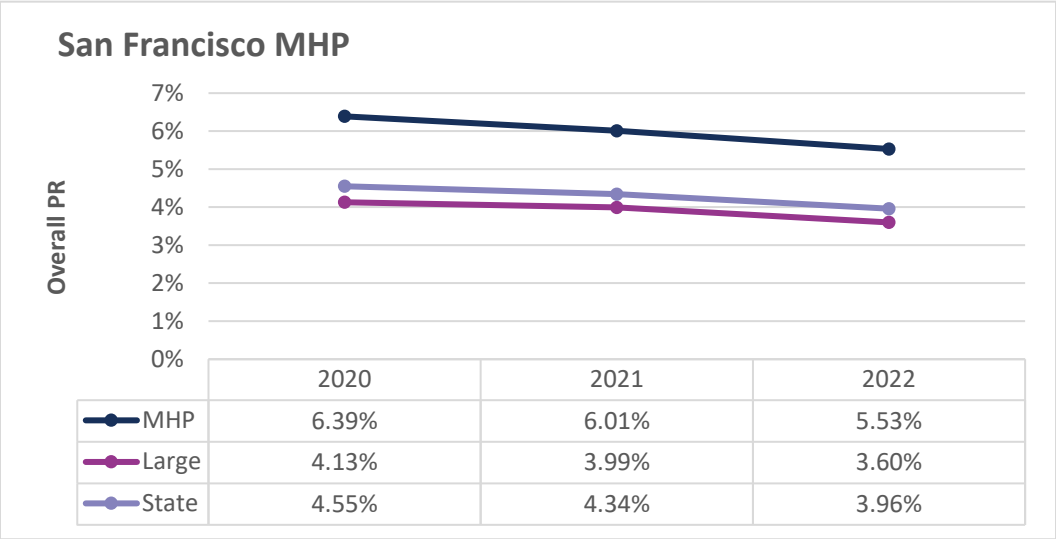
Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



- The AACM for Asian/Pacific Islander members was lower than the AACM for the MHP overall, indicating fewer and or less intensive/costly services were provided to this population.

- AACMs across racial/ethnic groups were trending upward for CY 2020 through 2022 except for Asian/Pacific Islander population.

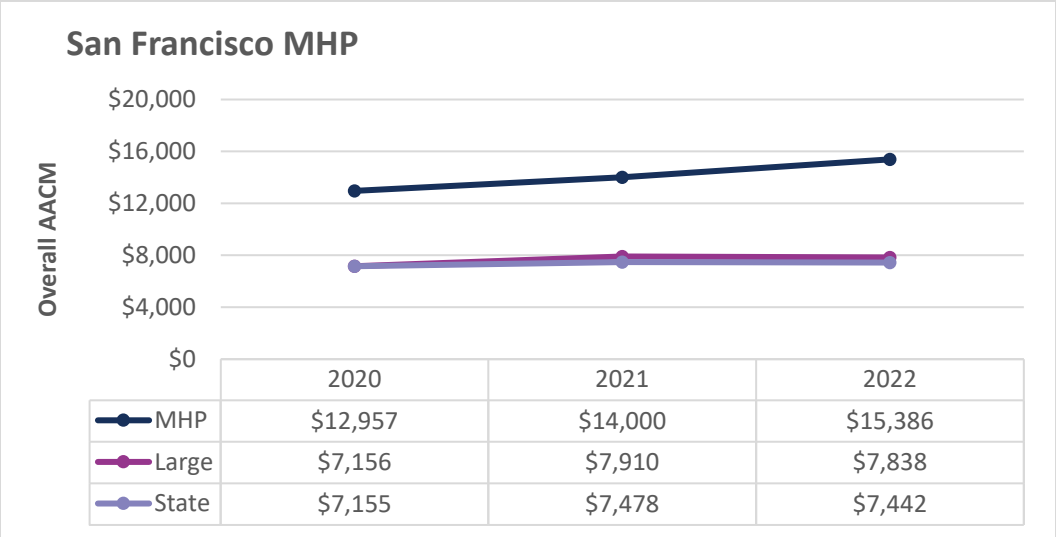
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	6.39%	6.01%	5.53%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- The MHPs PR is consistently higher than in similarly sized counties and statewide.
- PR in the MHP has been trending downward over time, reflecting similar trends seen statewide.

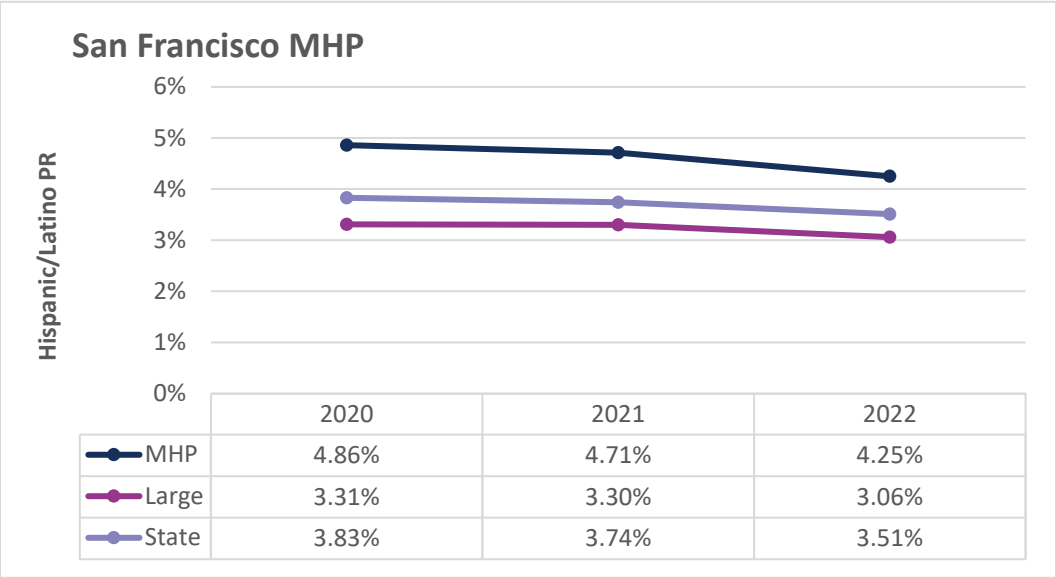
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$12,957	$14,000	$15,386
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- AACM in the MHP is consistently higher than in other large counties and statewide, though this gap has widened slightly over the past two years.

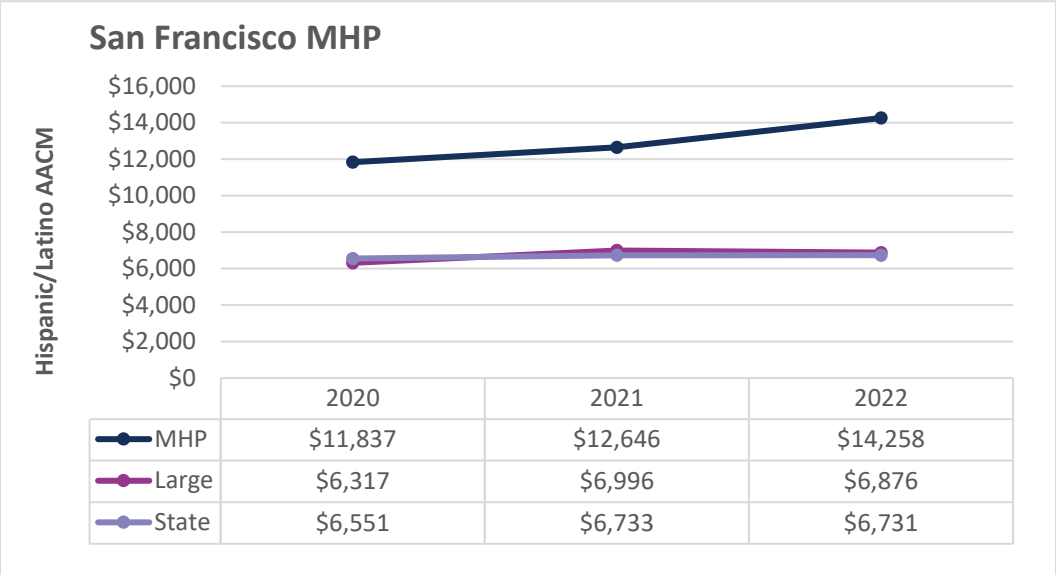
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	4.86%	4.71%	4.25%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- The PRs for the Hispanic/Latino populations are consistently higher than in large counties and statewide across all of the past three years, and all have been trending downwards.

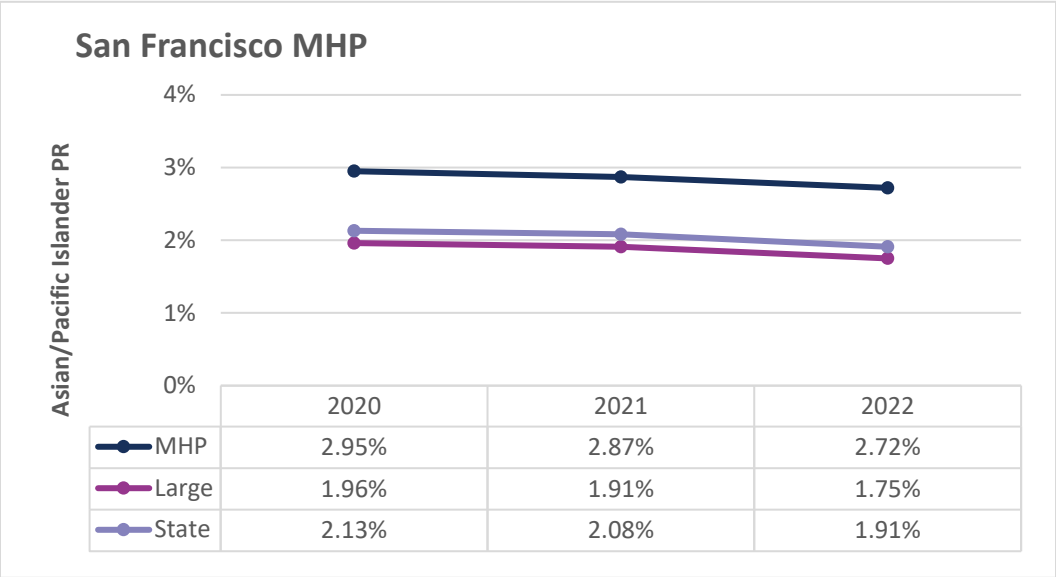
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$11,837	$12,646	$14,258
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- Hispanic Latino AACMs have been consistently higher in the MHP as compared to large counties and statewide.
- The gap between the MHP and large counties/statewide AACMs widened in CY 2022 as large county and statewide AACMs trended downwards while the MHP's increased.

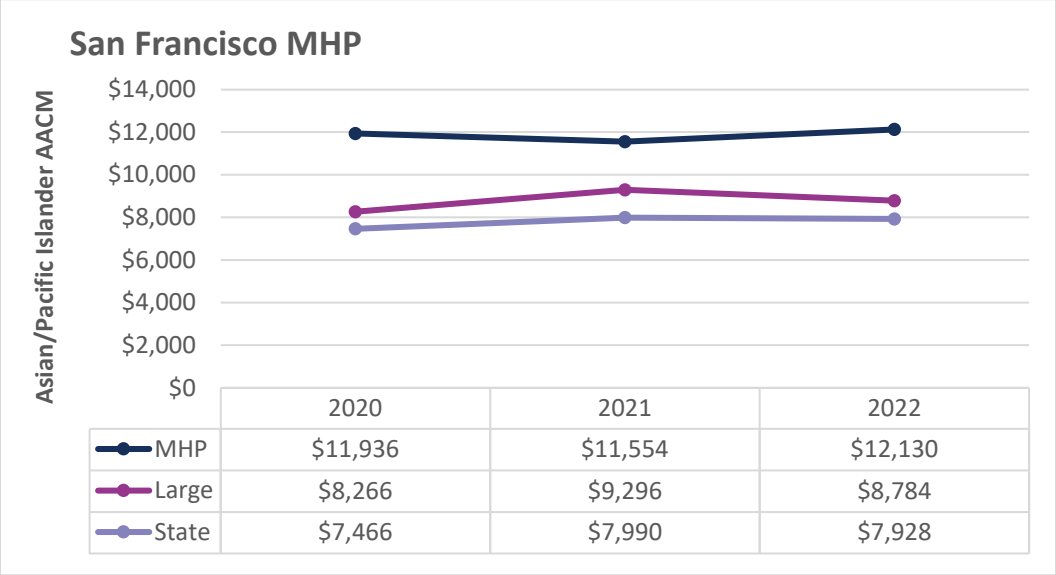
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.95%	2.87%	2.72%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- As with large counties and statewide, the Asian/Pacific Islander PR has been trending downward, though the MHP's PRs for this group has been consistently higher than either comparison.

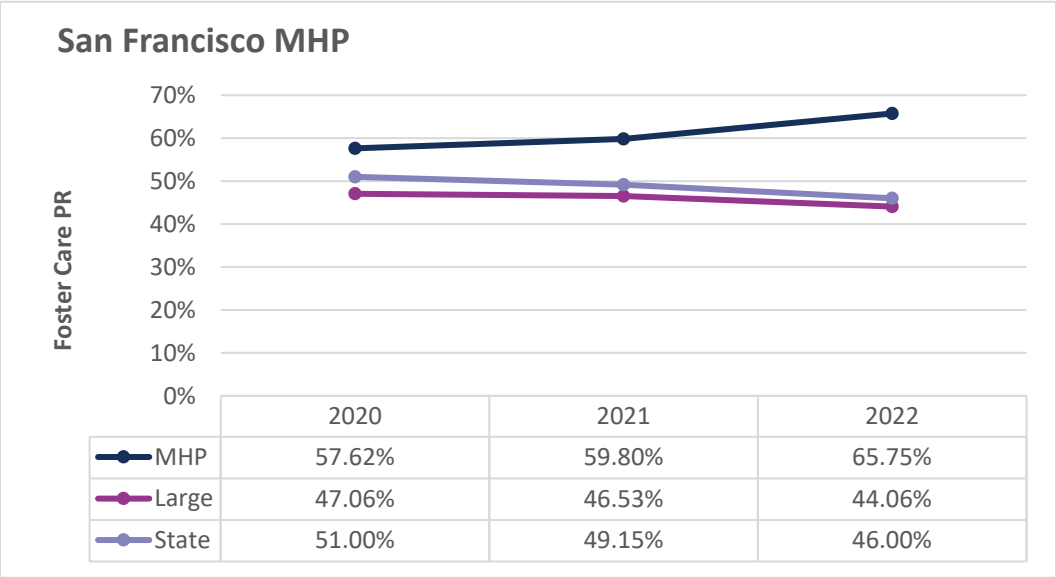
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$11,936	$11,554	$12,130
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM has been consistently higher than in large counties and statewide has been relatively stable over the past three years.

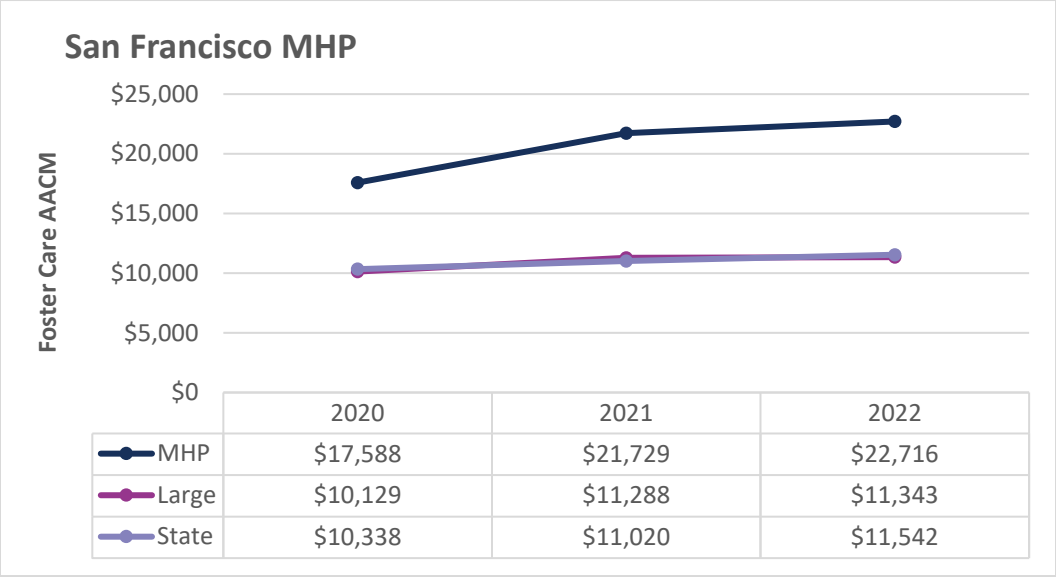
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	57.62%	59.80%	65.75%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- The MHP's FC PR has been higher than large county and statewide FC PRs in each of the past three years, with its highest rate at 65.75 percent in CY 2022. The MHP has increased its FC PR while both comparisons have decreased since CY 2020.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$17,588	$21,729	$22,716
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- MHP, large county, and statewide FC AACMs have increased each year for the past three years.
- The MHP has consistently had a substantially higher FC AACM than large counties and the state as a whole.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 10,682				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	926	8.7%	8	5	10.3%	14	8
Inpatient Admin	88	0.8%	37	17	0.4%	26	10
Psychiatric Health Facility	<11	-	22	8	1.2%	16	8
Residential	324	3.0%	82	71	0.3%	114	84
Crisis Residential	274	2.6%	25	19	1.9%	23	15
Per Minute Services							
Crisis Stabilization	1,369	12.8%	2,655	1,200	13.4%	1,449	1,200
Crisis Intervention	979	9.2%	174	94	12.2%	236	144
Medication Support	6,258	58.6%	367	205	59.7%	298	190
Mental Health Services	7,005	65.6%	792	455	62.7%	832	329
Targeted Case Management	4,635	43.4%	545	137	36.9%	445	135

- The most utilized adult services were mental health services, medication support, and targeted case management (TCM). This reflects the statewide utilization patterns, though TCM had a higher utilization rate in the MHP than statewide.
- For services that are billed per day there are some differences between the MHP and statewide in terms of average units. Most notable is the difference in the inpatient administrative days, with the MHP having an average of 11 days longer stay than seen statewide, reflecting known challenges in stepping people down from inpatient services to a lower LOC.
- For per minute services, crisis stabilization unit (CSU) services had an average of 1,206 minutes more billed than the statewide average for this service, an equivalent of more than 20 hours difference. The median units billed for CSU was the same as statewide, indicating that there may be some members with particularly large numbers of minutes billed, thus skewing the average (mean) upward. The other per minute service average units billed were comparable to statewide averages.

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

Service Category	MHP N = 624				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	16	2.6%	10	11	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	6	6	0.2%	19	8
Residential	<11	-	39	39	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	<11	-	1,053	1,104	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	13	2.1%	988	1,140	3.1%	1,166	1,095
Crisis Intervention	27	4.3%	555	310	8.5%	371	182
Medication Support	101	16.2%	397	284	27.6%	364	257
TBS	15	2.4%	3,522	2,930	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	121	19.4%	1,030	606	40.8%	1,458	441
Intensive Home-Based Services	84	13.5%	2,837	1,171	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	552	88.5%	2,327	1,030	95.4%	1,846	1,053
Targeted Case Management	487	78.0%	294	84	35.8%	307	118

- The most utilized FC youth services in the MHP were mental health services, TCM, and intensive care coordination (ICC). While TCM was utilized at a much higher rate in the MHP than statewide, ICC and, to a lesser extent, mental health services were utilized at lower rates in the MHP than statewide.
- Intensive home-based services and medication support were also utilized at lower rates than statewide.

IMPACT OF ACCESS FINDINGS

- The MHP continues to experience staffing shortages across county teams and in contracted CBOs. The SFDPH used innovation via concerted hiring efforts to address these shortages. They are approaching access with utilization management by looking more closely at reassessing members for the right level of care. Transitioning members who may benefit from a different level of care will manage the flow of services for new and recovering members. SFDPH is minimizing the effects of staffing shortage and preventing bottlenecks in the system, while maintaining system capacity and members' ability to access appropriate services in a timely manner.
- The lack of a reliable website is a missed opportunity for those in the community who seek to understand what services are available to them or their loved ones in the moment of a crisis, or simply to gain access to mental health outpatient services. For those who speak languages other than English, Spanish and Chinese, the website's missing Vietnamese threshold language translation may prevent the community from accessing services.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP consistently tracks and reviews data. Though they report on the full SOC the CBOs are not always consistent with their data submittal.

- The MHP uses the data received to identify areas of needed improvement. The MHP identified challenges in their methodology for follow-up after hospitalization and are now working with hospitals to identify all pathways for individuals to be referred from the hospital setting to BH.
- The low rates of follow-up resulted in the MHP creating care management teams and updated Memorandum of Understanding with local hospitals.
- The MHP has worked extensively with the EPIC team to identify, test, and validate the data format for collecting accurate data within the EPIC EHR.
- The MHP uses a varying standard percentage rate per age group for no-show rates for psychiatrists, though the MHP cannot accurately report on the meaning behind the chosen rates. The MHP does not determine a timeframe for reporting no-show rates.

TIMELINESS PERFORMANCE MEASURES

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

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

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	8.7 Business Days	10 Business Days*	82.1%
First Non-Urgent Service Rendered	10.5 Business Days	10Business Days**	67.7%
First Non-Urgent Psychiatry Appointment Offered	7.0 Business Days	15 Business Days*	89.7%
First Non-Urgent Psychiatry Service Rendered	8.9 Business Days	15Business Days**	83.7%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	6.8 Hours	48 Hours*	96.7%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	20.8 Calendar Days	7 Calendar Days	42.1%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	20.8 Calendar Days	30 Calendar Days	50.5%
No-Show Rate – Psychiatry	12.4%	Differs by age group**	n/a
No-Show Rate – Clinicians	5.6%	10.0%**	n/a

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

** MHP-defined timeliness standards

*** The MHP does not require prior authorization for urgent services.

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

FY 2022-2023

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

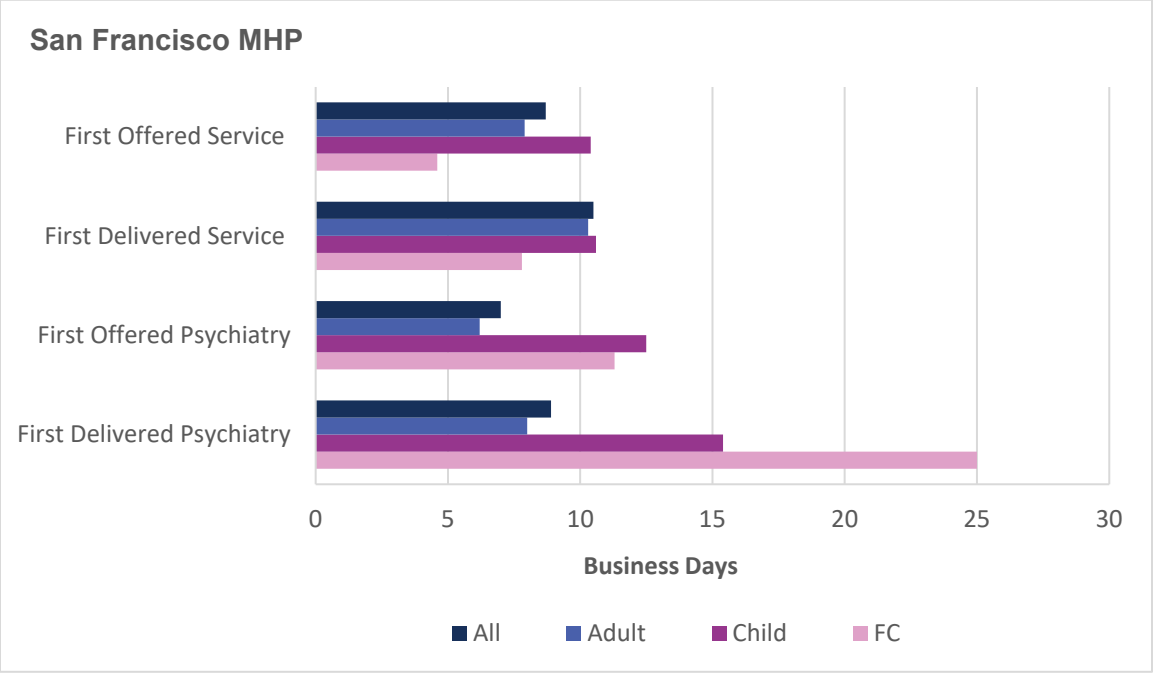


Figure 13: Wait Times for Urgent Services

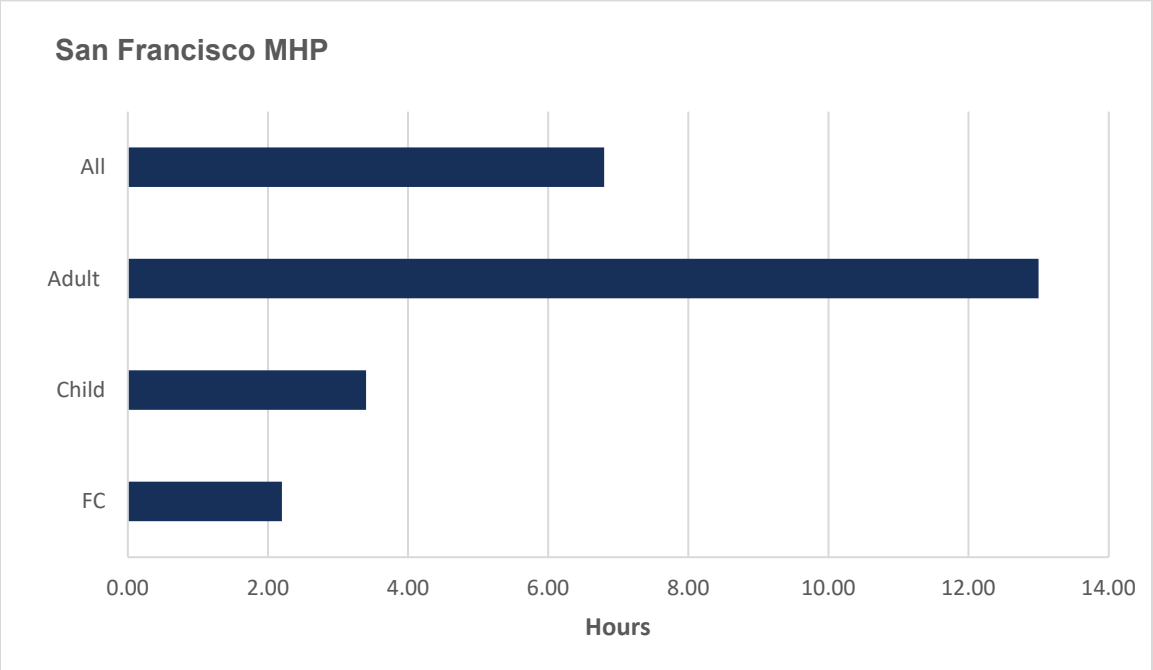
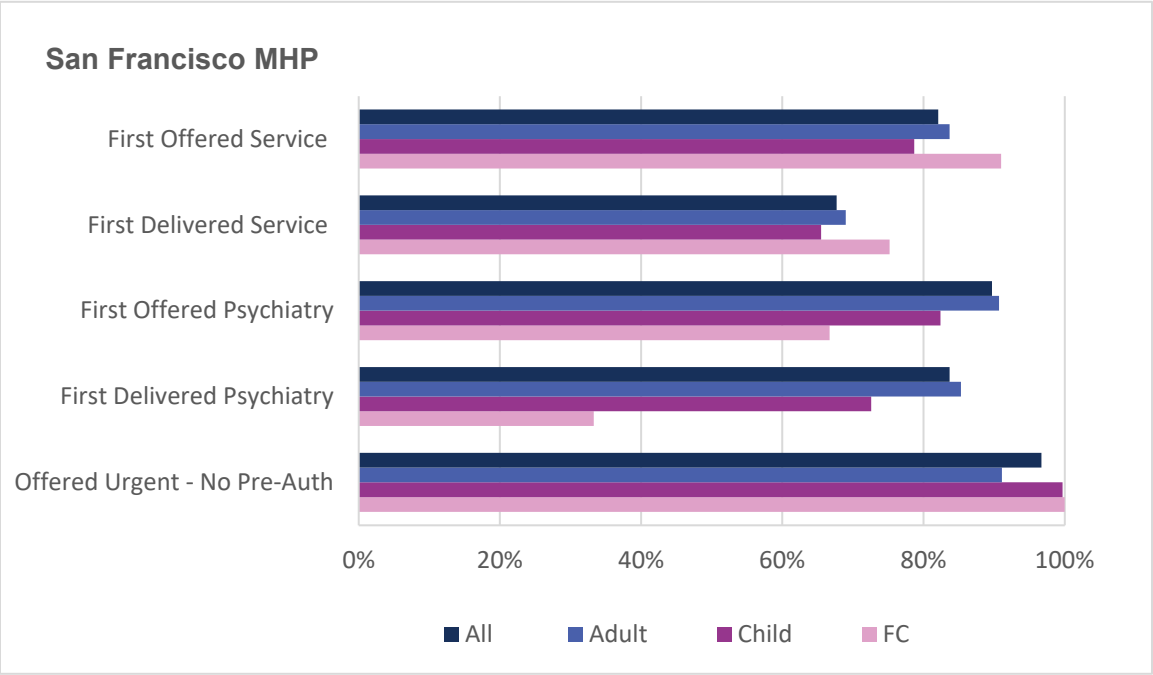


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent data extracted from two timeliness forms in the Avatar EHR: Timely Access Log and CSI Assessment. The Timely Access Log captures data at the client level whereas the CSI Assessment captures data at the treatment episode level.
- The MHP defined “urgent services” for purposes of the ATA as data extracted from the comprehensive crisis services (CCS) crisis evaluation form in Avatar EHR. There were reportedly 673 urgent service requests with a reported actual wait time for the overall population at 6.8 hours. The MHP does not offer urgent services that require pre-authorization separately.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered/rendered psychiatry services as the time of the psychiatry referral to the date of the first service provided by a Medical Doctor, Nurse Practitioner, or Pharmacist, with the stated assumption that those provider types will be either focused on, or at a minimum will address, psychiatric issues.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for the entire service delivery system. The MHP reports psychiatry no-show rates of 12.7 percent for adults, 8 percent for children/youth, and 9 percent for foster care youth specifically. The MHP reports no-show rates with

non-psychiatry clinical staff of 5.4 percent for adult, 6.3 percent for children/youth, and 2.1 percent for foster care youth specifically.

IMPACT OF TIMELINESS FINDINGS

- The MHP has identified several challenges with their current data reporting. The new EPIC EHR, which will be implemented in May 2024, is being created to ideally fix these current challenges. New data dashboards, training, policy and procedures, contract meetings, and user efficiency are all planned for the roll-out.
- The MHP does not set a standard percentage for psychiatrist no-show rates, and they vary by age group. Having set rates, assigning a timeframe, and an understanding those rates will provide the MHP with a standard for which to measure. This standard would assist in showing patterns with providers and areas of needed service improvement.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

The MHP established a formal quality assurance unit which is housed within the quality management unit. The compliance function is external to BHS.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI, and the annual evaluation of the QAPI. The MHP has several QICs, an overall SOC, AOA and CYF subgroup. In addition, a MUIC and a Substance Use/Drug Medi-Cal Organized Delivery System Quality Improvement Committee, CAB, and Provider Quality Improvement Committee.

The SOC QIC is comprised of QI staff, clinical leadership from AOA and CYF, analytic staff, and relevant subject matter experts, the director, and is scheduled to meet monthly. The MHP is seeking a more effective beneficiary and caregiver input mechanism, and thus far sees the CAB as the best format. Since the previous EQR, the MHP QIC met within in its subgroups of CYF, AOA SOC, Racial Equity Action Council, MUIC and Risk Management 56 times. Of the 30 identified FY 2022-23 QAPI workplan goals, the MHP met 13, with 6 partially met, and 11 were not met. The MHP plans to review all goals and objectives and ensure data accuracy.

The MHP utilizes the Child and Adolescent Needs and Strengths (CANS) to guide LOC decision-making. A shorter version of the CANS called Crisis Assessment Tool (CAT) has an LOC tool used for children/youth referred to crisis services.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), CANS, and Pediatric Symptom Checklist-35 (PSC-35).

The MHP is testing a LOC assessment decision tool. This tool once tested and validated will be entered into the Epic EHR to be used by front-line providers to increase the percentage of outpatient members with a LOC assessment.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP does an impressive job of collecting and analyzing medication monitoring through their MUIC.
- The MHP does not currently report back functional outcomes for members. This is expected to improve with the roll-out of the new EPIC EHR.
- The MHP received the CPS data and prepared program-level and system-of-care level dashboards accessible to programs but did not post results publicly due to a new SFDPH privacy guideline to suppress small numbers in public data sharing.
- Key informants both internal and external reported the lack of knowledge of available resources to refer members, or to seek services.

- The website does not offer a COC of resources that are easy to access, locate, in all county-priority threshold languages, or crisis information as basic as 988.
- Key informants who speak English as a second language reported taking much longer to write documentation. This discrepancy affects their time management and ability to complete tasks within the same expectations as native English speaker.
- The MHP does track and trend the four Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5

QUALITY PERFORMANCE MEASURES

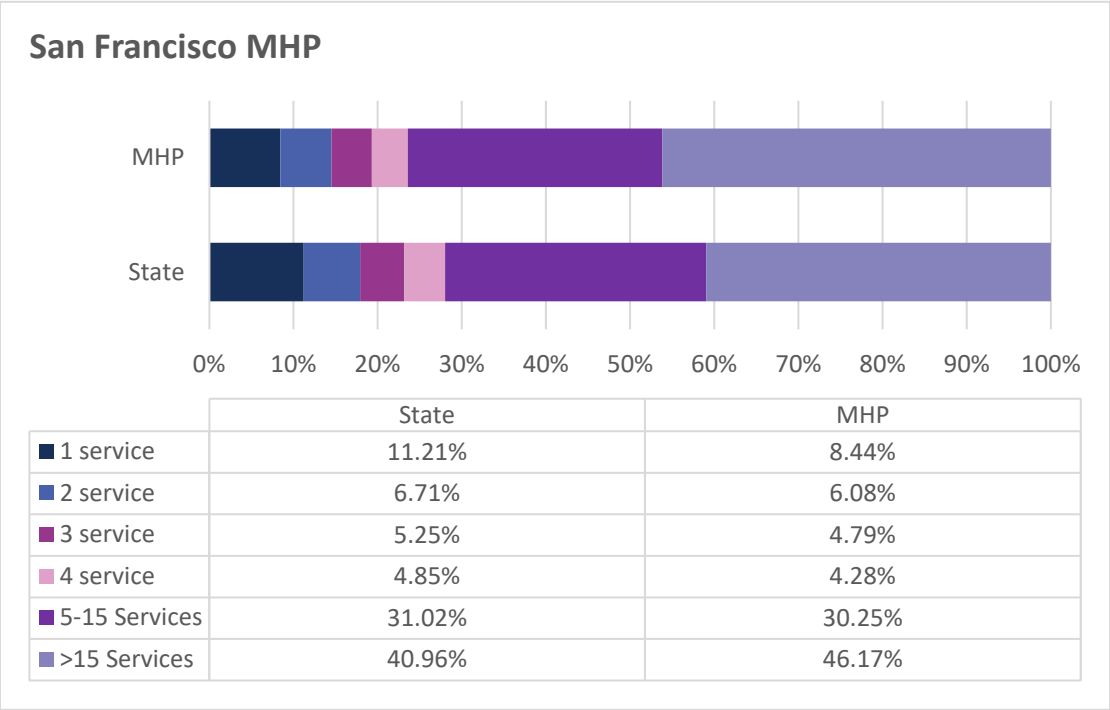
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



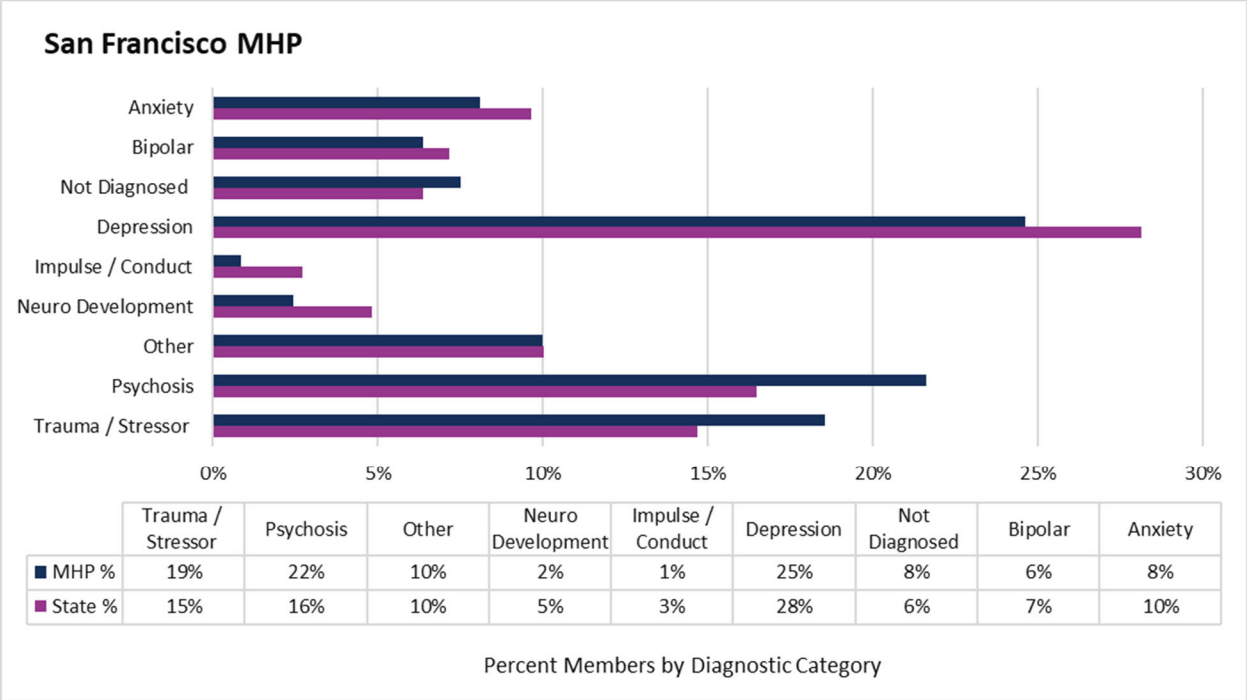
	State	MHP
1 service	11.21%	8.44%
2 service	6.71%	6.08%
3 service	5.25%	4.79%
4 service	4.85%	4.28%
5-15 Services	31.02%	30.25%
>15 Services	40.96%	46.17%

- The MHP's retention of members for five or more services was 76 percent, which is higher than the statewide rate of 72 percent.

Diagnosis of Members Served

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

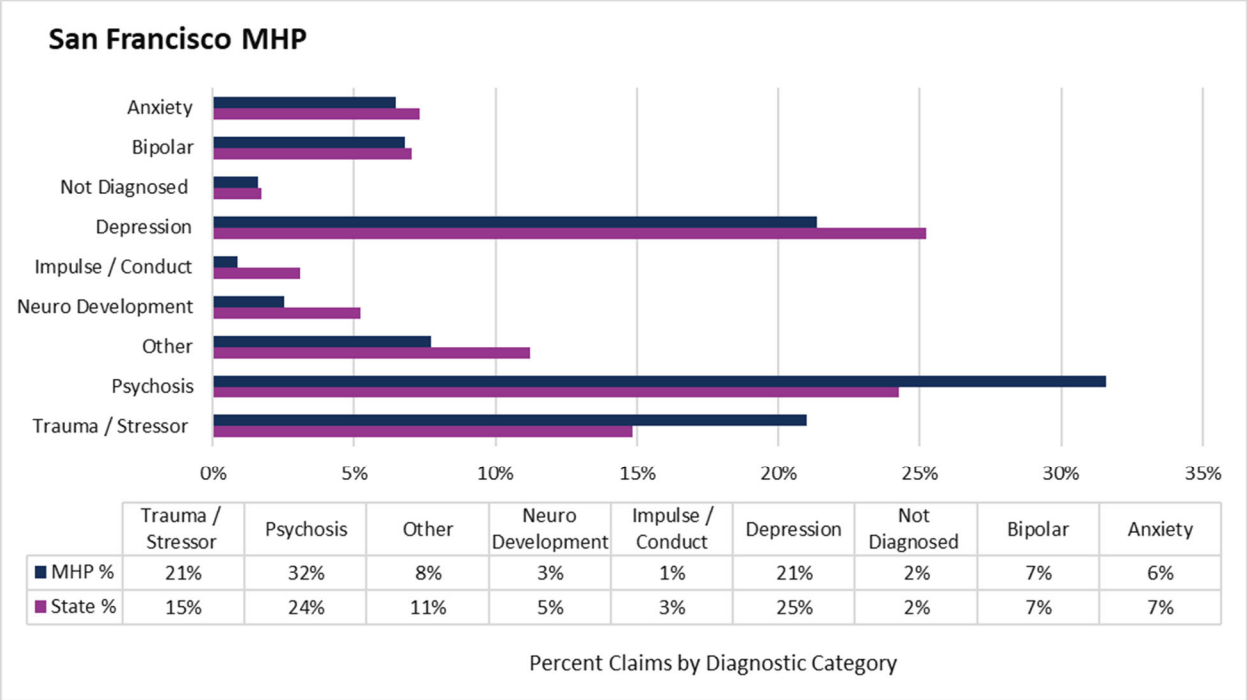
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	22%	10%	2%	1%	25%	8%	6%	8%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Diagnostic patterns in the MHP were overall comparable to statewide patterns, though there were higher percentages of members in the MHP receiving services for psychosis and trauma/stressors than statewide.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	21%	32%	8%	3%	1%	21%	2%	7%	6%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The distribution of approved claims across diagnostic categories was generally comparable to the distribution of diagnoses in the MHP. While 22 percent of members received services for psychosis, 32 percent of claims pertained to this diagnostic category, and 25 percent of members received services pertaining to depression, but claims submitted under that diagnostic category represented 21 percent of all claims.

Psychiatric Inpatient Services

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

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	909	1,208	1.33	7.68	8.45	$22,456	$12,763	$20,412,348
CY 2021	1,177	1,687	1.43	8.32	8.86	$18,315	$12,696	$21,556,462
CY 2020	1,177	1,811	1.54	9.06	8.68	$14,607	$11,814	$17,191,855

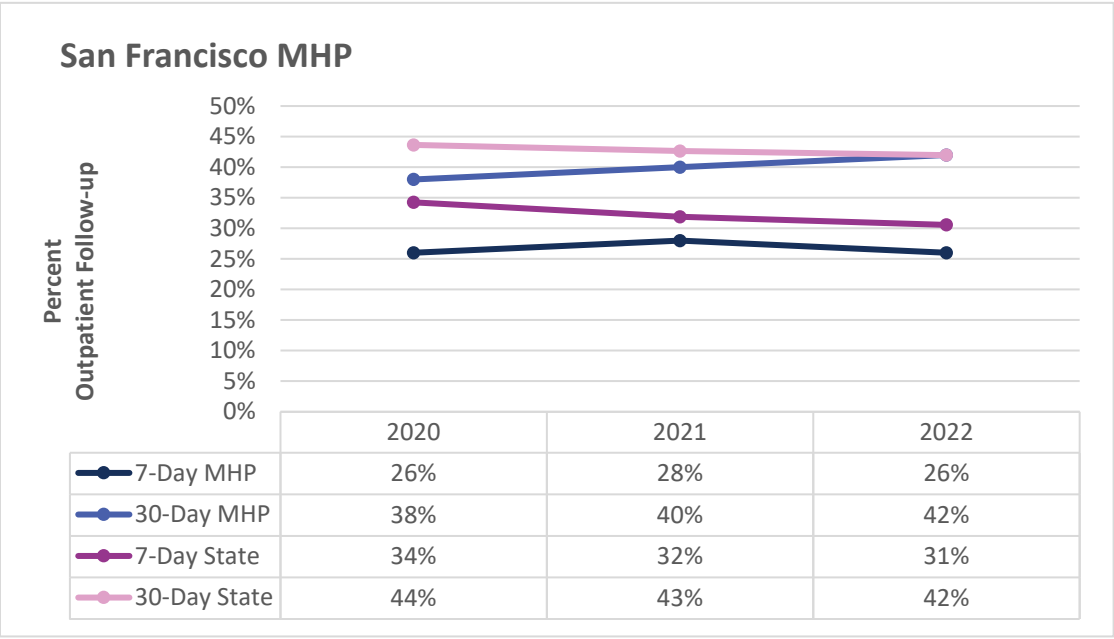
- The count of unique members receiving psychiatric inpatient services, as well as the total number of admissions to these services, were both down in CY 2022 from prior years.
- Members utilizing psychiatric inpatient services had an average of 1.33 admissions per member.
- The LOS in CY 2022 decreased by 0.6 days from CY 2021, but the cost of hospitalization as reflected in the AACM increased, and it is much higher than the statewide AACM.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

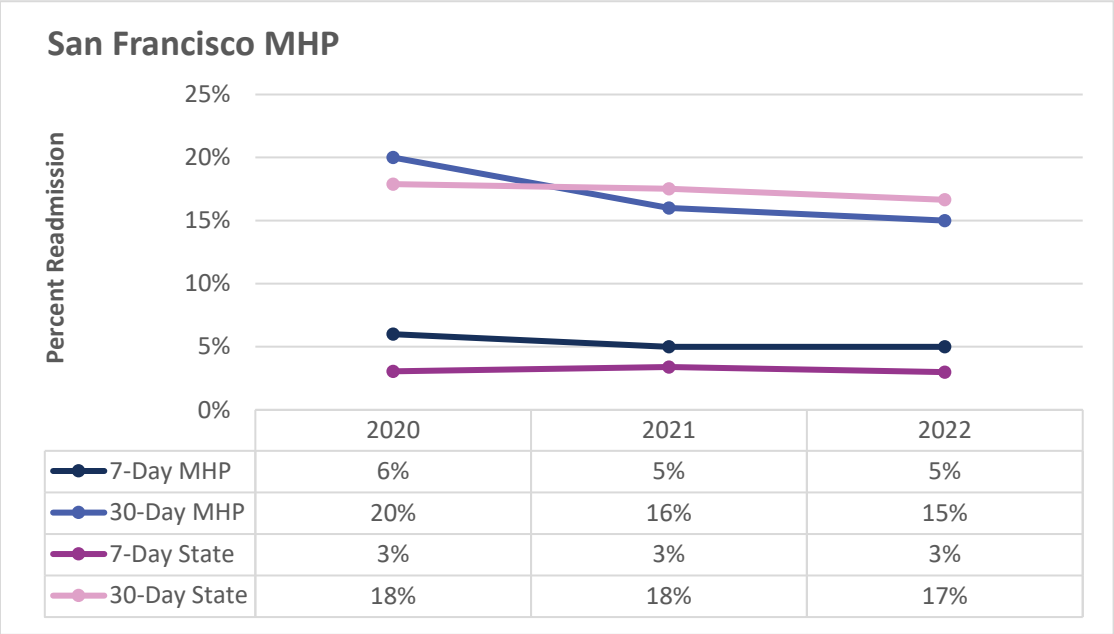
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	26%	28%	26%
30-Day MHP	38%	40%	42%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP has consistently had lower inpatient follow-up rates than statewide at both 7 and 30 days, though the 30-day rate for CY 2022 was the same as the statewide rate. The MHP has improved its 30-day follow-up rate since CY 2020.

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



	2020	2021	2022
7-Day MHP	6%	5%	5%
30-Day MHP	20%	16%	15%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's rate of members experiencing a readmission within 7 days after discharge from a psychiatric setting has consistently been slightly higher than statewide over the past three years, though the MHP's 30-day readmission rate has improved over the same time period and was slightly lower than statewide the past two years.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

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

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

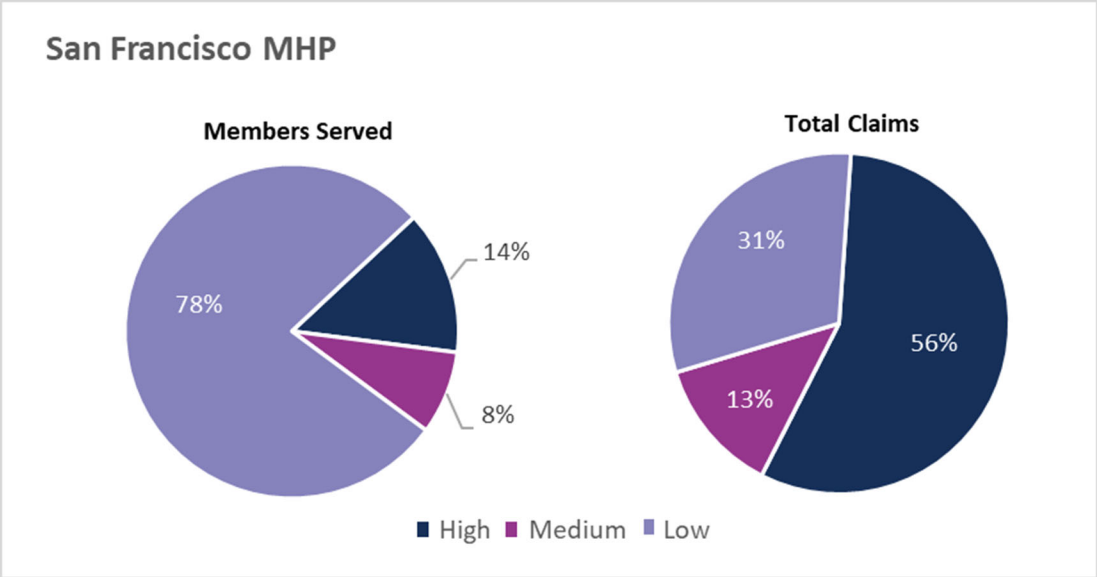
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	1,899	13.98%	56.39%	$117,856,170	$62,062	$47,961
	CY 2021	1,646	11.87%	50.79%	$98,601,138	$59,903	$47,145
	CY 2020	1,463	10.79%	46.43%	$81,526,363	$55,725	$45,834

- The count of HCMs in the MHP has steadily increased since CY 2020. The percentage of MHP members in the HCM category, and the percentage of claims attributed to those members, are both much higher than statewide.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	1,097	8.08%	12.86%	$26,868,305	$24,493	$24,212
Low-Cost (Less than $20K)	10,587	77.94%	30.75%	$64,269,830	$6,071	$4,455

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



- For CY 2022, about 78 percent of members served fell into the low-cost category, representing about 31 percent of claims. Medium-cost members represented 8 percent of the members served and about 13 percent of claims, and HCMs represented 14 percent of members served and about 56 percent of claims.

IMPACT OF QUALITY FINDINGS

- The MHP utilizes their MUIC to identify drug use evaluation, what are the changes in prescriptions, use and within age groups and ethnicities. Through this process it was identified that labs were not being completed. The solution was to bring phlebotomy to the clinic for ease of access for members.
- Vacancy rates remain a challenge both civil and throughout the CBOs. The MHP is working with their Human Resources department to look at retention, pay differentials, and peer certification. The challenge remains as the MHP hires staff, those staff often come from the CBOs, which continues the cycle of COC, available resources, and crisis information has contributed to the lack of movement of members, members being referred but without a warm handoff and then forgotten, and lack of knowledge of available services such as transportation, wellness centers, crisis number 988, or peer support. Key informants suggested a town hall or interactive open house to meet and learn about the resources within the SOC.
- Members are accessing the member portal on the website and key informants reported that, in particular access information is the only useful information on the website. The MHP is missing an opportunity to engage with members beyond

the member portal with the lack of updated information and resources on the website.

- Key informants reported that non-native English speakers have a difficult time with the amount of time it takes to translate documents from English to another language, and to document from a non-English language back to English. It has been suggested that applications that assist with dictation and proper grammar be provided to ensure timeliness and accuracy.
- Key peer informants suggest the creation of a peer hub to share program information, provide peer run training, and a central location to house resources that will tie in with an updated COC flow chart.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: "Adapt a LOC tool to support clients getting to the right LOC."

Date Started: 10/2023

Aim Statement: "By December 31, 2024, develop and implement a shortened and streamlined Level of Care Assessment decision tool with the involvement of front-line providers, that will: 1) increase the percentage of outpatient clients with an LOC reassessment within 30 days of their LOC assessment anniversary from 59% to 75%, and 2) refer or close 50% of clients whose LOC reassessment indicates the need in change of LOC."

Target Population: Adults and Transitional Age Youth

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

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

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

Summary

San Francisco BHS outpatient mental health programs are experiencing capacity challenges and have average lengths of stay nearing seven years. When members are not regularly reassessed to determine whether they are in the correct LOC, they may linger in services longer than necessary. While the mental health system of care experiences this as a capacity challenge, members' health may be affected by remaining in a LOC that may no longer be appropriate for them. The BHS adult SOC does not have a LOC tool that aids clinicians in determining changes in the level of need for their clients.

The MHP established a LOC workgroup to develop a LOC tool that will address: reduced documentation burden for providers; design a decision-making tool to determine the LOC for the member to enter or transition into another LOC; and increase the percentage of LOC reassessment to 75 percent. The LOC assessment will be included in the EPIC EHR build, and the MHP anticipates incorporating edits resulting from the pilot and providers' feedback during EPIC optimization.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: The MHP identified challenges in capacity due to members' lack of assessments and movement throughout the LOC. Tools such as the ANSA lacked the desired utility as a LOC tool. In consultation with the Praed foundation the MHP created a LOC tool that reduced documentation time, will be used for decision-making within the LOC, and will increase the percentage of LOC reassessment. The MHP then tested the tool and is piloting the tool with the OCC programs. The tool will be uploaded into the new EPIC EHR build for ease of access and reassessment.

CalEQRO recommendations for improvement of this clinical PIP:

- The MHP participated in email communication throughout the submittal process for the PIP and met with CalEQRO on 5/11/23 for a video planning meeting.
- Due to the perceived lack of follow through by CBOs on data tracking, the MHP will need to ensure training, compliance, and fidelity.
- Expand the tool in priority threshold languages.
- Provide members and clinicians with a user experience survey.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Hiring a Culturally Congruent Workforce"

Date Started: 01/2023

Aim Statement: “By June 30, 2024, include Black/African American (AA) lived experience as a qualification in the civil service hiring process, in order to hire ten more Behavioral Health Clinicians and Senior Behavioral Health Clinicians, and increase the Black/AA clinicians’ percentage to at least 18 percent, mirroring the Black/AA client population within BHS.”

Target Population: Black/AA clients accessing services at civil service clinics of all ages, genders, and mental health diagnosis.

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

Summary

The MHP experienced an inadequate number of Black/African American (AA) clinicians to serve their Black/AA clients. Racially congruent services are a proven strategy to disrupt racial health disparities across and within systems and communities. SFDPH-BHS values and prioritizes a workforce with direct, first-hand experience working in and with these communities, including staff reflecting their racial and ethnic diversity and life experiences.

The cultural mix of the clinical workforce does not mirror the BHS client population, which hinders the ability of cultural matching between clinicians and members. San Francisco law prohibits recruiting candidates based on their race. The MHP and HR piloted a lived experience qualification to be included in job descriptions when filling vacancies for positions that primarily serve clients from the Black/AA community. Job posting language will include the following language: “this position requires the proficient delivery of racially congruent services for Black/AA populations by employees who demonstrate lived experience with Black/AA populations.” The MHP is currently testing this new job description.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: The MHP identified an inadequate number of Black/AA clinicians to serve the members. Working with their Human Resources department they were able to create a job description that specifically was inclusive of Black/AA lived experience. The MHP will batch hire qualified Black/AA clinicians to provide racial congruent services.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The MHP participated in email communication throughout the submittal process for the PIP and met with the CalEQRO on 5/11/23 for a video planning meeting.
- Track the number of qualified clinicians hired and retained for over one year.
- Due to the clinical vacancy rate within CBO providers, a comparison between the civil and CBO trends may be warranted to determine if CBOs are also culturally diverse.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart Technologies/Avatar, which has been in use for 13 years. Currently, the MHP is actively implementing a new system, Epic, with scheduled completion of the phased rollout in May 2024, which requires heavy staff involvement to fully develop for implementation.

Approximately 1.94 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 2,290 named users with log-on authority to the EHR, including approximately 829 county staff and 1,461 contractor staff. Support for the users is provided by eight full-time equivalent (FTE) IS technology positions. Currently support for users is provided by eight FTE IS technology positions. Currently one FTE position that was vacant last year is in the onboarding process.

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

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	10%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP provides PHR access to all adult members.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with federally qualified health center (FQHC), community/rural health center (CHC – RHC), hospitals, primary care providers (PCP), and MCP.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has a strong fiscal team, with a claims denial rate of 1.16 percent which is lower than statewide rate of 5.92 percent.
- The MHP has hired a Director of Clinical Informatics to manage the transition from Avatar to Epic. Their EHR implementation has been very thoughtfully planned and is being executed in phases with assistance from SFDPH.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	33,732	$17,183,076	$273,926	1.59%	$16,909,150
Feb	32,777	$16,976,944	$135,223	0.80%	$16,841,721
Mar	38,412	$19,490,446	$403,998	2.07%	$19,086,448
April	35,810	$18,083,202	$221,013	1.22%	$17,862,189
May	34,835	$18,015,653	$302,218	1.68%	$17,713,435
June	32,357	$15,890,905	$124,929	0.79%	$15,765,976
July	29,347	$16,357,394	$152,185	0.93%	$16,205,209
Aug	32,856	$18,134,145	$206,686	1.14%	$17,927,459
Sept	30,933	$16,198,534	$155,351	0.96%	$16,043,183
Oct	30,520	$16,795,650	$107,836	0.64%	$16,687,814
Nov	30,494	$17,346,215	$164,378	0.95%	$17,181,837
Dec	27,690	$16,165,937	$139,599	0.86%	$16,026,338
Total	**389,763**	**$206,638,101**	**$2,387,342**	**1.16%**	**$204,250,759**

- The MHP's claims data reflects generally consistent claims volume throughout CY 2022.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Medicare Part B must be billed before submission of claim	920	$966,360	40.48%
Beneficiary is not eligible or non-covered charges	1,232	$723,258	30.30%
Other healthcare coverage must be billed first	187	$228,131	9.56%
Service location NPI issue	243	$182,714	7.65%
Other	324	$145,545	6.10%
Service line is a duplicate and repeat service modifier is not present	100	$78,045	3.27%
Deactivated NPI	158	$59,614	2.50%
Late claim submission	9	$3,674	0.15%
Total Denied Claims	**3,173**	**$2,387,341**	**100.00%**
Overall Denied Claims Rate	**1.16%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's denial rate of 1.16 percent was lower than the statewide rate of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- CalAIM implementation is underway which includes documentation and payment reform updates in the Avatar system. The MHP has established a strong network for information sharing, training, and communication within the MHP system.
- The MHP reports enhanced communication across Compliance, BHS system of care, and billing-driven CalAIM implementation.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP received the CPS data and prepared program-level and system-of-care level dashboards accessible to programs but did not post results publicly due to a new SFDPH privacy guideline to suppress small numbers in public data sharing. Some clinics also provide independent satisfaction surveys.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included 13 participants. All members participating receive clinical services from the MHP.

The high turnover of clinicians continues to impact the members, who report longer than average wait times for services, such as psychiatry or being "forgotten," when being referred to an alternate resource. The participants reported a lack of communication between providers or even a knowledge of available resources. The lack of care coordination hinders the quality of care. The participants reported appreciating the transition for TAY services to Adult Services, and the availability of telehealth.

Recommendations from focus group participants included:

- "Appointments are too short at 50 minutes, extend to an hour and a half."

- “Connect services together.”
- “Provide incentives like gift cards to encourage keeping appointments.”

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of family members who initiated services in the preceding 12 months. The focus group was held virtually and included six participants; a Cantonese language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

Participants expressed concern for high staff turnover and the length of time to first direct service. Children receiving services are typically transported by a family member and the participants were not aware of parent partner assistance or transportation. The participants were complimentary of the language services provided. The participants expressed concern that telehealth was not available to all families, as some providers reportedly did not have the funding to continue offering telehealth services.

Recommendations from focus group participants included:

- “Staff turnover is stressful for the parents and kids.”
- “Resume phone sessions.”
- “Give a retention bonus for staff.”
- “Staff is very young, not much older than my child.”

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of family members who initiated services in the preceding 12 months. The focus group was held virtually and included four participants; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

All partipating family members reported it being difficult to obtain initial services for their child. The participants reported that reminder calls were helpful and overall services received have been positive. The high turnover in staffing remains stressful for families as it is challenging to build relationships with clinicians when they are “always leaving.” The participants did not need transportation but were not aware of transportation options or resources such as parent partners.

Recommendations from focus group participants included:

- Participants reported sessions for their children are “only 15 minutes long” and feel they should be at least 45 minutes.
- “Have sessions when a child does not have to miss school.”
- “Provide an in-home option (for therapy).”

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall members and family members were satisfied with the actual therapeutic services they received. There was a unified concern regarding the high turnover in staff, and lack of telehealth services for youth. The lack of resource knowledge and high staff turnover may impact the CBO contracted services versus civil employment and has been reported as impacting member services.

CONCLUSIONS

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

STRENGTHS

1. The MHP continues to retain a group of psychiatric pharmacists who work to identify prescribing treads and participate in detailed data analysis through the MUIC. (Quality)
2. Members can participate and gain employment skills through an MHP sponsored vocational program in areas such as janitorial services, a café, mail room, and the Avatar helpdesk. (Quality)
3. With over 70 percent of billable services submitted through contracted organizations, the MHP reported a very low overall denial rate of 1.16 percent. (Quality, IS)
4. The MHP has prepared extensively for the upcoming EPIC EHR, with diligent planning and training efforts to mitigate issues that come with the role out of a new EHR. The MHP has solicited EPIC "champions" throughout the SOC, to assist with the role-out within the clinics and hired a Director of Clinical Informatics to oversee the implementation and engagement with CBOs. (Quality, IS)
5. The MHP created a new adult LOC tool to identify appropriate member placement and movement within the SOC. The tool has been developed, tested, validated, and will be integrated into the new EHR. (Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. There is a missed opportunity in the exchange of information for members who are accessing the updated public website when accessing their member portal. The current website continues to lack basic crisis service information such as 988 or easily identified services or resources the MHP offers. (Quality)
2. The MHP aspires to review all goals and objectives within the QAPI plan. Prior to establishing all new goals and objectives it is important to include the voice of the members to identify the desired impacts of the projected goals. (Quality)
3. Contracted CBOs, report a lack of preparation for the new EHR rollout, low capacity, lack of institutional knowledge, a high turnover rate, and continued challenges with the demands of CalAIM. The potential for incomplete compliance may be remedied by a collaborative open forum learning experience. (IS, Quality)

4. Internal key staff informants across the SOC reported an overall lack of knowledge of the COC, being unfamiliar with available resources, how to refer, and how to move members throughout the continuum. With 56 percent of Medi-Cal claims attributed to HCMs it may indicate a bottleneck in the SOC in stepping down to mild/moderate MCP services. (Access, Timeliness, Quality)
5. External key informants across the SOC reported an overall lack of knowledge of the COC, being unfamiliar with available resources such as transportation, peer/parent partners, wellness centers, easily accessible crisis information, and are not provided with a warm hand-off when being referred to other services such as the MCP. (Access, Quality)

RECOMMENDATIONS

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

1. Enhance the public facing website to include important information regarding MHP services. Utilize feedback from internal teams, the CAB, and peer contracted CBOs to identify immediate updates to the department's public website, including crisis and access to services phone numbers and addresses, and an updated COC flow chart; provide information in the priority threshold languages and explore with the SFDBH, and highlight BH crisis numbers. (Access, Quality)

   (This recommendation was continued from FY 2022-23.)
2. Expand on two or three outcome goals within the QAPI, by identifying impacts on member experience that coincide with achieved compliance goals. Utilize information about the member experience, including goal-specific surveys, LOC tools, and/or CPS results. (Quality)

   (This recommendation was continued from FY 2022-23.)
3. Improve the exchange of information to and from providers throughout the entire SOC and through all levels of employment, especially on department changes and expectations. This may include providing training, updating the provider webpage regularly, providing relevant contact information for inquiries with all communications to providers, and monitoring the usage of these communications. Similarly, work to improve data collection from the contracted providers so that data provides a complete picture of wait times in order to proactively manage system capacity. (Access, Timeliness, Quality)

   (This recommendation was continued from FY 2022-23.)
4. Create a COC flow chart for all staff throughout the SOC; provide up to date referral, location, and contact information, and member qualification; and ensure

members receive a warm hand-off when being referred for services. (Access, Quality)

5. Provide all members, their families/caregivers throughout the SOC a COC infographic to identify all available services and resources; improve accessibility to provider directory which include contact information, location, languages offered, and qualifications to access; highlighting benefits, if applicable, such as wellness centers, peer/parent partners, transportation, and crisis service; posting the resources on the department's public website. (Quality, Access)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Lead Quality Reviewer
Crisobal Hernandez, Quality Reviewer
Marcia Marsh, Lead Information Systems Reviewer
Leah Hanzlicek, Information Systems Reviewer
Pamela Roach, Lead Member/Family Member Reviewer
Jon Santoyo, Member/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Almeida	Angelica	AOA SOC Director	SFDPH - BHS
Anne	Fischer	Executive Director	NAMI SF
Baggetto	Simone	Director of Peer Services	CBO - NAMI SF
Berman	Charlie	Clinical Supervisor	DPH - Citywide AOT
Brown	Jessica	Director, Office of Justice, Equity, Diversity, and Inclusion/Mental Health Services Act	SFDPH - BHS
Brown	Jessica	Director, Office of Justice, Equity, Diversity, and Inclusion/Mental Health Services Act	SFDPH - BHS
Candler	Robin	Acting Director to Street Based and Justice Involved Behavioral Health Services	SFDPH - BHS
Chan	Weiki	Supervisor	DPH - Chinatown Child Development Center
Chan	Helen	LMFT	DPH - Chinatown North Beach
Chao	Molly	Principal Administrative Analyst	SFDPH - BHS
Cheung	Kali	TAY SOC Director	SFDPH - BHS
Cheung	Brian	Clinician	DPH - Chinatown Child Development Center
Clynes	Carla	Peer Support Specialist	CBO - SF Study Center
Collins	Renya	Clinician	DPH - outpatient clinic
Collins	Nathan	Clinical Social Worker	DPH - Citywide Case Management
DeSilva	Jason	Clinician	DPH - Foster Care Mental Health
Diaz	Claudia	Supervisor	DPH - Mission Family Center

Last Name	First Name	Position	County or Contracted Agency
El Muhammad	Ansar	Peer Counselor	CBO - RAMS, Inc.
Elie	Navid	Practice Improvement Analyst, CYF	SFDPH - BHS
Esteva	Nancy	Lead Peer Counselor/Service Coordinator	CBO - RAMS, Inc.
Ezzatyar	Afsaneh	Clinician	UCSF- Child and Adolescent Services
Farahmand	Farahnaz	CYF SOC Director	SFDPH - BHS
Felder	Stephanie	Director to Crisis Services	SFDPH - BHS
Frederico	Gloria	Director of Private Provider Network	SFDPH - BHS
Garcia	Desiree Skye	Peer Support Specialist	CBO - SF Study Center
Garcia-Marti	Violeta	Clinician	DPH - Family Mosaic Project
Geier	Michelle	Psychiatric Clinical Pharmacist Supervisor	SFDPH - BHS
Gonzalez	Ana	Co-Chief Medical Officer	SFDPH - BHS
Gregory	Hugh	Health Worker	DPH - TAY outpatient clinic
Guo	Sherman	Clinical Social Worker	DPH - CCOA
Ha	Kitty	QI Coordinator, QM	SFDPH - BHS
Helton	Tracey	MHSA Program Manager	SFDPH - BHS
Henriques	Erik	Director of Peer Services	Mental Health Association of SF
Henriquez	Metzi	Clinician	DPH - Southeast Child and Family Therapy Center
Hilley	Lisa	Assistant Director, CYF SOC	SFDPH - BHS

Last Name	First Name	Position	County or Contracted Agency
Hochenauer	Annie	Peer Support Specialist	CBO - Mental Health Association of SF
Holt	Hamilton	Deputy Medical Director	SFDPH - BHS
Hom	Kellee	Clinical Health Informaticist	SFDPH - BHS
Hom	Jeffrey	Director of BH Population Health	SFDPH - BHS
Huynh	Vy	Peer Support Specialist	CBO - Mental Health Association of SF
Inman	Lisa	Co-Chief Medical Officer	SFDPH - BHS
Jackson	Alexander	AOA SOC Deputy Director	SFDPH - BHS
Jacobsen	Patricia	Sr. BHC	DPH - Chinatown North Beach
Jerman	Petra	Director of Analytics, QM	SFDPH - BHS
Johnson	LaTisha	Parent Mentor	CBO - NAMI SF
Kim	Yoonjung	Interim Director, Residential System of Care	SFDPH - BHS
Kunins	Hillary	BHS & MHSF Director	SFDPH - BHS
Lee	Yuk Kiu	Health Care Analyst, Regulatory Affairs	SFDPH - BHS
Lopez	Marco	Director of Clinical Informatics	SFDPH - BHS
Lucas	Whitley	CalAIM Program Manager	SFDPH - BHS
Maranon	Theresa	Director of Pharmacy	SFDPH - BHS
Martin	Alecia	QM Director	SFDPH - BHS

Last Name	First Name	Position	County or Contracted Agency
Meier	Michelle	Training Manager, Workforce Development, JEDI	SFDPH - BHS
Momoh	Imo	Managed Care Director	SFDPH - BHS
Murdock	Craig	Director, SF Health Network-Behavioral Health Access Programs	SFDPH - BHS
Nish	David	Director of Operations	SFDPH - BHS
Pitbladdo	Veronica	Supervisor	DPH - Family Mosaic Project
Prentiss	Diane	Data Steward	SFDPH - BHS
Quinones	Servando	Peer Support Specialist	CBO - Mental Health Association of SF
Rasaily	Nanalisa	Patient Accounts Manager	SFDPH - BHS
Razo	Roxana	Clinician	DPH - Mission Family Center
Reijerse	Erick	Program Manager	DPH - Community Justice Center
Rocha	Maximilian	SOC Director	SFDPH - BHS
Rojas	Michael	Program Coordinator, Regulatory Affairs	SFDPH - BHS
Rubin	Britt	Peer Supervisor	CBO - RAMS, Inc.
Rubio	Ritchie	Director of Practice Improvement and Analytics, CYF	SFDPH - BHS
Sainkhuu	Solongo	Epidemiologist 2	SFDPH - BHS
Scarafia	Jeff	Deputy CIO	SFDPH
Sherwood	Deborah	Consultant, Quality Management	SFDPH - BHS

Last Name	First Name	Position	County or Contracted Agency
Shields	John	Security Operations Lead	SFDPH
Shiu	Annie	Program Manager, Utilization Management	SFDPH - BHS
Sinaga	Hasian	Director of Community & Workforce Empowerment	RAMS, Inc.
Spindel	Michelle	Supervisor	UCSF - Alliance Health Project
St. Andrews	Alicia	Program Coordinator, JEDI	SFDPH - BHS
Tanioka	Lorrie	Billing Manager	SFDPH - BHS
Thompson	Sharon	BIPOC Cultural Facilitator, Presenter & Educator	CBO - NAMI SF
Tomczak	Kathy	IS Contractor	SFDPH
Toomey	Chris	Epidemiologist 2	SFDPH - BHS
Tsan	Lenh	QI Coordinator, QM	SFDPH - BHS
Upchurch	Marc	Chief Information Security Officer	SFDPH
Vaughn	Ashley	Communications Specialist	SFDPH - BHS
Voelker	Kimberly	IT Ambulatory Care Manager	SFDPH - BHS
Ward	Jilleen	Clinician	CBO - A Better Way
Washington	Jazelle	Supervisor	DPH - Transitional Age Youth Services
Weisbrod	Heather	Director, Office of Coordinated Care	SFDPH - BHS
Williams	Tommy	Director	DPH - Central City Older Adults Clinic

Last Name	First Name	Position	County or Contracted Agency
Williams	Thomas	AOA Practice Improvement Coordinator	SFDPH-BHS
Woodbury	Moss	Clinician	CBO - Edgewood Center for Children and Families
Wozniak	Steven	Medical Director, South of Market Mental Health	SFDPH - BHS
Wu	Nikki	Clinician	CBO - Richmond Area Mental Health Services, Inc
Yu	Nancy	Regulatory Affairs Manager	SFDPH - BHS
Yu	Tammy	LCSW	DPH - Sunset Mental Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP is challenged with stagnant care, due to members' lack of reassessment and movement throughout the LOC. Tools such as the ANSA lacked the desired utility as a LOC tool. In consultation with the Praed foundation the MHP created a LOC tool that reduced documentation time, used for decision-making within the LOC and will increase the percentage of LOC reassessment. The MHP then tested the tool and is piloting the tool with the OCC programs. The tool will be uploaded into the new EPIC build for ease of access and reassessment.
General PIP Information	
MHP/DMC-ODS Name: San Francisco	
PIP Title: "Adapt a LOC tool to support clients getting to the right LOC."	
PIP Aim Statement: "By December 31, 2024, develop and implement a shortened and streamlined Level of Care Assessment decision tool with the involvement of front-line providers, that will; 1) increase the percentage of outpatient clients with an LOC reassessment within 30 days of their LOC assessment anniversary from 59% to 75%, and 2) refer or close 50% of clients whose LOC reassessment indicates the need in change of LOC."	
Date Started: 10/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Inclusion criteria • Meets medical necessity for specialty mental health services, • Access outpatient programs (excluding residential programs) • 18 years and older • Has an open episode for at least 365 days Exclusion criteria • On maintenance and medication only • Clients in residential programs
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): members will fill out the LOC at initial assessment and again at annual reassessment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): All programs will provide the LOC tool at initial assessment and at annual reassessment. Providers will use the tool to move members throughout the SOC, including step-down to a lower level of care.
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 will test, validate, and provide continued refinement of the tool. The MHP will oversee the use of the tool in the new EPIC EHR, training, and fidelity of use.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
# of LOC reassessments completed within 30 days of annual anniversary	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# of LOC reassessments needed to be completed within 30 days of annual anniversary	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# of client who are referred to a different LOC and/or closed when tool indicates appropriate	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
# of clients who are identified as needing a different LOC	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
% of reassessments completed within 30 days of annual anniversary	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
% of clients who are referred or closed when tool indicates appropriate	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
% of assessment items on the LOC tool compared to the ANSA	FY 2021-22		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: •The MHP participated in email communication throughout the submittal process for the PIP and met with the CalEQRO on 5/11/23 for a video planning meeting. •Due to the perceived lack of follow through by CBOs on data tracking, the MHP will need to ensure training, compliance and fidelity. •Expand the tool to the priority threshold languages. •Provide the members and clinicians with a user experience survey.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP identified an inadequate number of Black/African American (AA) clinicians to serve the members. Working with their Human Resources department they were able to create a job description that specifically was inclusive of Black/AA lived experience. The MHP will batch hire qualified Black/AA clinicians to provide racial congruent services.
General PIP Information	
MHP/DMC-ODS Name: San Francisco	
PIP Title: "Hiring a Culturally Congruent Workforce"	
PIP Aim Statement: "By June 30, 2024, include Black/African American (AA) lived experience as a qualification in the civil service hiring process, in order to hire ten more Behavioral Health Clinicians and Senior Behavioral Health Clinicians, and increase the Black/AA clinicians' percentage to at least 18 percent, mirroring the Black/AA client population within Behavioral Health Services."	
Date Started: 01/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Black/AA clients accessing services at civil service clinics of all ages, genders, and mental health diagnosis.	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information
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 will work with the HR department to batch hire qualified Black/AA clinicians with lived experience.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Increase Black/AA staff hire to equal 18 percent.	CY 2022		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify)

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: •The MHP participated in email communication throughout the submittal process for the PIP and met with the CalEQRO on 5/11/23 for a video planning meeting. •Track the number of qualified clinicians hired and retained for over one year. • Share results and lessons learned from this PIP with CBOs to encourage similar hiring practices for hiring a culturally diverse workforce.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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