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

SAN JOAQUIN FINAL REPORT

☒ MHP

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 26-28, 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 Joaquin" may be used to identify the San Joaquin County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 26-28, 2023

MHP Size — Large

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	8	2	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**24**	**2**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-up appointment within 7 days and 30 days of being seen in the emergency department (ED) for mental illness (FUM) Behavioral Health Quality Improvement Program (BHQIP)	Clinical	07/2022	Implementation	High
Intensive Home-Based Services (IHBS) Expansion	Non-Clinical	10/2021	Completed	High

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	7
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	2*
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	6
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- San Joaquin has an impressive analytic and reporting capability/capacity.
- San Joaquin places strong emphasis on cultural competency.
- The MHP has effective collaborations with partner stakeholders to help improve care and services for its members.
- San Joaquin has a robust medication monitoring program that includes a monthly discussion at the Pharmacy and Therapeutics Committee.
- The MHP has engaged in multiple staff retention and recruitment efforts, including for psychiatrists, and reduced overall staff vacancies from 27 percent to 21.7 percent.

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

- San Joaquin's PR for Latino/Hispanic remains lower than statewide and for similar size counties.

- Staff turnover and vacancies may impact members' satisfaction with the receipt of continuous and frequent MHP services.
- In the MHP's Assessment of Timely Access (ATA), there appear to be opportunities with first offered appointment and first offered non-urgent psychiatry appointment for adults, and first delivered services for adults and children that meet the 10-day and 15-day standards.
- The MHP has not adopted a standardized outcome tool to measure and report aggregate outcome results for adult members.
- There may be an opportunity for the implementation of an organized task force to address an increasing amount of fentanyl use in the county.

Recommendations for improvement based upon this review include:

- The MHP should continue efforts to increase Hispanic/Latino access.

  (This recommendation was continued from FY 2021-22 and FY 2022-23.)
- The MHP should evaluate any impact on members due to staff turnover or high caseloads and implement additional strategies, if needed, to ensure that members receive continuous and appropriately frequent services.
- San Joaquin should evaluate data for first offered appointment for adults, first offered non-urgent psychiatry appointment for adults, and first delivered services for adults, children, and FC. If necessary, the MHP should take action to improve results meeting the 10-day and 15-day standards.
- The MHP should adopt a standardized outcome tool to measure and report aggregate outcome results for adult members.
- San Joaquin should investigate a potential opportunity to organize or participate in a community-wide response to fentanyl use in the county.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for San Joaquin County MHP by BHC, conducted as a virtual review on September 26-28, 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.

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 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

The MHP experienced flooding in the area from December 2022 through March 2023. Operations were disrupted as a state of emergency was declared, MHP buildings were affected, and some employees had damage to their homes and could not get to work. Additional MHP outreach occurred to unhoused individuals, offering to transport them to shelters.

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.

- San Joaquin reported changes in leadership that included hiring a new Director and Deputy Finance Director. Additionally, the MHP appointed a new Deputy Director to oversee the mental health decriminalization programs and InSpire.
- The MHP implemented the California Mental Health Services Authority's (CalMHSA) semi-statewide Electronic Health Record (EHR) and performance management system, SmartCare by Streamline Healthcare Solutions (Streamline), on July 1, 2023.
- The MHP initiated a transition for individuals under the age of 21 years within Children and Youth Services (CYS). San Joaquin retains FC youth from entering the Adult System of Care (ASOC) until the age of 21 and expanded the intake of new clients into CYS up to age 20.
- San Joaquin has partnered with CalMHSA and HealthForce Partners for the MHP's staff retention and recruitment strategies including loan repayment, stipend, scholarship programs, and retention bonuses.
- The MHP has initiated the Medi-Cal mobile crisis services benefit. It is in the beginning stages and San Joaquin is currently having meetings and developing policies in preparation for implementation.
- The MHP concluded training in Radically Open Dialectical Behavioral Therapy. The MHP has 20 clinicians with the skills necessary to employ the model.
- San Joaquin reported several Justice and Decriminalization Division (JDD) initiatives including increased housing, development of an outpatient program for

justice involved and at-risk adults, and transitioning of clients who are justice involved to JDD from the Managed Care Plan (MCP) and ASOC.

- The MHP expanded its treatment options for members seeking help with eating disorders.

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 from FY 2022-23

Recommendation 1: Evaluate current efforts to increase Hispanic/Latino access. If there has been no improvement in access (e.g., increase in PR or some other indicator), modify or implement new strategies that address some of the underlying causes.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reported starting a PIP in April 2023 to improve the Hispanic/Latino PR. San Joaquin reviewed data and developed focus group protocols. The next phase will be to develop interventions.
- The MHP's PR for Hispanic/Latino has not improved. In 2022 it was 2.53 percent, and 2.56 percent in 2021. This recommendation will be continued.

Recommendation 2: Conduct a brief/time-limited but focused study on time to subsequent appointments for new and established members to better determine the impact of short-staffing on timeliness to services, which is not captured in the MHP's current indicators.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has a tracking process for timeliness of services following the assessment; however, it did not determine the impact of short staffing on timeliness of services.

- San Joaquin relocated staff to the intake program to bridge the gap between assessments and subsequent appointments for adults. The MHP indicated that this was not the best solution to address the staffing issue.
- There remains an opportunity to meet the timeliness standards and determine the impact of short staffing. This item is rated partially addressed but will not carried over due to other priority recommendations identified.

Recommendation 3: Use 10-business days and 15-business days as one of the benchmarks to determine timeliness of delivered first service and first psychiatry appointments, respectively.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP reported data using the 10-business day and 15-business day benchmarks as recommended.

Recommendation 4: Analyze staffing patterns relative to member/family member preferred language and implement solutions if warranted.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In January 2023 the MHP analyzed data for member-preferred languages and languages spoken by providers. As a result, they identified a gap in the Lodi area and successfully relocated a Spanish-speaking clinician to the Lodi clinic.
- San Joaquin reported that there have been notable additions to their Spanish-speaking staff within the Children's Division and 31 percent of clinical staff in the division possess Spanish language proficiency.
- The MHP reported actively recruiting and retaining Spanish-speaking staff that include incentives, retention bonuses, and loan repayment programs.

Recommendation 5: Analyze findings from various data collected, share the meaning/implications of the findings, and implement subsequent action as needed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Quality Assessment & Performance Improvement Council (QAPIC) routinely reviews data during the meetings, as well as plans initiatives to address areas of deficiencies.
- The MHP analyzed data and has initiatives in place including a new PIP to address Hispanic/Latino PR, "On the Spot" assessments for JDD, development of a Consumer Perception Survey (CPS) workgroup, and improvements to lab orders for presumptively transferred youth.

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 48.35 percent of services were delivered by county-operated/staffed clinics and sites, and 51.62 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 84.42 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as through the following system entry points: crisis, walk-ins at outpatient clinics, transitional-age youth program, and Latino-focused community-based program. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Staff at the Access Line screen prospective members and then connect them to appropriate programs and services. The program staff conduct the assessment and schedule subsequent appointments for services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 5,753 adults, 3,487 youth, and 661 older adults across eight county operated sites and seven contractor-operated sites. Among those served, 899 members received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

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 Joaquin County, the time and distance requirements are 30 miles and 60 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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- San Joaquin expanded staff recruitment and retention efforts and has held a monthly retention committee for the last 14 months. The MHP decreased its staff vacancy rate by more than five percentage points from the prior year.
- The MHP has a psychiatrist stationed at a federally qualified health center (FQHC) to assure successful connection for warm hand-offs.
- The MHP has a robust program for addressing cultural and linguistic needs of its members.
- San Joaquin does not have specific dedicated staff to provide transportation for members. MHP staff may provide transportation for members; however, they need to stop what they are doing to provide transportation. This can burden the staff and lead to delays in the completion of other already assigned tasks.
- Although the MHP offers information in Spanish on its website, the links are in English, i.e., “Spanish” instead of “Español.”

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 Joaquin demonstrates more challenges to access to care than was seen statewide.

Table 3: San Joaquin 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	330,772	10,769	3.26%	$79,183,020	$7,353
CY 2021	310,962	10,670	3.43%	$76,850,863	$7,203
CY 2020	288,881	10,495	3.63%	$70,768,421	$6,743

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.

- While total members eligible has increased 14.5 percent from CY 2020 to CY 2022, PR has declined from 3.63 percent in CY 2020 to 3.26 percent in CY 2022. This indicates that the increase in total members served has not kept pace with the increase in the total members eligible.
- Total approved claims and AACMs have increased each year from CY 2020 to CY 2022.

Table 4: San Joaquin MHP 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	38,204	377	0.99%	1.50%	1.82%
Ages 6-17	86,571	2,738	3.16%	5.01%	5.65%
Ages 18-20	18,719	574	3.07%	3.66%	3.97%
Ages 21-64	159,043	6,555	4.12%	3.73%	4.03%
Ages 65+	28,237	525	1.86%	1.64%	1.86%
Total	**330,772**	**10,769**	**3.26%**	**3.60%**	**3.96%**

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 largest eligibility group by age was adults ages 21-64, followed by youth ages 6-17. The MHP's PRs are lower than the similar sized county and statewide rates for those in age categories 0-5, 6-17 and 18-20.
- While the MHP PR for those aged 21-64 exceeds the similar-sized county (4.12 percent vs. 3.73 percent) and statewide rates (4.12 percent vs. 4.03 percent), the MHP PR for those aged 6-17 is less than both the similar-sized county (3.16 percent vs. 5.01 percent) and statewide rates (3.16 percent vs. 5.65 percent).

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

Threshold Language	# Members Served	% of Members Served
Spanish	1,001	9.58%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had one threshold language, Spanish, and 9.58 percent of those served identified Spanish as a preferred language.

Table 6: San Joaquin 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	88,424	2,870	3.25%	$17,274,530	$6,019
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.

The MHP's ACA PR is comparable to the overall PR (3.25 percent vs. 3.26 percent). The ACA AACM is lower than that of the overall AACM ($6,019 vs. $7,353). 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: San Joaquin MHP PR Members Served by Race/Ethnicity, CY 2022

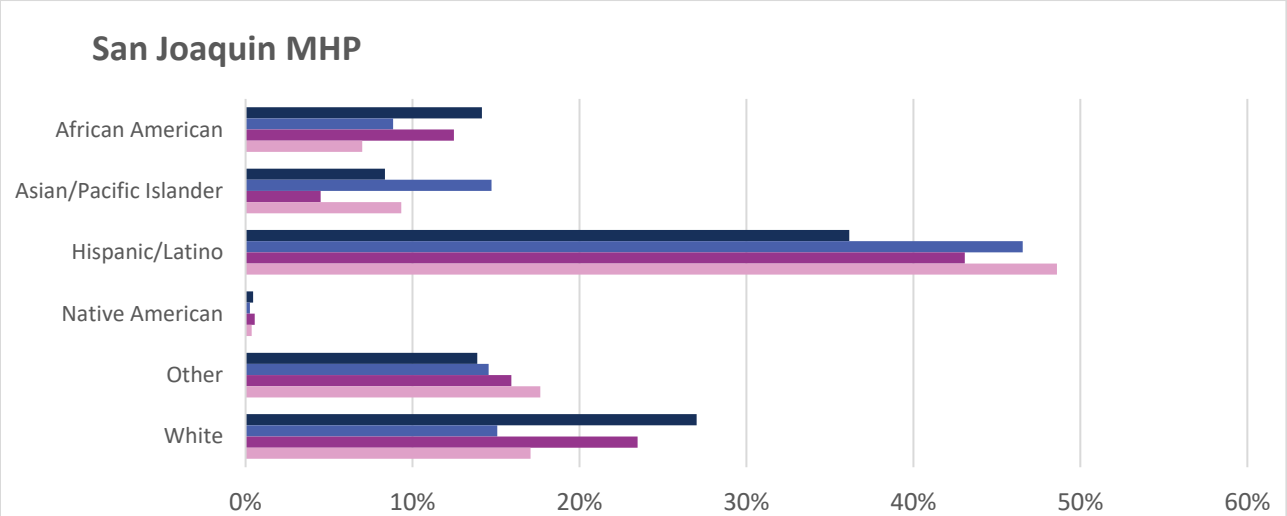
Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	29,235	1,524	5.21%	7.08%
Asian/Pacific Islander	48,725	899	1.85%	1.91%
Hispanic/Latino	153,954	3,894	2.53%	3.51%

Native American	858	49	5.71%	5.94%
Other	48,152	1,494	3.10%	3.57%
White	49,850	2,909	5.84%	5.45%
Total	**330,774**	**10,769**	**3.26%**	**3.96%**

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.

- PRs were lower than the corresponding statewide PRs for all racial/ethnic groups except the White category.
- The Hispanic/Latino population makes up the largest group of eligibles by race/ethnicity in the MHP, 47 percent of total eligibles, and has the second lowest PR. Asian/Pacific Islander members had the lowest PR of any group.

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



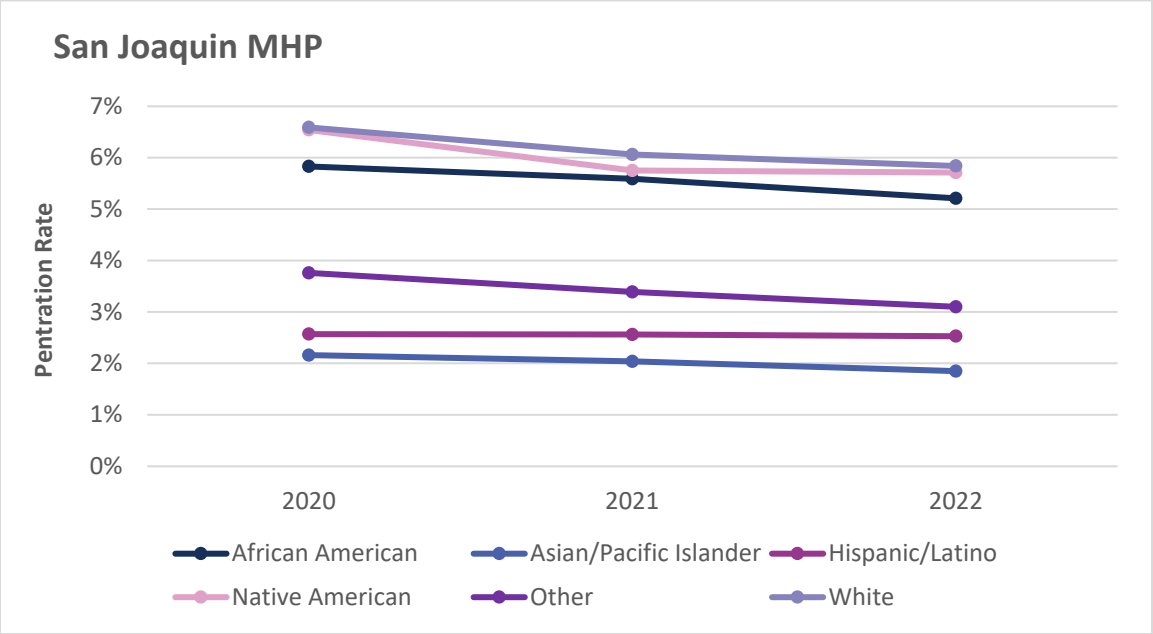
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	27%	14%	0%	36%	8%	14%
MHP % Eligible	15%	15%	0%	47%	15%	9%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- While White was the most proportionally overrepresented racial/ethnic group in the MHP, the most proportionally underrepresented groups were Hispanic/Latino and Asian/Pacific Islander.
- The MHP had a comparable proportion of White and Hispanic/Latino eligibles and a higher proportion of Asian/Pacific Islander eligibles than the state as a whole.

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),

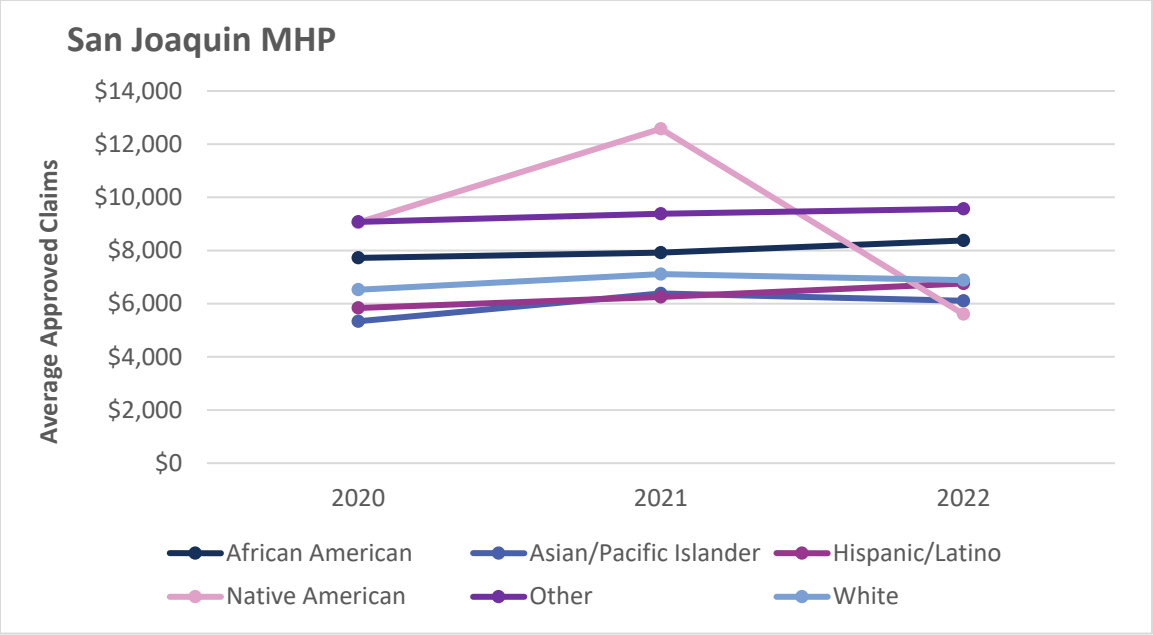
and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

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



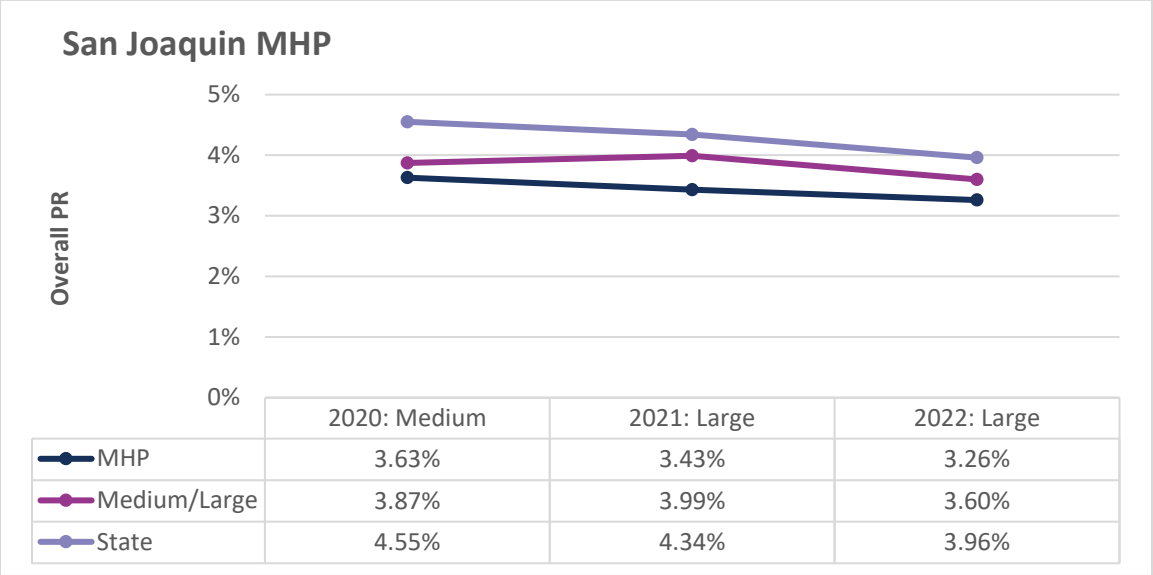
- PRs for White, Native Americans, and African Americans have consistently been the highest over the past three years, whereas PRs for Asian/Pacific Islanders, Hispanic/Latinos, and Other have consistently been the lowest.

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



- The AACM for Native American members displayed notable variation from CY 2020 to CY 2022. It should be noted that Native American members were zero percent of all members served, and when a population is small, outliers can impact averages (means) in a way that appears dramatic.
- AACMs for Hispanic/Latino, African American, and Other increased slightly from CY 2021 to CY 2022.

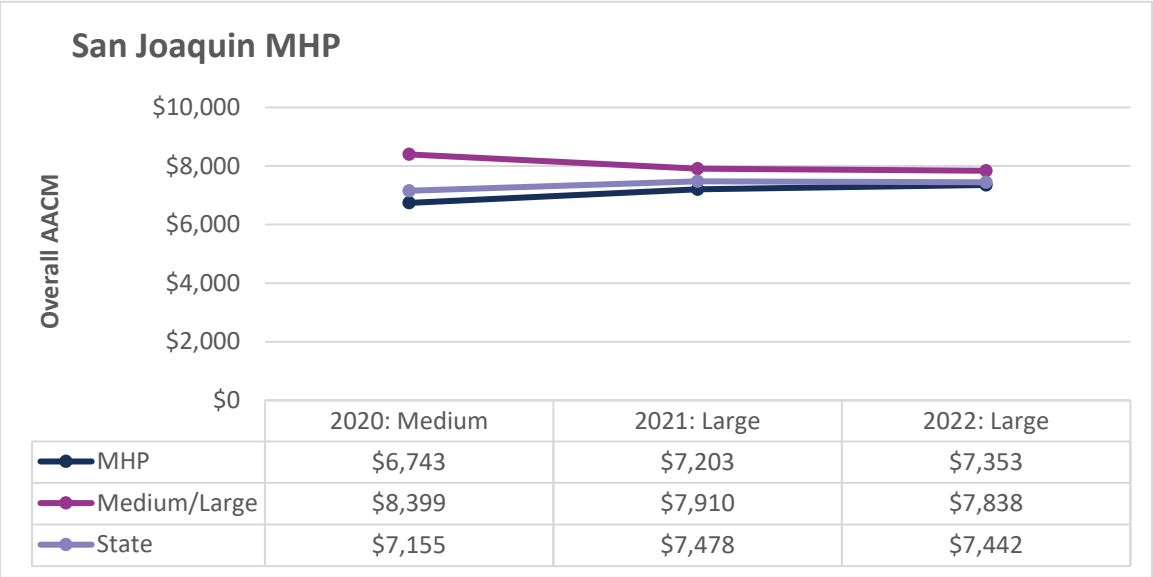
Figure 4: Overall PR, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	3.63%	3.43%	3.26%
Medium/Large	3.87%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- Overall PRs for the MHP, large counties, and the state as a whole declined from CY 2021 to CY 2022. In CY 2022, the MHP's PR was below that of both the large county rate (3.26 percent vs. 3.60 percent) and statewide rate (3.26 percent vs. 3.96 percent).

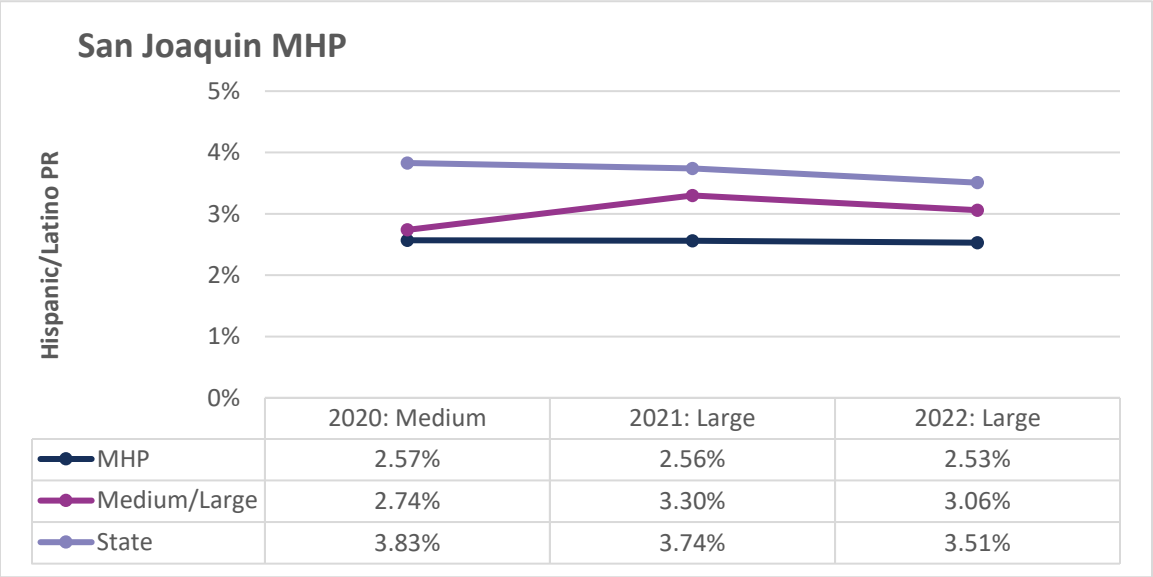
Figure 5: Overall AACM, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	$6,743	$7,203	$7,353
Medium/Large	$8,399	$7,910	$7,838
State	$7,155	$7,478	$7,442

- While the MHP's overall AACMs were below the medium/large county AACMs from CY 2020 to CY22, the MHP's AACM was just slightly lower than the statewide AACM in CY 2021 and CY 2022.

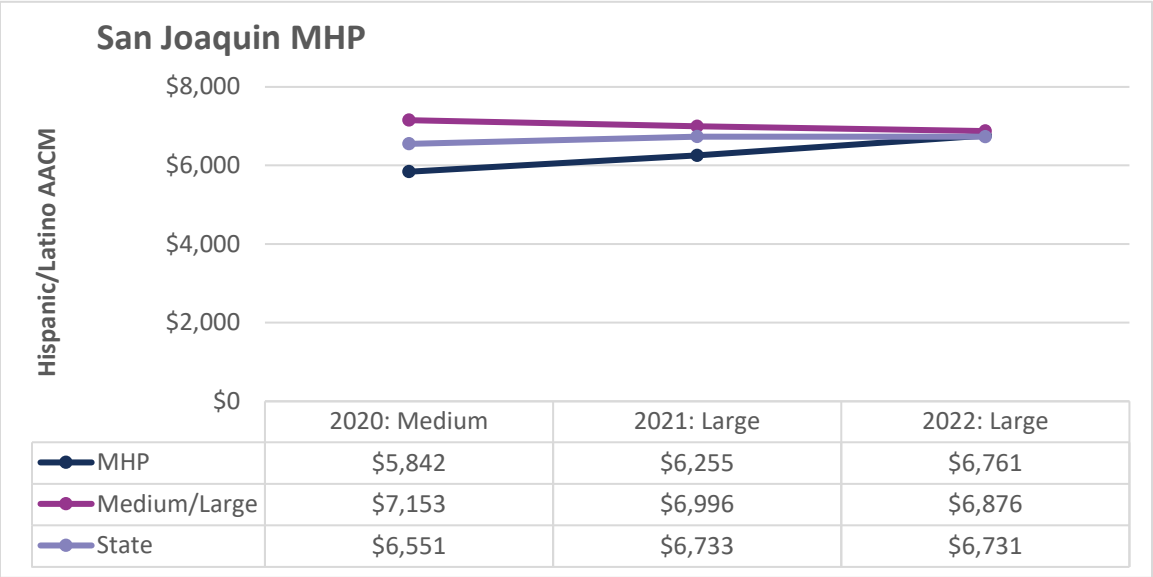
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	2.57%	2.56%	2.53%
Medium/Large	2.74%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- The MHP's Hispanic/Latino PR has been consistently lower than medium/large sized county and statewide rates from CY 2020 to CY 2022. In CY 2022, the PR for this population ranked 41 out of 56 MHPs in the state.
- Hispanic/Latino PR has been decreasing in the MHP over the past three years.

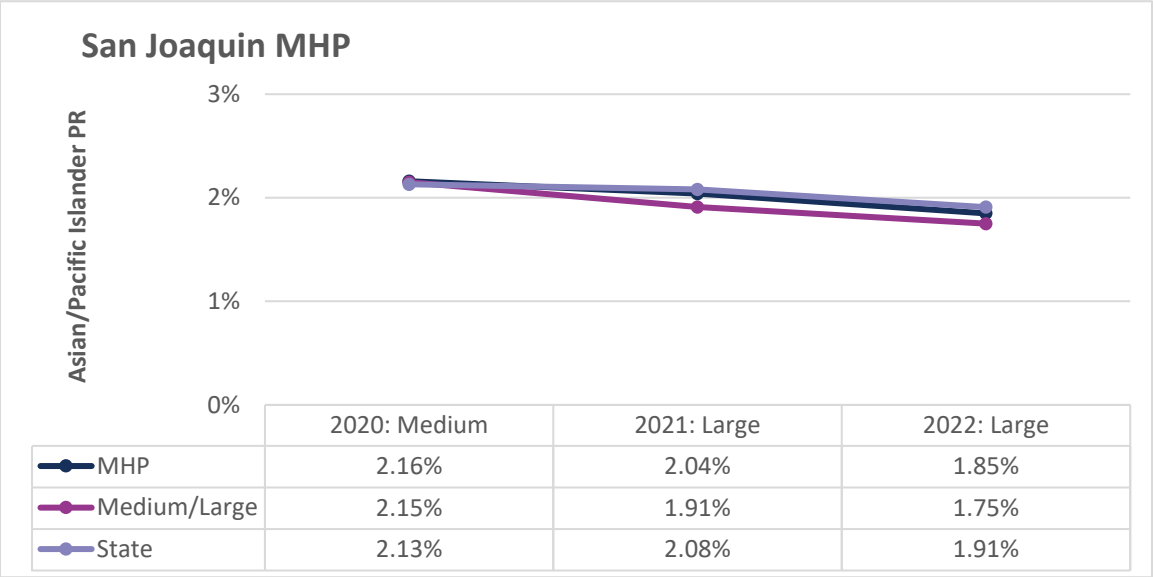
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	$5,842	$6,255	$6,761
Medium/Large	$7,153	$6,996	$6,876
State	$6,551	$6,733	$6,731

- The MHP's Hispanic/Latino AACM increased each year from CY 2020 to CY 2022 and is now comparable to the AACMs for this group statewide and in similar sized counties.

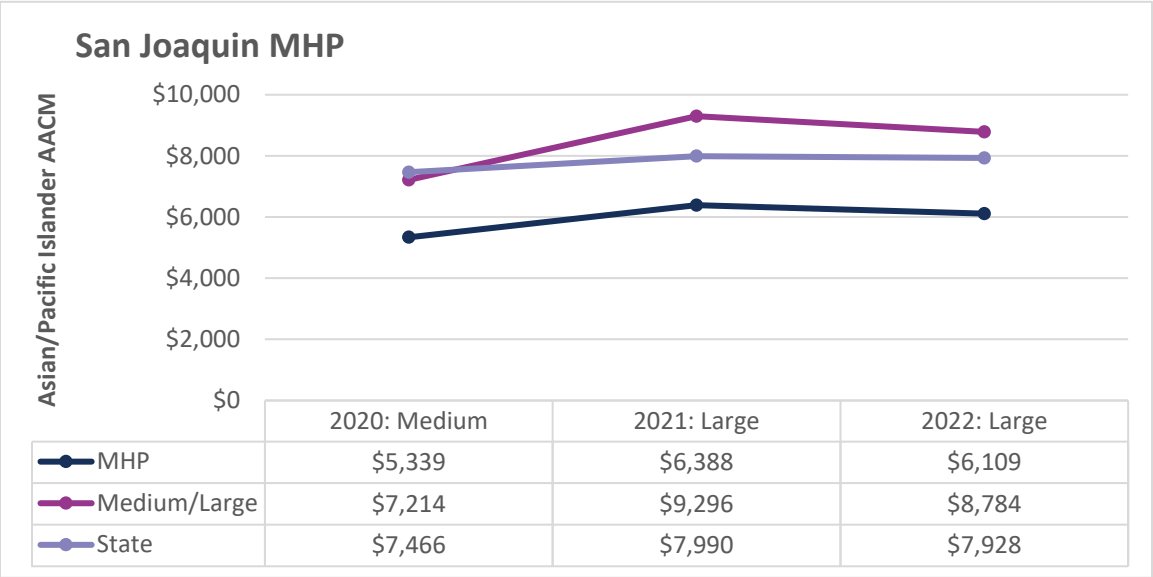
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	2.16%	2.04%	1.85%
Medium/Large	2.15%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- In CY 2022, the MHP's Asian/Pacific Islander PR is just above the large county rate and just below the statewide rate.

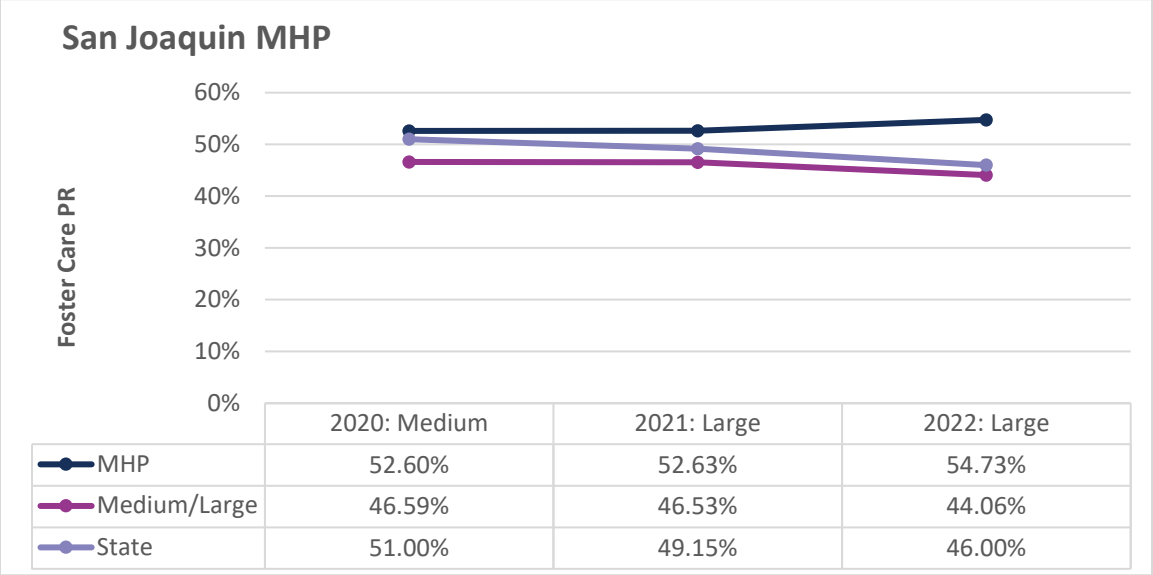
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	$5,339	$6,388	$6,109
Medium/Large	$7,214	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM has been markedly lower than that of medium/large sized county and statewide averages across each of the last three years.

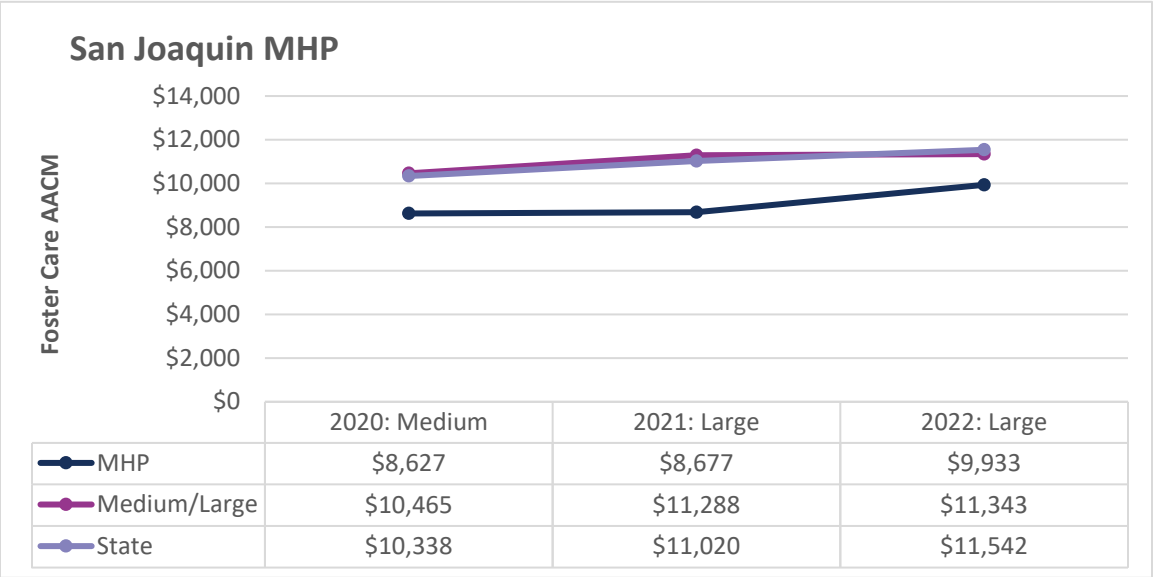
Figure 10: Foster Care PR, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	52.60%	52.63%	54.73%
Medium/Large	46.59%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- The MHP's FC PR has exceeded medium/large sized county and statewide rates from CY 2020 to CY 2022. While the statewide and large sized county FC PR declined from CY 2021 to CY 2022, the MHP's FC PR increased.

Figure 11: Foster Care AACM, CY 2020-22



	2020: Medium	2021: Large	2022: Large
MHP	$8,627	$8,677	$9,933
Medium/Large	$10,465	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide, medium/large sized county, and MHP FC AACMs have increased each year for the past three years.
- The MHP's FC AACM has been less than medium/large sized counties and statewide averages from CY 2020 to CY 2022.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 7,656				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	201	2.6%	8	5	10.3%	14	8
Inpatient Admin	<11	-	21	13	0.4%	26	10
Psychiatric Health Facility	148	1.9%	30	14	1.2%	16	8
Residential	54	0.7%	94	87	0.3%	114	84
Crisis Residential	216	2.8%	37	23	1.9%	23	15
Per Minute Services							
Crisis Stabilization	866	11.3%	1,681	1,200	13.4%	1,449	1,200
Crisis Intervention	2,114	27.6%	208	135	12.2%	236	144
Medication Support	5,600	73.1%	270	200	59.7%	298	190
Mental Health Services	3,316	43.3%	886	240	62.7%	832	329
Targeted Case Management	4,160	54.3%	301	74	36.9%	445	135

- The MHP's combined inpatient and Psychiatric Health Facility (PHF) utilization rate was lower than the combined statewide rate (4.5 percent vs. 11.5 percent).
- While MHP's crisis intervention rate was more than twice the statewide rate (27.6 percent vs. 12.2 percent), the crisis stabilization utilization rate at the MHP was 13 percent less than the statewide rate (11.3 percent vs. 13.4 percent).
- The MHP's utilization rates for targeted case management (54.3 percent vs. 36.9 percent) and medication support (73.1 percent vs. 59.7 percent) are higher than statewide rates.

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

Service Category	MHP N = 868				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	31	3.6%	9	8	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	32	32	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	16	16	0.1%	24	22
Full Day Intensive	<11	-	867	867	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	16	1.8%	1,598	1,200	3.1%	1,166	1,095
Crisis Intervention	97	11.2%	324	170	8.5%	371	182
Medication Support	283	32.6%	317	265	27.6%	364	257
TBS	56	6.5%	2,122	1,269	3.9%	4,077	2,457
Therapeutic FC	<11	-	1,545	1,545	0.1%	911	495
Intensive Care Coordination	604	69.6%	696	312	40.8%	1,458	441
Intensive Home-Based Services	299	34.4%	673	322	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	801	92.3%	1,471	895	95.4%	1,846	1,053
Targeted Case Management	573	66.0%	209	110	35.8%	307	118

- The MHP's crisis stabilization utilization rate is 42 percent higher than the statewide rate (1.8 percent vs. 3.1 percent).
- The MHP's targeted case management utilization rate is higher than the statewide rate (66 percent vs. 35.8 percent).
- Intensive Home-Based Services and Intensive Care Coordination utilization were higher than statewide rates, indicating the MHP has made good efforts to implement Pathways to Well-Being services for FC youth.

IMPACT OF ACCESS FINDINGS

- The PRs for those aged 0-5 and 6-17 were below that of statewide rates, possibly indicating lower service accessibility in the Childrens System of Care (CSOC).
- Hispanic/Latino PR remains lower than the large county and statewide rates for CY 2022, indicating a potential need for increased outreach to this population.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- San Joaquin has a county-developed application for tracking member timeliness of services. This has allowed the MHP to continue to track results during the SmartCare transition, when the EHR cannot provide a full range of reporting.

- San Joaquin monitors and reports separate results in the ATA specifically for Latino/Hispanic/Spanish-Speaker members as part of their ongoing PIP process.
- The MHP's 7-day and 30-day post psychiatric inpatient follow-up rates are higher than statewide. The MHP's 7-day and 30-day psychiatric readmission rates demonstrated noticeable declines in CY 2022. San Joaquin attributes the decrease to their efforts.
- San Joaquin continues to offer a post PHF clinic day on Tuesdays for discharged members to receive follow-up care.

TIMELINESS PERFORMANCE MEASURES

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

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

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.3 Business Days	10 Business Days*	85%
First Non-Urgent Service Rendered	15 Business Days	10 Business Days*	67%
First Non-Urgent Psychiatry Appointment Offered	11 Business Days	15 Business Days*	81%
First Non-Urgent Psychiatry Service Rendered	26.4 Business Days	15 Business Days*	65%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	0.8 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	10.6 Calendar Days	7 Calendar Days	72%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	10.6 Calendar Days	30 Calendar Days	84%
No-Show Rate – Psychiatry	14%	15%**	n/a
No-Show Rate – Clinicians	13%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: CY 2022			

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

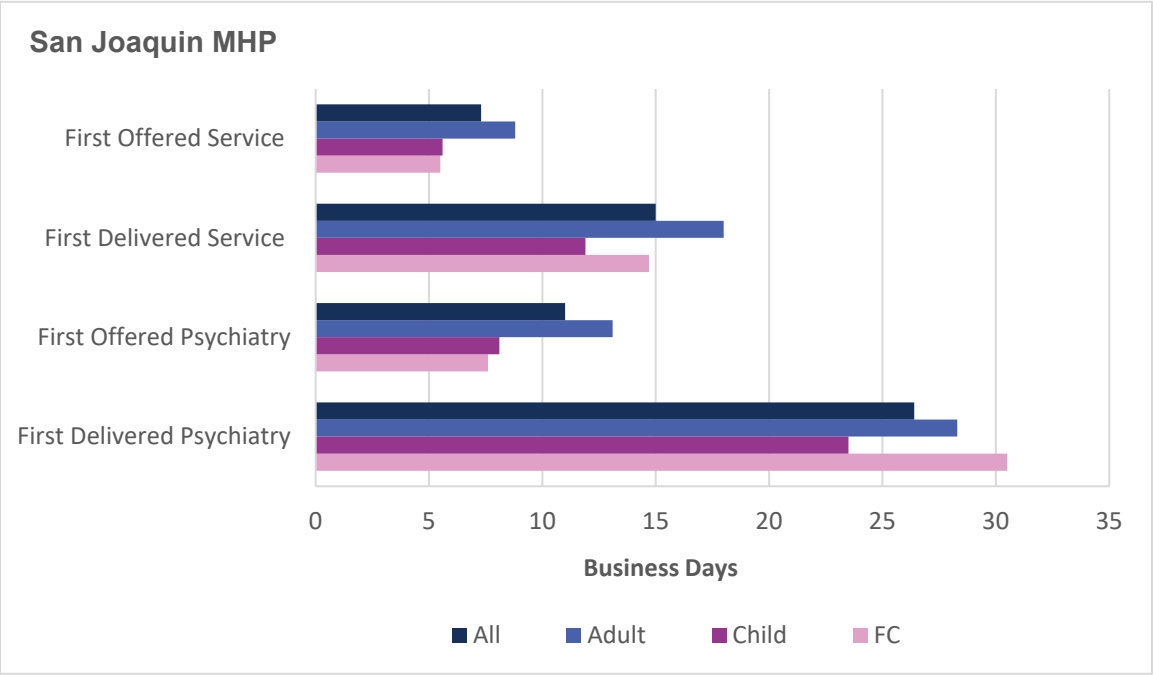


Figure 13: Wait Times for Urgent Services

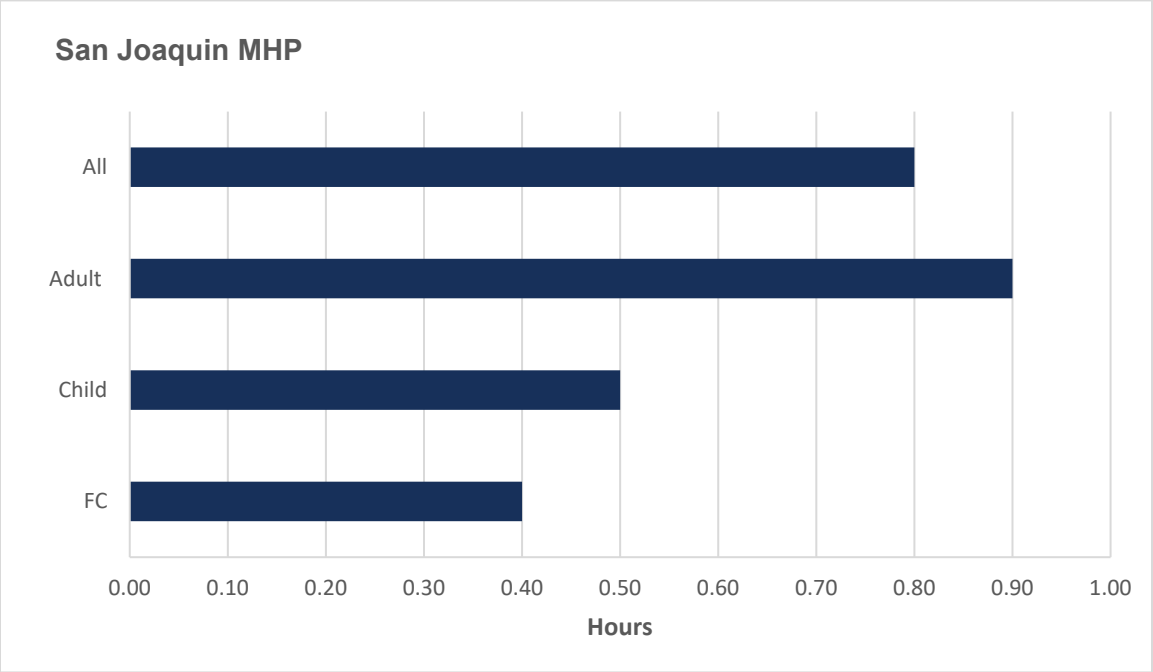
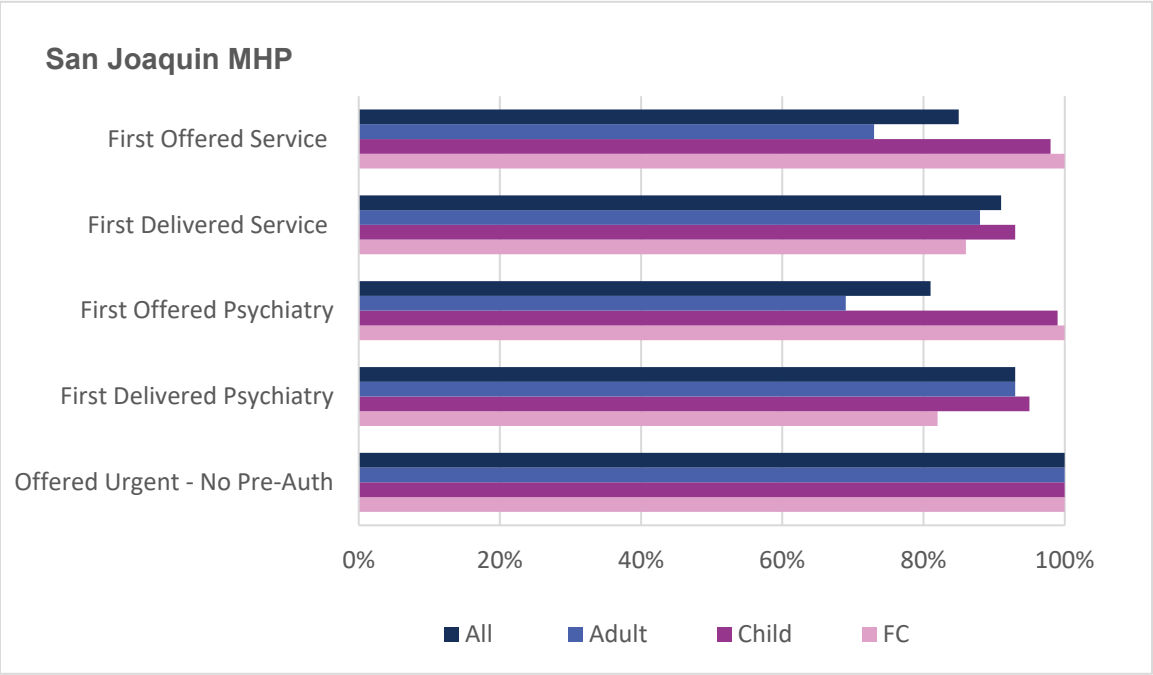


Figure 14: Percent of Services that Met Timeliness Standards



- 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 the entire service system and they derive data from their county-developed timeliness application. The application tracks the date of first contact and first offered clinical intake assessments for individuals seeking specialty mental health services through county-operated and contractor-operated programs. The application data are matched by client identifier to first documented service in the EHR.
- The MHP defined "urgent services" for purposes of the ATA as "a condition that requires immediate attention and if not addressed, could result in significant deficits." This includes all Crisis Clinic walk-ins. There were reportedly 1,518 urgent service requests with a reported actual wait time to services for the overall population of 0.8 hours. The MHP does not offer urgent services that require prior authorization.
- San Joaquin defines timeliness to first delivered/rendered psychiatry service as date of referral to date of rendered prescriber appointment documented in the application or date of first billed prescriber appointment from the EHR, whichever occurred sooner.
- 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 county-operated services only. San Joaquin reports the no-show rate for psychiatrists for all services as 14 percent. The average no-show rate for non-

psychiatry clinical staff for all services was 13 percent. The MHP's standard for no-shows is 15 percent.

IMPACT OF TIMELINESS FINDINGS

- San Joaquin's county-developed timeliness application allows the MHP to continually track and monitor timeliness data for its members. The results are reviewed routinely at committee meetings.
- There appear to be opportunities with first offered appointment and first offered non-urgent psychiatry appointment for adults, and first delivered services for adults and children that meet the 10-day and 15-day standards.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the QAPIC. QAPIC is also responsible for quality assurance/compliance. The MHP monitors its quality processes through the QAPIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QAPIC, comprised of MHP leadership, deputy directors, program managers, the compliance officer, and other staff, is scheduled to meet every other month. Since the previous EQR, the MHP QAPIC met ten times. Of the 61 identified FY 2022-23 QAPI workplan goals, the MHP met 74 percent.

The MHP utilizes the following level of care (LOC) tool: Child and Adult Needs and Strengths Assessment.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths-50 and Pediatric Symptom Checklist-35. San Joaquin uses Objective Arts to run reports to examine outcomes by program, staff, and member.

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	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	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Met

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

- San Joaquin uses standardized tools to measure outcomes for youth and data are analyzed by Objective Arts.
- The MHP has four wellness centers and a strong peer support staff program that encourages career advancement.
- The MHP administers the CPS and presented the most recent findings to stakeholders. San Joaquin developed a workgroup to address the findings. The workgroup is in the process of conducting focus groups to obtain member input.
- The MHP has not adopted a standardized outcome tool to measure the progress of adult members.
- The MHP tracks the Healthcare Effectiveness Data and Information Set (HEDIS) measures that are 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:

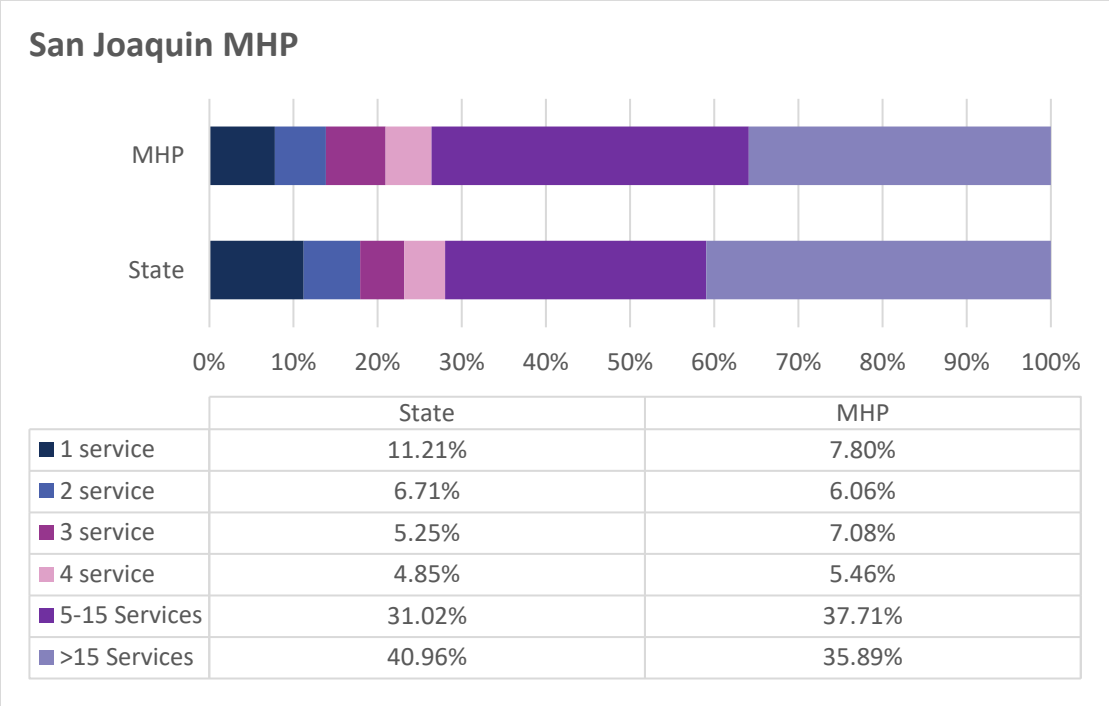
- Retention in Services
- Diagnosis of Members Served

- 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 5 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



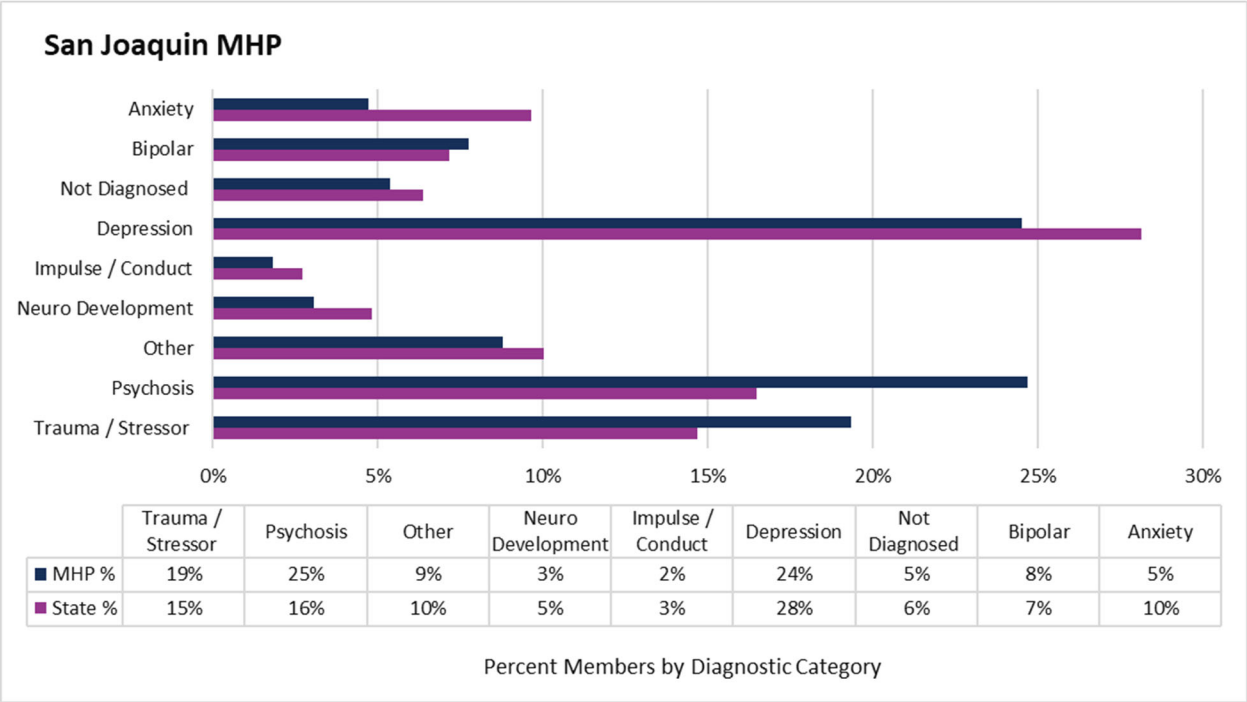
	State	MHP
1 service	11.21%	7.80%
2 service	6.71%	6.06%
3 service	5.25%	7.08%
4 service	4.85%	5.46%
5-15 Services	31.02%	37.71%
>15 Services	40.96%	35.89%

- The MHP had fewer members receiving a single service than is seen statewide (7.80 percent vs. 11.21 percent).
- The MHP's proportion of members receiving greater than 15 services is lower than statewide (35.89 percent vs. 40.96 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.

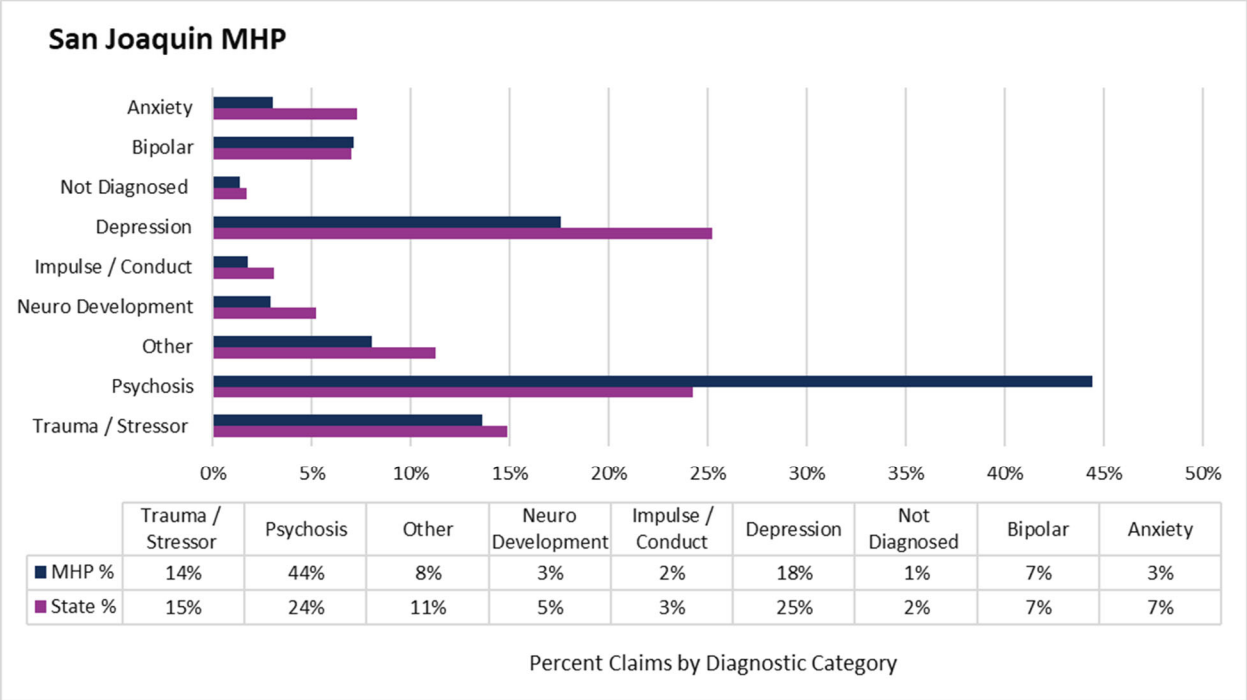
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	25%	9%	3%	2%	24%	5%	8%	5%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Sixty-eight percent of members had one of three diagnoses: psychosis (25 percent), depression (24 percent), and trauma/stressor (19 percent).
- The MHP's diagnostic rate for psychosis exceeds the statewide rate by 56 percent (25 percent vs. 16 percent).

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	44%	8%	3%	2%	18%	1%	7%	3%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- While the MHP's approved claims by diagnostic category generally aligned with diagnostic patterns when compared to statewide data, the psychosis diagnosis percentage was notably higher than the statewide rate (25 percent vs. 16 percent) as were the approved claims for this diagnosis (44 percent vs. 24 percent).

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS.

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	527	646	12.86	8.45	$23,172	$12,763	$12,211,439
CY 2021	665	940	11.24	8.86	$21,470	$12,696	$14,277,460
CY 2020	678	881	10.79	8.68	$18,293	$11,814	$12,402,716

- CY 2022 showed fewer Medi-Cal members and fewer inpatient admissions than prior years but a slightly longer ALOS. The MHP's ALOS is over three days longer and much more costly than statewide.

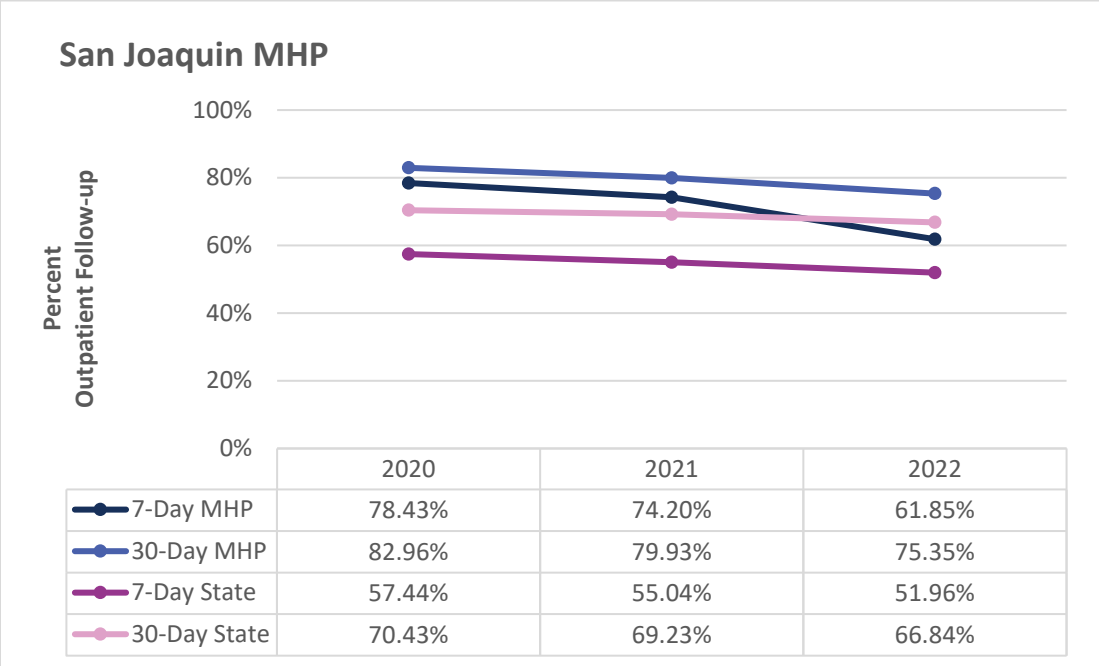
- CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

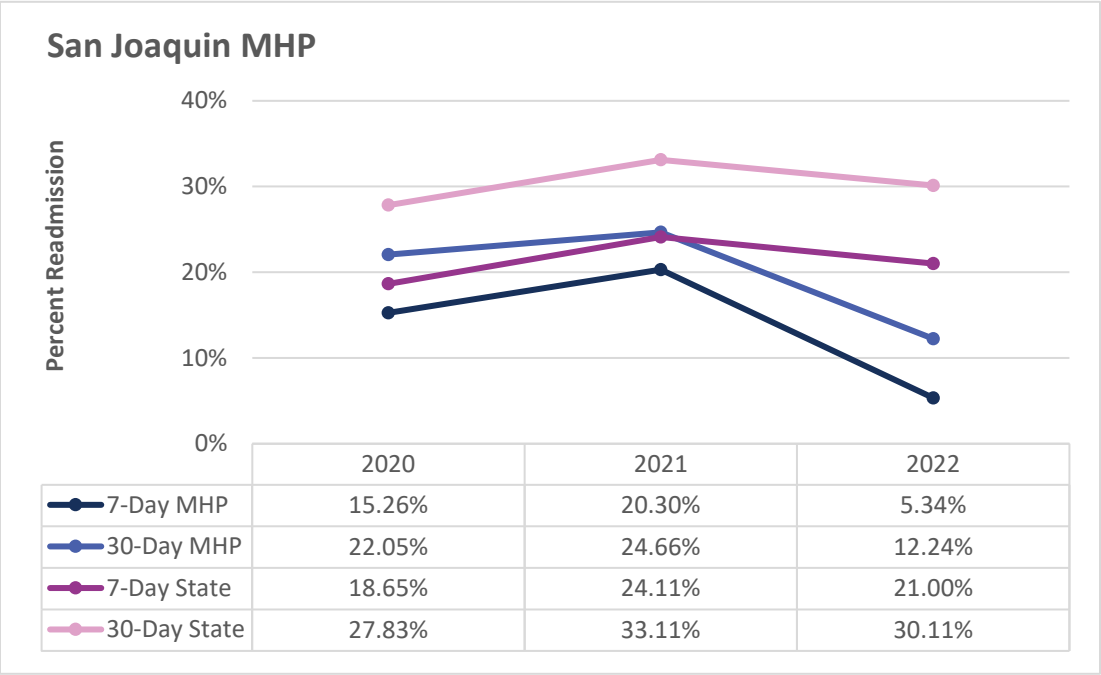
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	78.43%	74.20%	61.85%
30-Day MHP	82.96%	79.93%	75.35%
7-Day State	57.44%	55.04%	51.96%
30-Day State	70.43%	69.23%	66.84%

- The MHP's 7- and 30-day follow-up rates decreased each year from CY 2020 to CY 2022, though the MHP's follow-up rates for both points in time exceeded statewide rates across all three CYs represented above.

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



	2020	2021	2022
7-Day MHP	15.26%	20.30%	5.34%
30-Day MHP	22.05%	24.66%	12.24%
7-Day State	18.65%	24.11%	21.00%
30-Day State	27.83%	33.11%	30.11%

- The MHP's 7- and 30-day readmission rates declined substantially from CY 2021 to CY 2022.
- The MHP's 7- and 30-day readmission rates have consistently been lower than statewide rates for the past three years. The MHP's longer ALOS may attribute to fewer readmissions.

High-Cost Members

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

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

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

Table 14: San Joaquin 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	484	4.49%	38.09%	$30,162,848	$62,320	$48,102
	CY 2021	460	4.31%	37.99%	$29,197,882	$63,474	$47,047
	CY 2020	444	4.23%	37.32%	$26,410,429	$59,483	$47,433

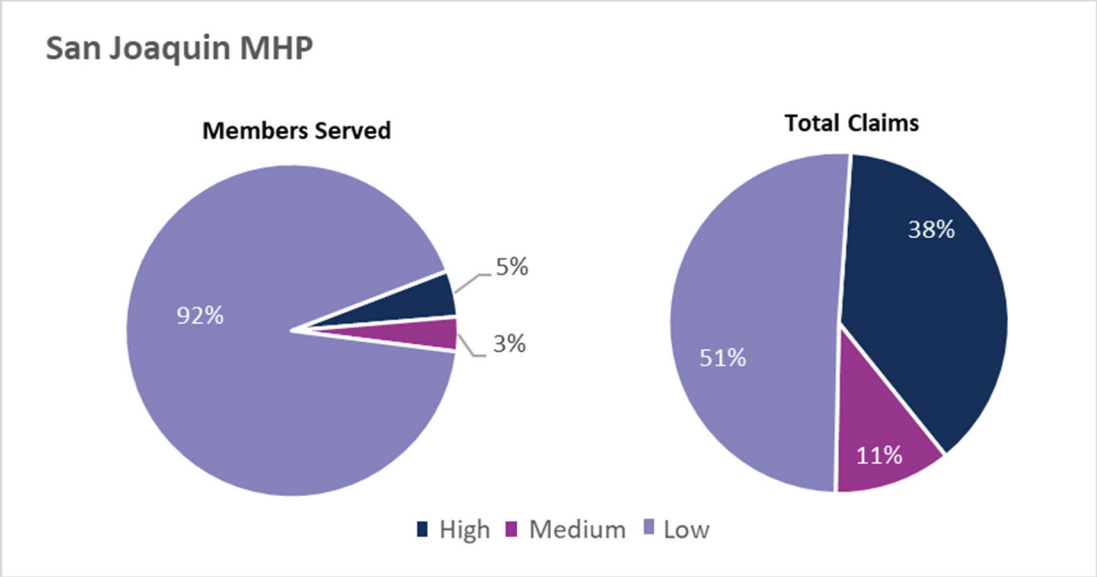
- The number of HCMs increased each year from CY 2020 to CY 2022. In CY 2022, the percent of HCMs was just below the statewide rate (4.49 percent vs. 4.54 percent).
- The MHP’s CY 2022 percent of HCM approved claims dollars exceeded the statewide rate (38.09 percent vs. 33.86 percent). The AACM was higher than the statewide average in CY 2022 ($62,320 vs. $55,518).

Table 15: San Joaquin 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)	360	3.34%	11.11%	$8,794,947	$24,430	$24,230
Low-Cost (Less than $20K)	9,925	92.16%	50.80%	$40,225,225	$4,053	$2,518

- Low-cost members comprised 92.16 percent of those served and 50.80 percent of the approved claims dollars were attributed to this population.

Figure 20: Members Served and Approved Claims by Claim Category, CY 2022



- The proportions of members in each cost category and the proportions of claims attributable to each group were comparable to statewide, with a slightly higher proportion of claims associated with HCMs (38 percent vs. 34 percent) and a slightly lower proportion associated with low-cost members (51 percent vs. 54 percent) than statewide.

IMPACT OF QUALITY FINDINGS

- Depression spending was lower than would be expected with 24 percent of members having received services and 18 percent of claims dollars spent on this diagnostic category. This indicates lower spending on this population than is seen statewide with 28 percent of claims dollars attributed to 25 percent of members with a psychosis diagnosis.
- San Joaquin noted that the county has a substantial amount of drug use occurring and this could be contributing to the MHP's higher psychosis diagnostic rate when compared to the statewide rate (25 percent vs. 16 percent).

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: FUM BHQIP

Date Started: 07/2022

Aim Statement: By Q4 2023, the MHP will significantly increase the percentage of St. Joseph Hospital's mental health and intentional self-harm related ED visits that receive 7- and 30-day follow-ups, over the 2022 baseline of 70.9 percent and 80.3 percent, respectively, by implementing: (1) patient & provider education and promotion; (2) closed-loop referrals; and (3) centralized follow-up.

Target Population: Medi-Cal members of any age who discharge from the ED with a principal diagnosis of mental illness or intentional self-harm.

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

The MHP submitted the FUM BHQIP for its clinical PIP. The focus of the PIP is increasing 7- and 30-day follow-up for members with ED visits for mental health or intentional self-harm at St. Joseph's Hospital. San Joaquin limited the PIP to the ED with the highest proportion of relevant cases and is seeking statistically significant improvement in the results.

The MHP has multiple strategies to improve 7- and 30-day follow-up including distributing promotional flyers and posters (English and Spanish) to seven hospital EDs to educate members about how to access services, referral strategies, resources, and training materials to ED managers, social workers, and navigators, deploying Xferall, an electronic referral application to receive real-time direct message referrals from EDs, and a centralized point of entry for all incoming ED referrals. Whenever possible, ED providers may make a phone-based warm handoff to the MHP access team. Interventions began in Spring 2023.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence. The MHP implemented multiple interventions that include member, provider, and system changes and provided intervention evaluation data.

CalEQRO did not provide TA to San Joaquin for this PIP outside of the annual review as the MHP did not request it.

CalEQRO recommendations for improvement of this clinical PIP:

- The MHP should confirm whether hospitals are including the flyers in the discharge paperwork and complete the additional training with discharge nurses and social workers, as needed, since this is a key intervention.
- The PIP should clearly define the performance measures and include results in a table format for comparison across measurement periods.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: IHBS Expansion

Date Started: 10/2021

Date Completed: 03/2023

Aim Statement: By March 2023, can San Joaquin County's CYS increase the number of Medi-Cal eligibles who receive IHBS services and the number of IHBS services provided per member by 20 percent over the FY 2021-22 baseline period by: (1) restructuring programs to prioritize IHBS services and support continuity of care; (2) cultivating more effective family engagement practices to encourage participation; and (3) automating screening and referral process to ensure children/youth do not fall through the cracks?

Target Population: Medi-Cal members under the age of 18 who meet medical necessity criteria for SMHS. Other targets include foster youth, ages 18-20.

Status of PIP: The MHP's non-clinical PIP is completed.

Summary

The MHP identified that few youth who are eligible for IHBS get this service and youth who receive IHBS in San Joaquin receive fewer services than youth in other MHPs and across the state. The MHP posits that a great proportion of youth in San Joaquin are at-risk and ought to be accessing these services at the same, if not higher, rate than youth in other MHPs. The PIP team identified some factors that likely contributed to underuse of this service, including the requirement for families to transfer to new programs and new staff to receive additional services; insufficient capacity in the ASOC to provide services to youth 18-20 years of age (and therefore, not offer the services); insufficient staff understanding of IHBS to promote this service to families.

The team has three interventions: restructure the outpatient program to enable continuity of care and promote IHBS specialization among staff; cultivate family engagement and understanding of supportive services; and automate the screening and referral of youth who meet criteria. Interventions were implemented in July 2022. The MHP reported that at this time, the automated screening and electronic referral form is not in SmartCare, which the MHP transitioned to in July 2023. Therefore, the MHP needed to change to using a paper form until the form can be included in SmartCare.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence. There was a significant increase in the percentage of CYS members who received IHBS, and it was determined that PIP interventions likely led to the improvement.

CalEQRO did not provide TA to San Joaquin for this PIP outside of the annual review as the MHP did not request it.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Investigate reasons for only 48 percent of eligible families receiving timely services within 15 days and address barriers to timely services.

- Continue to examine whether the average number of services for clients may be improved.

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 the CalMHSA semi-statewide EHR, SmartCare by Streamline. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 2.4 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 1,043 named users with log-on authority to the EHR, including approximately 630 county staff and 413 contractor staff. Support for the users is provided by 10.5 full-time equivalent (FTE) IS technology positions. While the MHP has a County IT department, with 8.4 FTE vacancies, currently all behavioral health allocated positions are filled.

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

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☒ Real Time ☐ Batch	10%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	10%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	80%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

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

Interoperability Support

The MHP is a member or participant in the Manifest MedEx HIE. Manifest MedEx facilitates the exchange of healthcare data for 36 million Californians via its network comprised of more than 1,800 healthcare organizations including 125 hospitals, and 13 health plans including four of the state's largest health plans, Anthem Blue Cross of California, Inland Empire Health Plan, and Health Plan of San Joaquin. The MHP engages in electronic exchange of information with FQHCs, hospitals, primary care providers (PCPs), and MCPs.

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 implemented the semi-statewide EHR, SmartCare by Streamline, on July 1, 2023. Streamline will provide base product patch updates while CalMHSA will be responsible for system customization.
- Staff are reported to be continuing to adjust and understand the functionality of the new SmartCare system.
- Contract providers have full access to the SmartCare system.
- The MHP's participation in the Manifest MedEx HIE allows for accurate and timely electronic exchange of health information between health information networks, including PCPs and hospitals.
- The MHP's denied claims rate of 3.19 percent is lower than the statewide rate of 5.92 percent.
- While data analytics and reporting were well developed and a strength for the MHP with the Clinician's Gateway/Sharecare system, this functionality is still being developed in SmartCare. The rebuilding of reporting functionality is not limited to the MHP but is true for all SmartCare counties due to the recent implementation and continued development of the system.
- The MHP maintained a data warehouse that replicated the Clinician's Gateway/Sharecare system and plans to develop this functionality with the newly implemented SmartCare system to support data analytics and reporting.
- There is an operations continuity plan for critical business functions that is maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency, and it is tested annually.

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 Joaquin MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	20,717	$6,118,464	$292,160	4.78%	$5,826,304
Feb	20,727	$5,944,943	$262,676	4.42%	$5,682,267
Mar	25,103	$7,261,963	$215,538	2.97%	$7,046,425
April	22,111	$6,441,644	$193,064	3.00%	$6,248,580
May	22,407	$6,815,748	$196,867	2.89%	$6,618,881
June	22,104	$6,685,847	$214,947	3.21%	$6,470,900
July	20,261	$5,825,828	$141,843	2.43%	$5,683,985
Aug	22,152	$6,342,567	$160,130	2.52%	$6,182,437
Sept	22,909	$6,117,176	$143,877	2.35%	$5,973,299
Oct	22,531	$7,038,437	$261,063	3.71%	$6,777,374
Nov	21,362	$6,494,724	$175,150	2.70%	$6,319,574
Dec	20,800	$6,314,323	$214,285	3.39%	$6,100,038
Total	**263,184**	**$77,401,664**	**$2,471,600**	**3.19%**	**$74,930,064**

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	4,368	$1,148,863	46.48%
Medicare Part B must be billed before submission of claim	2,516	$663,397	26.84%
Member is not eligible or non-covered charges	875	$360,426	14.58%
Late claim submission	1,328	$207,235	8.38%
Service location NPI issue	78	$37,952	1.54%
Deactivated NPI	265	$25,300	1.02%
Service line is a duplicate and repeat service modifier is not present	166	$20,438	0.83%
Other	19	$6,541	0.26%
Place of service incomplete or invalid	2	$1,448	0.06%
Total Denied Claims	**9,617**	**$2,471,600**	**100.00%**
Overall Denied Claims Rate	**3.19%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The claims denial rate for CY 2022 of 3.19 percent is lower than the statewide denial rate of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- While the SmartCare system will provide the benefit of new and updated functionality, the MHP reported having an extensive number of previously developed in-house reports and dashboards. The review of these reports and dashboards to identify desired reporting availability in the new system will be a focus of the MHP over the next year.
- The MHP is able to share electronic health information between providers via the Manifest MedEx HIE.
- A robust data analytic staff, combined with bi-monthly Data Committee meetings with manager-level participation, effectively supports the reporting and analytic needs of the organization.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the annual CPS and provided a presentation from April 2023 that summarized the May 2022 survey results. A total of 573 surveys were collected, and 422 were labeled as "Complete" by state analysis. San Joaquin analyzed the findings and developed a workgroup. The workgroup is in the process of conducting focus groups to obtain member input.

PLAN MEMBER/FAMILY FOCUS GROUP(S)

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

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

Consumer Family Member Focus Group One

The first group was English speaking Transitional Age Youth (TAY) ages 16 to 25 years who identify as Latino/Hispanic. The focus group was held virtually and included seven participants. A language interpreter was not needed for this group. All members participating receive clinical services from the MHP.

Two members who started services in the past year reported the process was easy. All members in the group reported that they receive a reminder before an appointment and all members indicated a family member is available to transport them to appointments. If there ever are transportation issues, members are aware that telehealth options for appointments are available. Members reported that their family can be involved in treatment. All members reported that things have been going well and appointments are helpful. Some members had used the national crisis line (988) and indicated wait times of 30 minutes to two hours for someone to answer.

Recommendations from focus group participants included:

- More frequent appointments.
- Have a consistent therapist. It is difficult to establish a connection with a new therapist.
- Offer group therapy.

Consumer Family Member Focus Group Two

The second group was English speaking parents/caregivers of children who began receiving IHBS in the past 12 months. The focus group was held virtually and included two participants. A language interpreter was not needed for this focus group. All family members participating have a family member who receives clinical services from the MHP.

To protect confidentiality of the two participants in attendance, feedback received during the session is incorporated into other sections of this report to ensure anonymity.

Consumer Family Member Focus Group Three

The third group was English and Spanish speaking adults. The focus group was held virtually and included six participants. A language interpreter (Spanish speaking) was used for this focus group. All members participating receive clinical services from the MHP.

Three of the focus group members started services in the past 12 months. The members indicated the process of starting services was easy and there were no barriers or challenges. Members in the group agreed that the MHP provides services addressing their cultural and linguistic needs. If members need Spanish speaking services, they receive them. Most members were satisfied with the frequency of visits; however, a member suggested that she would like more frequent sessions and longer sessions. Overall, the members expressed satisfaction with the services they receive.

Recommendations from focus group participants included:

- More group therapy options.
- More options to socialize, and social gatherings outside of the center.

SUMMARY OF MEMBER FEEDBACK FINDINGS

A common theme shared from members was difficulty when their clinician is changed, and they “start over” building rapport and tell their story all over again. Another commonality amongst some members was the desire for more frequent appointments with their therapist. Sometimes it may be months in between appointments, depending on the situation. Most of the members had appointments at a frequency that worked for them. Generally, members were appreciative of the services they receive from the MHP and expressed overall satisfaction. Member recommendations mostly pertained to wanting more groups and social support activities.

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. San Joaquin has an impressive analytic and reporting capability/capacity. Timeliness data are reviewed in ASOC, CSOC and in QAPI meetings. (Timeliness, Quality)
2. San Joaquin places strong emphasis on cultural competency. The MHP offers cultural competence training and opens the training to contracted providers to attend. To reduce racial, ethnic, cultural, and linguistic disparities, the Cultural Competency Committee is initiating member focus groups to gather information from consumers, providers, and the community on questions related to barriers to access and possible solutions. Additionally, the MHP initiated a PIP to increase the Latino/Hispanic PR. (Access, Quality)
3. The MHP has effective collaborations with partner stakeholders to help improve care and services for its members. San Joaquin has partnerships with a wide range of agencies. For example, the MHP participates in outreach to the homeless, going out in the community to locate individuals. (Access)
4. San Joaquin has a robust medication monitoring program that includes a monthly discussion at the Pharmacy and Therapeutics Committee. The MHP monitors data regarding medications and labs. As a result, San Joaquin made process improvements to the lab ordering process for youth. (Quality)
5. The MHP has engaged in multiple staff retention and recruitment efforts, including for psychiatrists, and reduced overall staff vacancies from 27 percent to 21.7 percent. The MHP makes efforts to attract and retain bilingual staff members and reports having ample Spanish speaking staff. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. San Joaquin's PR for Latino/Hispanic remains lower than statewide and similar size counties. (Access)
2. Staff turnover and vacancies may impact members' satisfaction with the receipt of continuous and frequent MHP services. (Timeliness, Quality)
3. In the MHP's ATA, there appear to be opportunities with first offered appointment and first offered non-urgent psychiatry appointment for adults, and first delivered

services for adults and children that meet the 10-day and 15-day standards. (Timeliness).

4. The MHP has not adopted a standardized outcome tool to measure and report aggregate outcome results for adult members. (Quality)
5. There may be an opportunity for implementation of an organized task force to address fentanyl use in the community. (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. Continue efforts to increase Hispanic/Latino access. If there has been no improvement in access (e.g., increase in PR or some other indicator), modify or implement new interventions to address underlying causes. (Access)

   (This recommendation was continued from FY 2021-22 and FY 2022-23.)
2. Evaluate any impact on members due to staff turnover or high caseloads and implement additional strategies, if needed, to ensure that members receive continuous and appropriately frequent services. Having the capacity to deliver the appropriate LOC is an important consideration. (Timeliness, Quality)
3. Evaluate timeliness data for first offered appointment for adults, first offered non-urgent psychiatry appointment for adults, and first delivered services for adults, children, and FC. If necessary, the MHP should take actions to improve results meeting the 10-day and 15-day standards. (Timeliness)
4. The MHP should adopt a standardized outcome tool to measure and report aggregate outcome results for adult members. (Quality)
5. Consider investigating a potential opportunity to organize or participate in a community-wide response to fentanyl use in the county. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers; San Joaquin's MHP annual EQR was conducted as planned.

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 Joaquin 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) –Transitional Age Youth (ages 16 to 25 years) who identify as Latino/Hispanic, Parents/Caregivers of Children who receive IHBS, and English and Spanish speaking Adults
Fiscal/Billing
Clinical Line Staff Group Interview (Began employment in the last 12 months)
Clinical Supervisors Group Interview (Outpatient, Inpatient, Justice, and Community Integration)
Contract Providers Group Interview (Serving Youth and Adults)
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 Group Interview (Serving Youth and Adults)
Peer Inclusion/Peer Employees within the System of Care
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Christy Hormann, Lead Quality Reviewer
Elaine Crandall, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Gloria Marrin, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Akagha	Ben	Regional Director	Turning Point Community Programs
Alcarez	Marlen	Chief Mental Health Clinician	SJC BHS
Amador	Keith	Mental Health Clinician III	SJC BHS
Archangel	Alex	Senior Director	GLOM
Balmaceda	Angelo	Management Analyst III	SJC BHS
Barajas	Lauren	Mental Health Clinician III	SJC BHS
Barret	Patricia	Chairwoman BHAB	BHAB
Berdahl	Michelle	Substance Abuse Program Manager	SJC BHS
Bickham	Donna	Deputy Director	SJC BHS
Bringas	Giselle	Chief Mental Health Clinician	SJC BHS
Brown	Monique	Chief Mental Health Clinician	SJC BHS
Camello	Bena	Mental Health Clinician III	SJC BHS
Chavez	April	Mental Health Clinician III	SJC BHS
Clinton	Stefenee	Chief Mental Health Clinician	SJC BHS
Curtiss	Megan	Chief Mental Health Clinician	SJC BHS
Del Toro	Jose	Chief Mental Health Clinician	SJC BHS
DeWitte	Tiffany	Deputy Director	SJC BHS
Dunn	Cara	Assistant Director	SJC BHS
Eliab	Sonya	Mental Health Clinician III	SJC BHS
Englent	Kimberly	Accounting Manager	SJC BHS
Fabian	Todd	Director	UOP Gipson Center

Last Name	First Name	Position	County or Contracted Agency
Fernandez	Tatiana	Psychiatric Technician	SJC BHS
Fields	Michael	CEO	Peer Recovery Services
Flores	Courtney	Chief Mental Health Clinician	SJC BHS
Flores	Michele	Mental Health Outreach Worker	SJC BHS
Frederiksen	Janelle	Management Analyst III	SJC BHS
Gallacher	Veronica	Chief Mental Health Clinician	SJC BHS
Garcia	Juan	Mental Health Clinician III	SJC BHS
Garcia	Julio	Chief Mental Health Clinician	SJC BHS
Garibaldi	Michelle	Chief Mental Health Clinician	SJC BHS
Gonsalez	Alicia	Mental Health Clinician III	SJC BHS
Gonzales	Leticia	Mental Health Specialist II	SJC BHS
Guerrero	Melissa	Mental Health Clinician III	SJC BHS
Gutoman	Jon Christopher	Mental Health Clinician III	SJC BHS
Hall	Tondria	Core Program Manager	Aspiranet
Hannah	Kathy	Deputy Director	SJC BHS
Hansen	Sophia	Program Manager	University of the Pacific
Hawkins	Nichole	Chief Mental Health Clinician	SJC BHS
Helsby	Sherri	Chief Mental Health Clinician	SJC BHS
Herrick	Kara	Chief Mental Health Clinician	SJC BHS
Holguin	Shawna	Staff Nurse I	SJC BHS
Hollowell	Shirley	Nursing Department Manager	SJC BHS
Hudson	Dana	Chief Mental Health Clinician	SJC BHS
Jackson	Sasha	Chief Mental Health Clinician	SJC BHS

Last Name	First Name	Position	County or Contracted Agency
Jefferson	Renae	Mental Health Outreach Worker	SJC BHS
Jimenez	Hope	Accountant III	SJC BHS
Jones-Mitchell	Shahloh	Management Analyst III	SJC BHS
Jordan	Jerry	Mental Health Outreach Worker	SJC BHS
Kavanagh	Priscilla	Chief Mental Health Clinician	SJC BHS
Lilly	Isaiah	Deputy Director	SJC BHS
Lippert	Leonard	Interim Executive Director	El Concilio
Lofton	Ebony	Mental Health Outreach Worker	SJC BHS
Lorenz	Art	Program Administrator	Telecare
Lozano	Nia	Medical Director	SJC BHS
Maniti	Shayne	Senior Psychiatric Technician	SJC BHS
Massey	Terrance	Deputy Director	SJC BHS
Mayoya	Marcellina	Mental Health Outreach Worker	SJC BHS
Mejia	Matthew	Mental Health Outreach Worker	SJC BHS
Merrit-Armas	Nicole	Mental Health Outreach Worker	SJC BHS
Meuangkhoth	Angela	Management Analyst II	SJC BHS
Molina	Rico	Chief Mental Health Clinician	SJC BHS
Morales	Leo	Mental Health Clinician III	SJC BHS
Morris	Allie	Clinician	SJC BHS
Morris	Robert	Department Applications Analyst IV	SJC BHS
Myotte	Wendy	Chief Mental Health Clinician	SJC BHS
Nguyen	Thao	Mental Health Clinician III	SJC BHS
Parker	Sabrina	Vice President of Program Management	GLOM

Last Name	First Name	Position	County or Contracted Agency
Pelletier	Paul	Substance Abuse Program Manager	SJC BHS
Pettis	Betsey	Deputy Director	SJC BHS
Pollock	Leora	Chief Mental Health Clinician	SJC BHS
Poulos	Cynthia	Staff Nurse IV	SJC BHS
Prado	Ines	Mental Health Specialist II	SJC BHS
Pruitt	Katie	Program Director	Turning Point Community Programs
Rambo	Chelsea	Chief Mental Health Clinician	SJC BHS
Regaldo	Bernice	Mental Health Clinician I	SJC BHS
Reinhardt	Janae	Clinical Director	Children's Home of Stockton
Roberts	Sharmaine	Chief Mental Health Clinician	SJC BHS
Roeum	Raksmey	Program Administrator	Telecare – Jeremy House
Sabean	Jeff	Deputy Director	SJC BHS
Saelee	Cindy	Chief Mental Health Clinician	SJC BHS
Santiago	Regina	Mental Health Clinician III	SJC BHS
Schmidt	Katarzyna	Mental Health Clinician I	SJC BHS
Shingu	Eric	Substance Abuse Program Manager	SJC BHS
Spruill	Jennifer	Chief Mental Health Clinician	SJC BHS
Stanley	Anastacia	Chief Mental Health Clinician	SJC BHS
Susskind	Jennifer	Lead Planner & Evaluator	Praxis
Tacata	Alicia	Management Analyst III	SJC BHS
Tutupalli	Lohit	Pharmacy Manager	SJC BHS
Valentine	Genevieve	Director	SJC BHS
Valles	Monique	Mental Health Outreach Worker	SJC BHS

Last Name	First Name	Position	County or Contracted Agency
Vasquez	Jessie	Mental Health Specialist II	SJC BHS
Vieira	Fay	Deputy Director	SJC BHS
Viles Reed	Teresa	Clinical Director	Valley Community Counseling
Vivero	Joaquin	Substance Abuse Program Manager	SJC BHS
White	Holly	Executive Director of Behavioral Services	University of the Pacific
Wieland	Jessica	Chief Mental Health Clinician	SJC BHS
Wilson	Tia	Mental Health Specialist II	SJC BHS
Windhem	Melissa	Mental Health Specialist II	SJC BHS
Yim	Donna	Department Information Systems Manager	SJC BHS
Yocham	Amanda	Chief Mental Health Clinician	SJC BHS

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 submitted the FUM BHQIP for its clinical PIP. Results indicated a decline in both the MHP's 7- and 30-day follow-up rates. The PIP included baseline results from 2022 and intervention evaluation data.
General PIP Information	
MHP/DMC-ODS Name: San Joaquin	
PIP Title: FUM BHQIP	
PIP Aim Statement: By Q4 2023, the MHP will significantly increase the percentage of St. Joseph Hospital's mental health and intentional self-harm related ED visits that receive 7- and 30-day follow-ups, over the 2022 baseline of 70.9 percent and 80.3 percent, respectively, by implementing: (1) patient & provider education and promotion; (2) closed-loop referrals; and (3) centralized follow-up.	
Date Started: 07/2022	
Date Completed: In progress	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ 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): Members with an ED visit at St. Joseph's Hospital for mental health or intentional self-harm.	

General PIP Information						
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): Promotional flyers and posters to hospital EDs.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Resources and training materials to ED managers, social workers, and navigators to support appropriate referrals.						
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): Deploy Xferall, an electronic referral application, to receive real-time direct message referrals from EDs. Establish a centralized Point of Entry for all referrals.						
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**
7-day follow-up	2022	70.9%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
30-day follow-up	2022	80.3%	☒ 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 should confirm whether hospitals are including the flyers in the discharge paperwork and complete the additional training with discharge nurses and social workers, as needed. • The PIP should clearly define the performance measures and include results in a table format for comparison across measurement periods.

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 that few youths eligible for IHBS get this service and youth who receive IHBS in San Joaquin receive fewer services than in other MHPs and across the state. The MHP implemented interventions in 2022 and reported second remeasurement results in this year's submission. There was a significant increase in the percentage of CYS members who received IHBS.
General PIP Information	
MHP/DMC-ODS Name: San Joaquin	
PIP Title: IHBS Expansion	
PIP Aim Statement: By March 2023, can San Joaquin CYS increase the number of Medi-Cal eligibles who receive IHBS services and the number of IHBS services provided per member by 20 percent over the FY 2021-22 baseline period by: (1) restructuring programs to prioritize IHBS services and support continuity of care; (2) cultivating more effective family engagement practices to encourage participation; and (3) automating screening and referral process to ensure children/youth do not fall through the cracks?	
Date Started: 10/2021	
Date Completed: 3/2023	
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): Medi-Cal members under the age of 18 who meet medical necessity criteria for SMHS. Other targets include foster youth, ages 18-20.
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): Cultivate more effective family engagement practices.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):
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): Restructure programs to support continuity of care and promote IHBS specialization. Automate screening and referral process.

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
Average number of children/youths receiving IHBS services monthly	2021-22	130	March-May 2023	263	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of children/youth population receiving IHBS	2021-22	8.2%	March-May 2023	14.1%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent 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
Average number of services received monthly per child/youth receiving IHBS services	2021-22	2.23 services per client each month	March-June 2023	2.35 services per client each month	☒ 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): Completed

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

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

EQRO recommendations for improvement of PIP:

- Investigate reasons for 48 percent of eligible families receiving timely services within 15 days and address barriers to ensure members receive timely services.
- Continue to examine whether the average number of services per member may be improved.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM THE MHP DIRECTOR

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