Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

RIVERSIDE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

May 9-11, 2023

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Hybrid

Date of Review — May 9-11, 2023

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	1	4	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	2	2	0
Timeliness of Care	6	3	3	0
Quality of Care	10	7	3	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**17**	**9**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improve continuity of care and engagement in community outpatient services for detention mental health consumers when they are released.	Clinical	07/2020	Other: Completed	Low
Milestone 3d HEDIS FUM 7/30	Non-Clinical	09/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	9

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has developed specialized programs that enhance available levels of care for beneficiaries, supported by robust performance tracking and reporting.
- Recovery services and utilization of individuals with lived experience are integrated with all programs.
- Leadership team members demonstrate strong knowledge and creative efforts in implementing system changes driven by CalAIM and other changes.
- Health Information Exchange (HIE) and other joint databases support the MHP's tracking of health indicators and social determinants of care.
- The stable electronic health record (EHR) installation, supported by strong fiscal, IS and analytic support, are enabling implementation of CalAIM changes in a timely manner.

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

- Development of a clinical and technical telehealth protocol is critical to the appropriate utilization of this important resource.
- Due to unanticipated increases in MCP referrals from DHCS screening tool implementation and existent high vacancy levels, the MHP has been required to implement practices that may increase wait times and use of crisis systems in lieu of routine care.

- The MHP's criteria for tracking timeliness in several of the required categories appears to result in significant under-reporting of events and aggregate timeliness.
- The MHP's Quality Improvement (QI) Work Plan lacks inclusion of tracked metrics and inclusion of trend data in addition to narrative conclusions.
- The MHP's website presence continues to present both navigational and informational challenges.

Recommendations for improvement based upon this review include:

- Develop a clinical telehealth policy that provides guidance as to the clinical and technical issues to be considered when this methodology is being considered for a beneficiary.
- In order to address the workforce capacity issues, the MHP needs to research and implement priorities of job applicants and existing staff, such as hybrid schedules and strategies that improve work-life balance and workplace wellness.
- The MHP needs to research and implement improved criteria for timeliness tracking in areas such as first non-urgent psychiatry service and urgent care to ensure its parameters for event capture are complete and comprehensive.
- The MHP's integrated MHP/SUD QI Work Plan should consider greater inclusion of tracked objectives, and a modification of format that would incorporate trend data with each item in addition to narrative conclusion statements.
- The MHP's website navigation would benefit from a review of navigation and information presentation. The review team suggests the involvement of beneficiaries and caregivers, to ensure that necessary links are easily accessed and furnish the necessary information.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Riverside County MHP by BHC, conducted as a hybrid review on May 9-11, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's 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 beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has experienced loss of clinical and psychiatry staff, and difficulties recruiting and retaining new hires. CalEQRO worked with the MHP to design an alternative hybrid agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Added a Deputy of Peer Services
- Staffing retention and recruitment challenges
- Increased crisis requests emerging post-pandemic
- Hybrid office/remote work days for some programs
- Weekly CalAIM meeting with workgroups to implement changes
- Peer certification process initiated and incorporation of peers as a new provider type
- Opened Restorative Transformation Center (Mental Health Rehabilitation Center) for specialized incompetent to stand trial and assisted outpatient treatment populations
- Initiated the Behavioral Health Quality Improvement Program
- Initiated the Riverside University Health System – Behavioral Health (RUHS-BH) Recovery Village in Hemet
- Piloting a partnership with American Medical Response for the Community Assessment and Transportation Team (CATT) to divert behavioral health crises from emergency departments and directly to more appropriate destinations

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Develop a process to incorporate prescriber peer review results in an annual summary of findings for both directly operated and contract providers, which is then circulated and used as a quality improvement instrument of system trends.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is currently in the process of developing a database that will incorporate prescriber peer reviews. This will enable summary reporting of peer review findings, and distribution of these aggregate findings to practitioners, informing of practice trends. This should alert practitioners to documentation and other trends, improving care.
- Due to the focus on CalAIM changes in requirements, involving training of county and contract staff, the MHP has not been able to devote more attention to this topic.
- Although the MHP has yet to fully complete this recommendation, it is currently engaged in a process that will support use of findings through use of a database that will aggregate results to improve the use of medications and alert practitioners to needed changes in the process and documentation of medication management services. Therefore, considering the current momentum in this area, this recommendation will not be carried over for the current review period.

Recommendation 2: Develop a referral and capacity management system which provides up-to-date information of system program capacity and ensures that referral sources, such as CARES, are able to make referrals that result in timely response to

requests. Inclusion of psychiatry capacity in this process is essential to critical access to medications.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Riverside county is in talks with vendors regarding the design of a referral and capacity management system that integrates data for all public facing departments. This project is slated for completion in December of 2023.
- Currently, CARES (access line) utilizes a system that permits clinics to identify access appointment slots within the scheduling calendar. Access call operators may directly book these appointments with beneficiaries. While providing an initial appointment, this system does not address program treatment capacity.
- The internal changes required due to CalAIM and other initiatives have made it difficult to incorporate capacity into the CARES system. Some of the challenges the MHP is working with is accounting for travel and documentation time since it will be excluded from EHR and calendar scheduling, given the limitations of the current EHR. With these unknowns, it is currently impossible to project treatment capacity with accuracy.
- While this recommendation is partially addressed, given the unresolved complications due to EHR limitations and related payment reform changes, this recommendation will not be continued for this current review period, and deferred to when payment reform impacts are resolved. Currently, it does not seem realistic that the MHP will be able to accurately address treatment capacity.

Recommendation 3: Investigate myAvatar slow response and unplanned downtime across all county locations to identify the underlying issues and develop and implement a plan to decrease unplanned downtime and improve response times that do not meet behavioral health standards.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP communicated concerns about the Netsmart MyAvatar performance to the vendor in November of 2022. Collaborative work occurred through the end of 2022.
- As of January 2023, downtime has significantly decreased and overall performance has improved for end users.
- The MHP plans to establish regular recurring meetings with the vendor to review and address future performance issues when they arise.

Recommendation 4: Develop and implement a Business Continuity Plan (BCP).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is in the process of completing a BCP, but the workload associated with CalAIM implementation, payment reform, and other changes has consumed available bandwidth. The MHP anticipates completion within the next six months.
- In that the MHP anticipates completion of the BCP within the near future, this recommendation will not be continued.

Recommendation 5: Implement website navigational improvements, testing changes with beneficiaries and caregivers before implementation.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP notes that the responsibility for website content has shifted to the RUHS public relations unit. This means the MHP has no direct responsibility for gathering input or testing website content with beneficiaries.
- There remain navigational challenges including finding information on crisis line and access to mental health services in a direct manner.
- The MHP is recommended to provide beneficiary and access staff website feedback to the public relations unit.
- This recommendation will be carried over for the FY 2023-24 review period.

Recommendation 6: Develop a clinical telehealth policy that clearly describes the criteria for approval or denial of telehealth requests, with an included appeal process.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Riverside University Health Systems – Behavioral Health (RUHS-BH) is currently revising the telehealth policy and consent form, but due to current CalAIM demand on resources this is incomplete.
- As the MHP has not identified a timeframe for completion, this recommendation will be continued for the coming review period (FY 2023-24).

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 54 percent of services were delivered by county-operated/staffed clinics and sites, and 46 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: Department of Public Social Services (DPSS), Probation, the school systems, and direct presentation to MHP clinics or contract agencies. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. When calling the Access Line, individuals are screened using the appropriate adult/child screening instrument and directed to the appropriate MHP/MCP level of care. If directed to an MHP or MHP-contracted program, the individual starts the assessment process but may also receive needed service before the assessment is complete.

In addition to clinic-based MH services, the MHP provides psychiatry and/or MH services via telehealth video/phone to youth and/or adults**.** In FY 2021-22, the MHP reports having provided telehealth services to 2646 adult beneficiaries, 5,033 youth beneficiaries, and 226 older adult beneficiaries across 64 county-operated sites and 17 contractor-operated sites. Among those served, 2,281 beneficiaries 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 beneficiaries 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 contained in Table 1A and Table 1B.

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

For Riverside County, the time and distance requirements are 30 miles and 60 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- 1A – This sub-element is considered met overall. However, the specific issue adequacy of bilingual capacity is considered by many who participated in this review to be insufficient. The alternatives to on-staff resources are the Language Line contract and arrangements with an interpreting service. However, the interpreting service requires one to two weeks advance notice, and their interpreters may be reluctant to participate in the duration of a full clinical assessment, which can be lengthy. The reported need is for increased on-staff bilingual capacity. Interpreting for the deaf and hard of hearing is another area in which more capacity is needed.
- 1B – While the MHP has developed strategies to improve recruitment and retention, some of the elements that have high interest of clinical staff seem to be considered as not implementable. These include broad adoption of flexible work schedules, particularly with some component of work from home. In addition, an overall departmental focus on wellness from the leadership level was mentioned as another potential strategy, including budget allocations for morale improvement activities. This component is considered partially met.
- 1C – Collaboration and coordination of care is considered a strength of the RUHS-BH system. As a component of the RUHS health system umbrella, the MHP is linked and integrated with 13 RUHS Federally Qualified Health Centers, of which there are three mobile clinics, community health centers, the medical center, and public health. This also includes a psychiatric residency program.
- 1D – Service Access and Availability is considered partially met. The development of a new RUHS website with components for each division has spanned multiple years, and remains incomplete. Beneficiaries continue to experience difficulties easily accessing essential information. It is important for the website changes to be vetted with key staff, beneficiaries and family members.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, Riverside's access to mental health services fell slightly as its PR went down by 0.5 percentage points between CY 2019-21.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	937,594	32,948	3.51%	$175,638,523	$5,331
CY 2020	864,240	32,590	3.77%	$147,124,768	$4,514
CY 2019	837,834	33,510	4.00%	$163,505,217	$4,879

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

- The decrease in PR took place mostly due to a 12 percent increase in Medi-Cal eligibles in the county during CYs 2019-21 while the number of beneficiaries slightly decreased.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	107,326	1,333	1.24%	1.69%	1.96%
Ages 6-17	249,073	9,789	3.93%	5.40%	5.93%
Ages 18-20	55,394	1,779	3.21%	4.06%	4.41%
Ages 21-64	455,583	18,604	4.08%	4.24%	4.56%
Ages 65+	70,220	1,443	2.05%	1.69%	1.95%
Total	**937,594**	**32,948**	**3.51%**	**3.99%**	**4.34%**

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

- The MHP's PR of 3.51 percent is lower than both the similar-sized county and statewide averages. This is reflected in most age groups except for the older adult group aged 65 and higher. For the latter, the MHP PR is higher than both the similar-sized MHP and statewide averages.
- The difference in the PRs is most pronounced for the children aged 6-17, the second largest among the age groups. For this age group, the MHP's PR is 27.2 percent lower than the similar-sized MHP average and 33.7 percent lower than the statewide PR.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	4,311	13.08%
Threshold language source: Open Data per BHIN 20-070		

- Riverside has only one threshold language, Spanish. Thirteeen percent of its beneficiaries served in CY 2021 were listed with Spanish as their primary language.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	275,284	9,418	3.42%	$46,251,798	$4,911

Large	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- For Riverside, the PR and the AACB were closer to its corresponding overall figures unlike the state or the similar-sized counties.

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

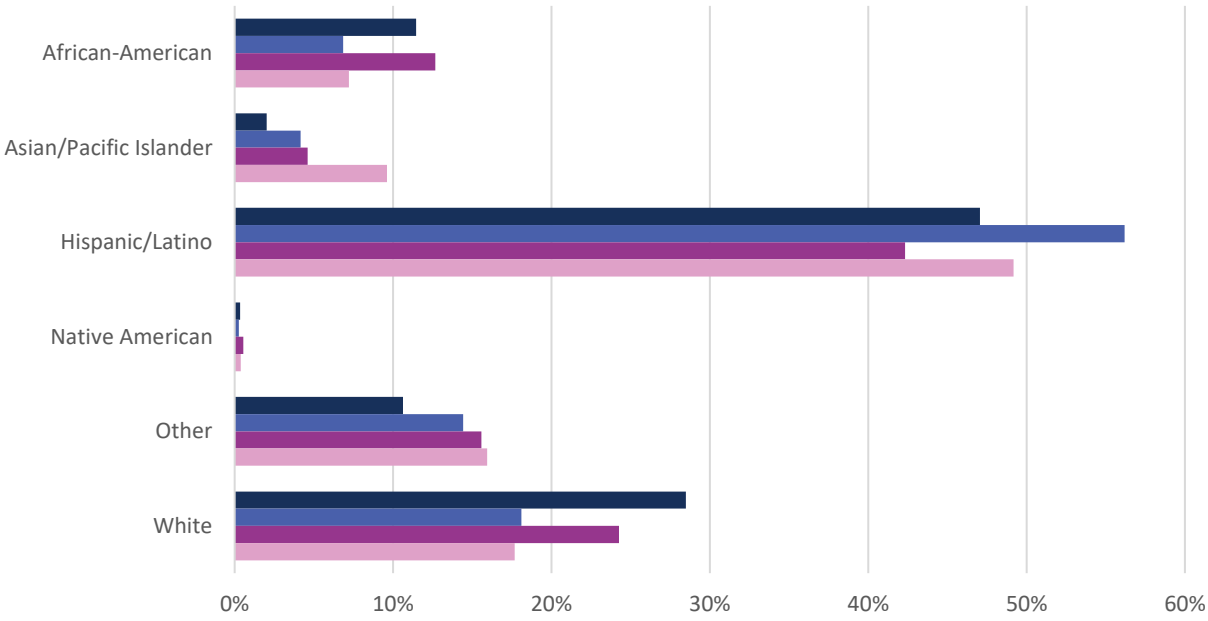
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	64,177	3,777	5.89%	7.64%
Asian/Pacific Islander	39,001	664	1.70%	2.08%
Hispanic/Latino	526,880	15,507	2.94%	3.74%
Native American	2,482	114	4.59%	6.33%
Other	135,263	3,500	2.59%	4.25%
White	169,794	9,386	5.53%	5.96%
Total	**937,597**	**32,948**	**3.51%**	**4.34%**

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

- For all race/ethnicity groups, the MHP's PR was lower than the state. However, for Latino/Hispanic, Other, and African-American beneficiaries, the PRs were much lower than the corresponding state PRs, while the White PR was more comparable to the state.

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

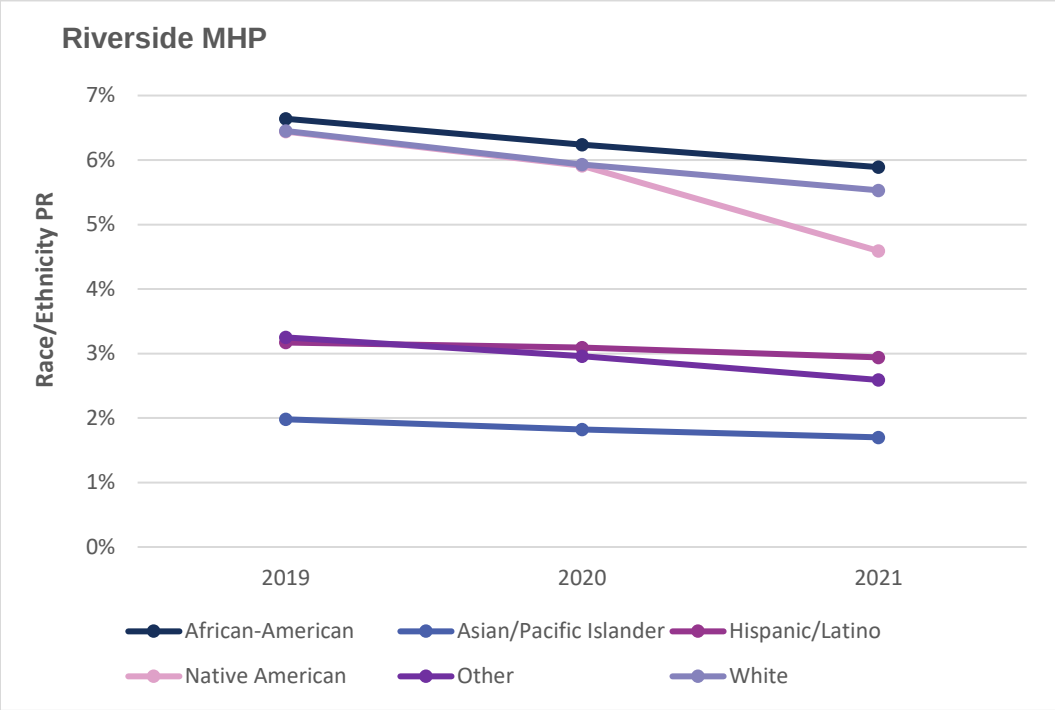


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	28%	11%	0%	47%	2%	11%
MHP % Eligible	18%	14%	0%	56%	4%	7%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Figure 1 shows the disparity in access for Latino/Hispanic, Other, and African American beneficiaries by comparing the percentage of Medi-Cal eligibles and the percentage served. Despite being the largest group of eligibles (56 percent), the Latino/Hispanic beneficiaries accounted for 47 percent of the beneficiaries served. In contrast, Whites accounted for 18 percent of the eligibles, but 28 percent of those served.

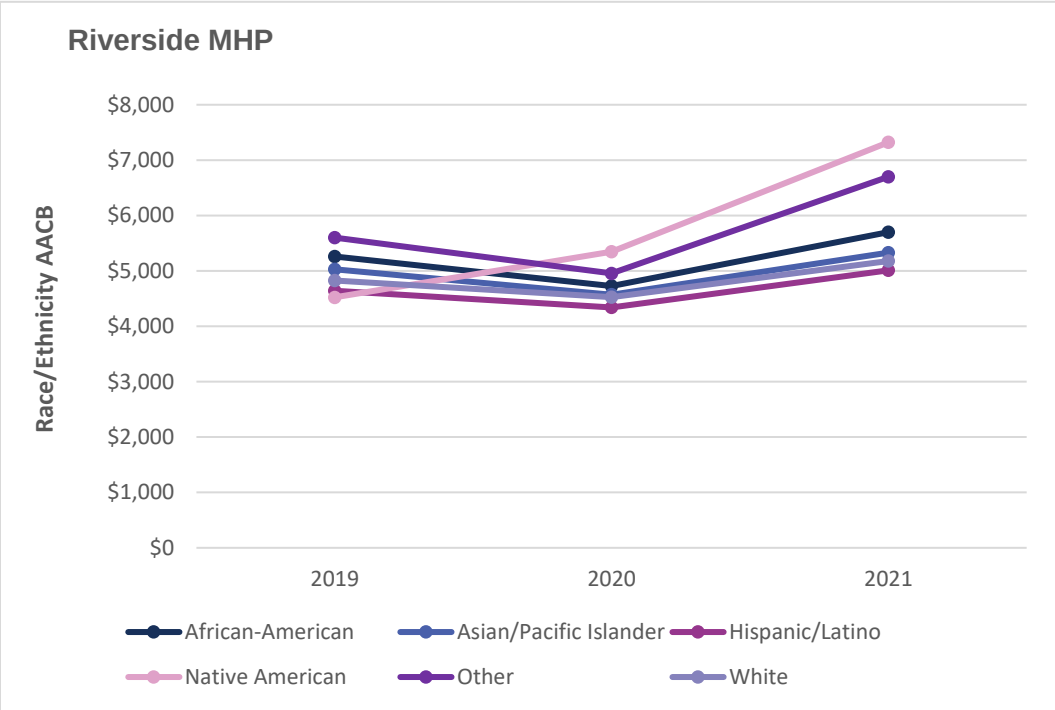
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



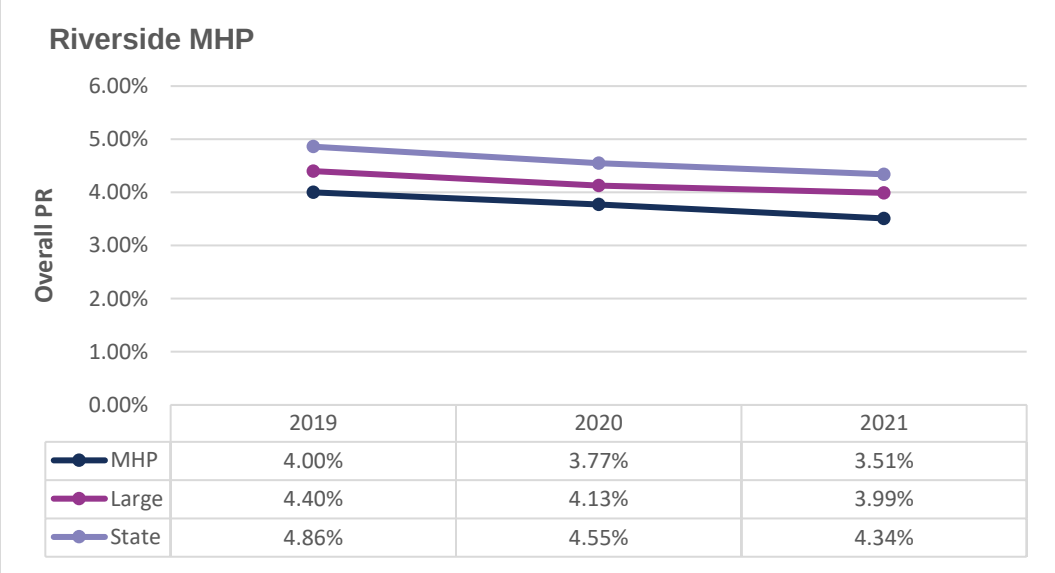
- In general, the PR for all race/ethnicity groups in Riverside declined between CYs 2019-21. Asian/Pacific Islanders had the lowest PR and African Americans and Whites had the highest PR for all three years.

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



- The AACBs for all race/ethnicity groups increased between CYs 2020-21. While the Native Americans showed the highest increase, it is based on a relatively low count of beneficiaries. The Other race/ethnicity group showed the next highest increase of more than $1,500 per beneficiary.

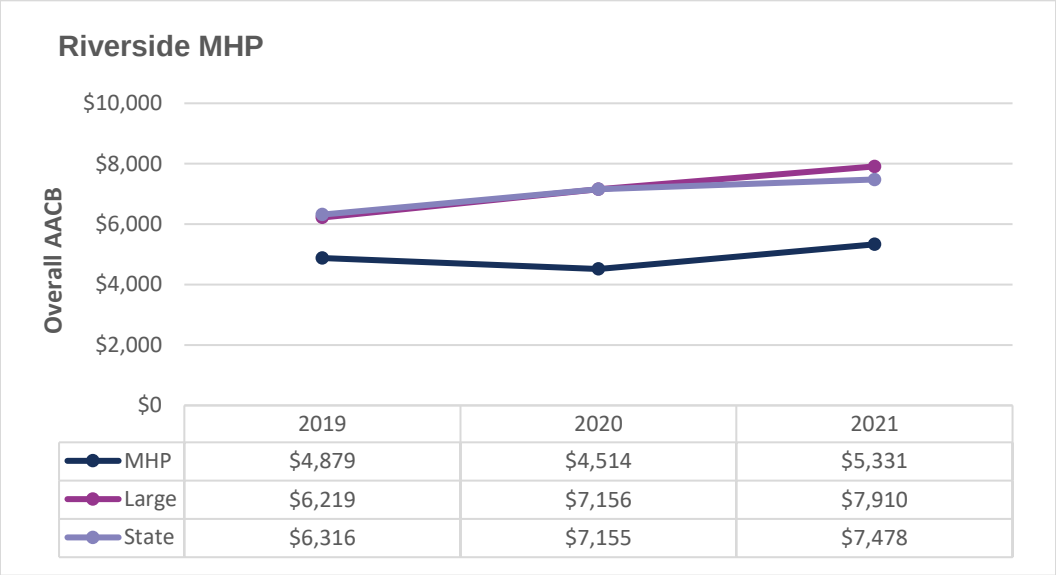
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.00%	3.77%	3.51%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

- The MHP's overall PR was consistently lower than the statewide and similar-sized MHP averages for all three years between CYs 2019-21. All three showed declines in each of these CYs.

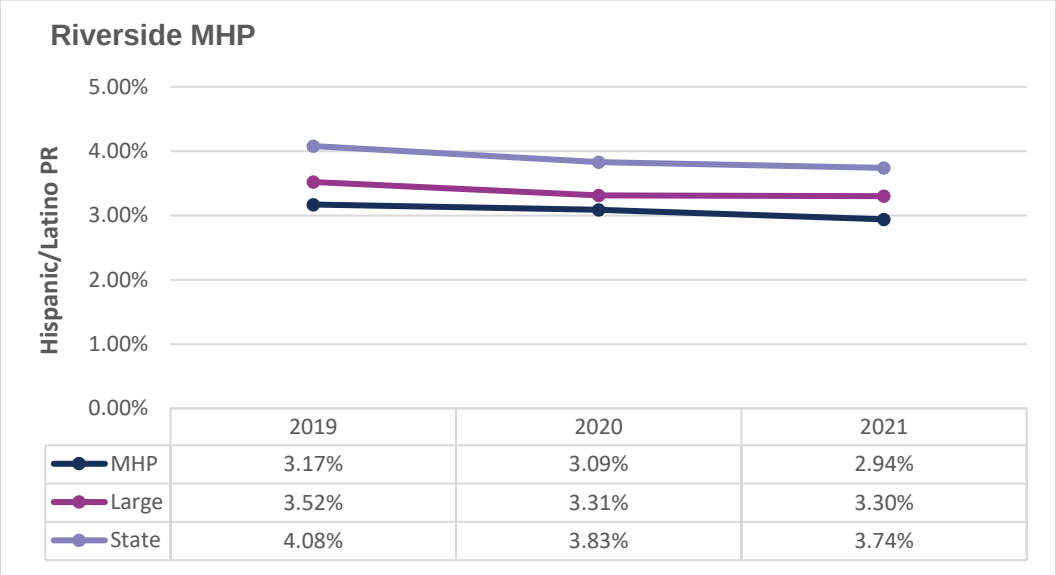
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,879	$4,514	$5,331
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

- While Riverside's AACB went up in CY 2021, it was consistently lower than the similar-sized MHP and statewide AACB averages, both of which had similar AACBs for all three years.

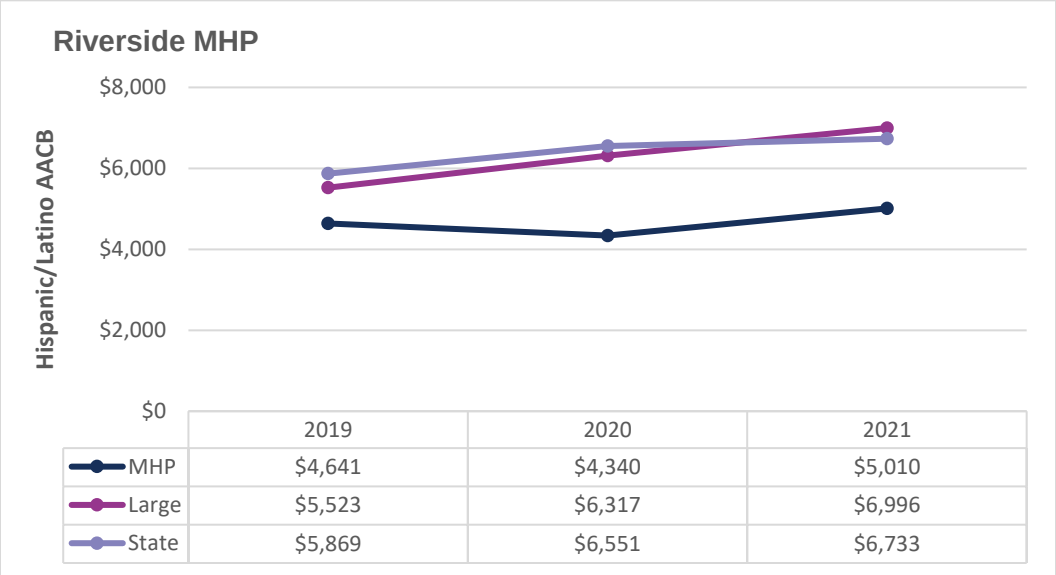
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.17%	3.09%	2.94%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

- While the large MHP's Latino/Hispanic PR tend to be lower than the overall statewide PR, Riverside's Latino/Hispanic PR was even lower for all three years between CYs 2019 and CY2021.

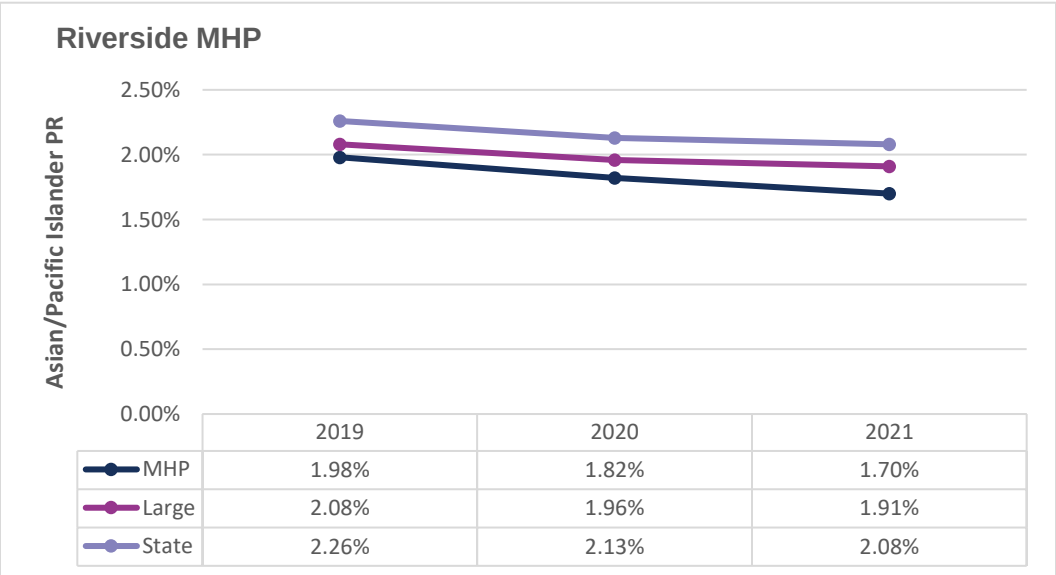
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,641	$4,340	$5,010
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

- The Latino/Hispanic AACB trend for Riverside mirrors its overall AACB trend and its Latino/Hispanic AACB has been consistently lower than the similar-sized MHP and statewide averages.

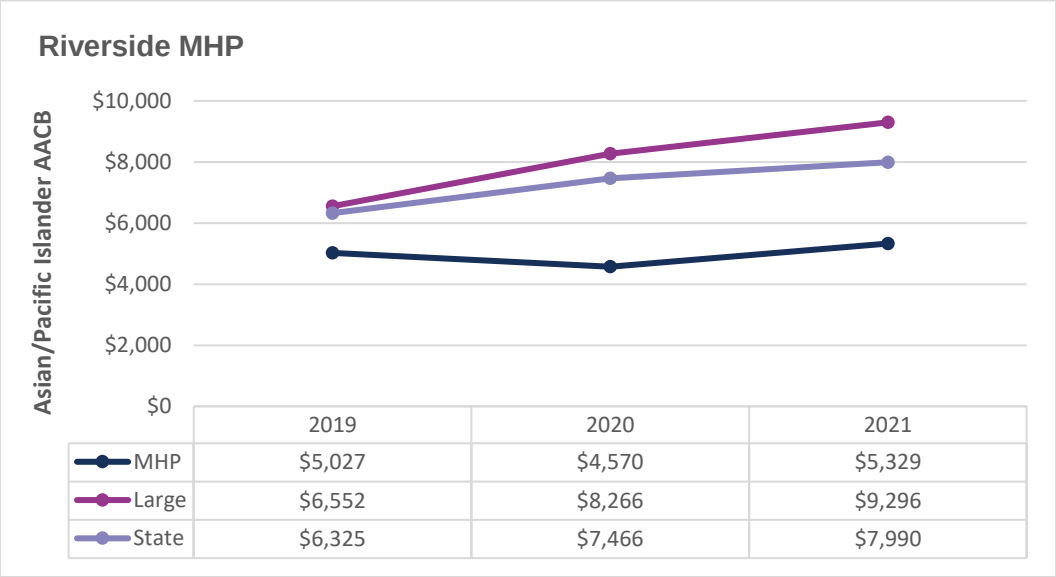
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.98%	1.82%	1.70%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

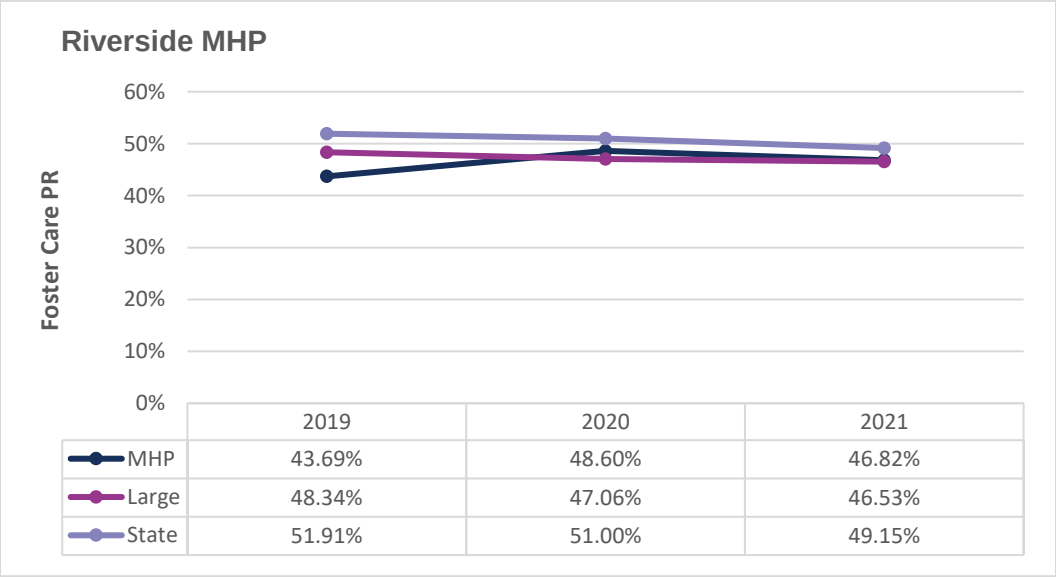
- The Riverside Asian/Pacific Islander PR declined between CY 2019 and CY 2021, and was consistently lower than the corresponding similar-sized MHP and statewide averages.

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



- Riverside's Asian/Pacific Islander AACB trend is very similar to its overall AACB and consistently lower than the statewide and large MHP AACB.

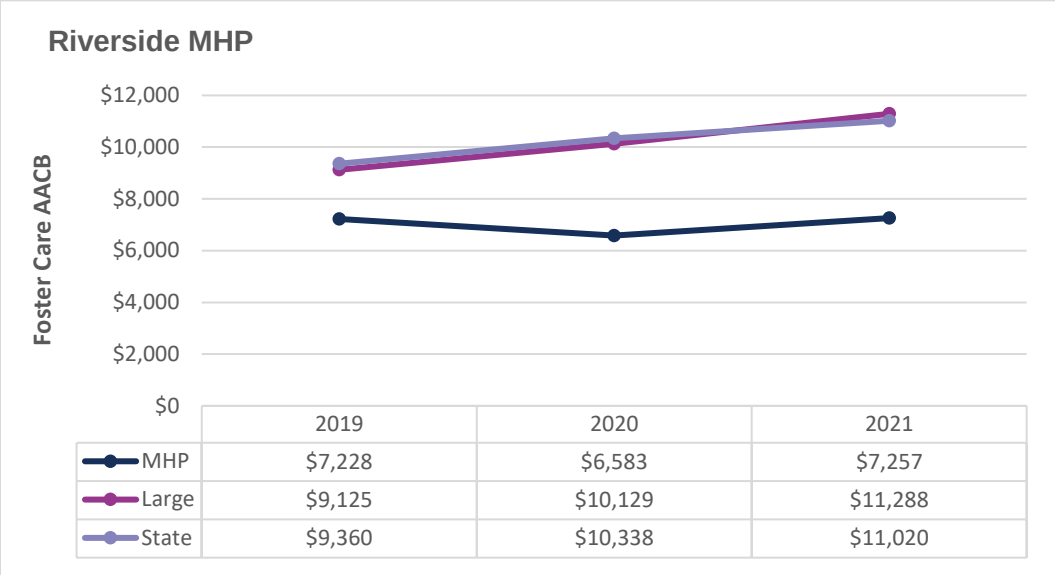
Figure 10: Foster Care PR CY 2019-21



- The Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.

- Riverside's FC PR increased between CY 2019 and CY 2020, then declined slightly in CY 2021. In CY 2020 and CY 2021, Riverside's FC PR was slightly higher than the large MHP FC PR.

Figure 11: Foster Care AACB CY 2019-21



- Statewide FC AACB has increased each year.
- The MHP's FC AACB decreased in CY 2020 and then recovered to its CY 2019 level in CY 2021. However, throughout these three years, Riverside's FC AACB remained much lower than the statewide and large MHP AACBs which were very similar to each other.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 21,828				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	1,776	8.1%	9	5	11.6%	16	8
Inpatient Admin	231	1.1%	21	6	0.5%	23	7
Psychiatric Health Facility	366	1.7%	9	5	1.3%	15	7
Residential	26	0.1%	169	162	0.4%	107	79
Crisis Residential	689	3.2%	16	14	2.2%	21	14
Per Minute Services							
Crisis Stabilization	5,503	25.2%	1,670	1,200	13.0%	1,546	1,200
Crisis Intervention	1,171	5.4%	273	200	12.8%	248	150
Medication Support	12,918	59.2%	302	210	60.1%	311	204
Mental Health Services	11,247	51.5%	754	260	65.1%	868	353
Targeted Case Management	6,208	28.4%	409	110	36.5%	434	137

- For the adult beneficiaries, the MHP's inpatient and psychiatric health facility utilization was less than the statewide rate. It also had lower average units than the corresponding statewide rates.
- While nearly two-thirds of the statewide beneficiaries received mental health services, just over a half of the Riverside beneficiaries did so. They also received less mental health services per capita than statewide. Similarly, a lower percentage of Riverside beneficiaries received targeted case management compared to the state.
- Riverside beneficiaries received medication support at a comparable rate to the state.
- The MHP utilized crisis stabilization at nearly double the statewide rate while providing crisis intervention at half the statewide rate.

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

Service Category	MHP N = 2,034				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	77	3.8%	9	7	4.5%	14	9
Inpatient Admin	5	0.2%	5	5	0.0%	5	4
Psychiatric Health Facility	2	0.1%	5	5	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	3	0.1%	19	18	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	2	0.1%	39	39	0.5%	97	78
Per Minute Services							
Crisis Stabilization	98	4.8%	1,541	1,200	3.1%	1,398	1,200
Crisis Intervention	100	4.9%	298	172	7.5%	404	198
Medication Support	724	35.6%	302	248	28.3%	394	271
TBS	115	5.7%	6,183	3,954	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	1,129	55.5%	710	258	40.0%	1,351	472
Intensive Care Coordination	488	24.0%	1,897	1,360	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	1,837	90.3%	1,497	953	96.3%	1,848	1,103
Targeted Case Management	591	29.1%	217	100	35.0%	342	120

- For FC beneficiaries, Riverside provided medication support to a fifth higher percentage of the beneficiaries than statewide. It also provided Therapeutic Behavioral Services, Intensive Care Coordination, and Intensive Home-Based Services at a higher rate than the state average.

IMPACT OF ACCESS FINDINGS

- The relationship of the lower use of crisis intervention and mental health services with higher use of crisis stabilization requires further investigation.

- The higher level of necessary services to the FC beneficiaries is a positive trend for the MHP.
- Riverside noted that when participating in the testing of the DHCS screening and transition tools that no increase in referrals occurred. But since formally rolled out in January of 2023, the MHP has noted an increase in referrals to their services has occurred.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- 2A – The MHP's tracking of first non-urgent request to first offered appointments includes only one lifetime event for any beneficiary. This includes those circumstances wherein an individual has discontinued services from months to

years. Limiting reporting to once ever systematically under-reports the timeliness metric. This component is considered partially met.

- 2B – The MHP data set is limited to when the first psychiatric service is the first delivered service, thus excluding the majority of routine requests that occur secondary to other MHP services. This approach is unique to this MHP and significantly under-reports first non-urgent psychiatry service. Since the intent of this metric is to reflect the capacity of the MHP in this area, this element is considered partially met.
- 2C – Similar to 2A and 2B, the MHP utilizes a narrow definition that under-reports actual events. The MHP reported a total of 73 urgent events across both directly-operated and contracted systems. In addition, the MHP appears unable to capture the time to service, presenting an overall average of zero hours. Due to the inability to report an accurate number of requests and the average time to service, this component is considered partially met.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12month period of CY 2022. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care, with the exception of no-shows, which is directly-operated services only.

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

Table 11: FY 2022-23 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.17 Business Days	10 Business Days*	83.3%
First Non-Urgent Service Rendered	16.5 Business Days	14 Business Days**	68.8%
First Non-Urgent Psychiatry Appointment Offered	10.8 Business Days	15 Business Days*	83.1%
First Non-Urgent Psychiatry Service Rendered	41.1 Business Days	19 Business Days**	46.1%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	35.6 Days	7 days**	33.7%
No-Show Rate – Psychiatry	14.3%	10%**	n/a
No-Show Rate – Clinicians	6.5%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022			

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

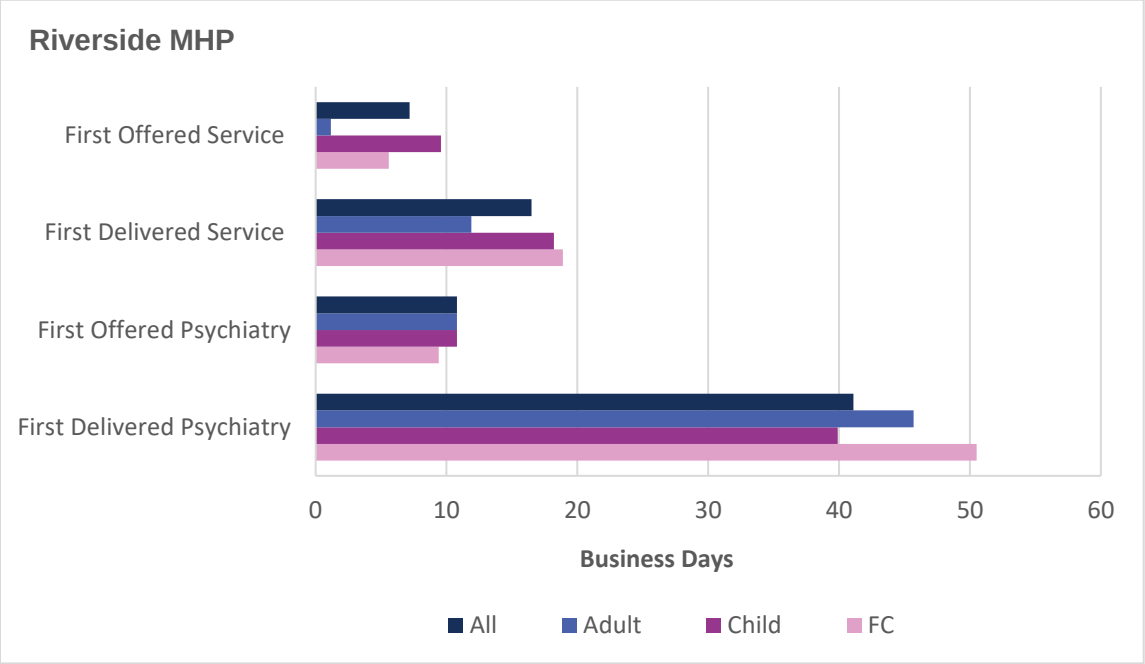


Figure 13: Wait Times for Urgent Services

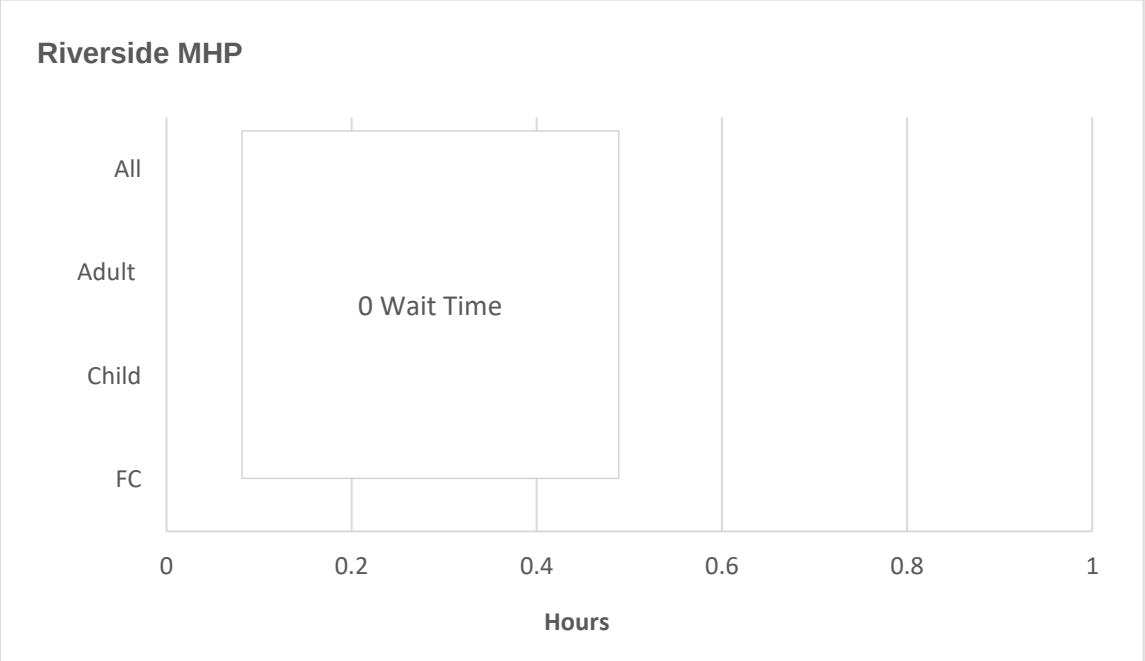
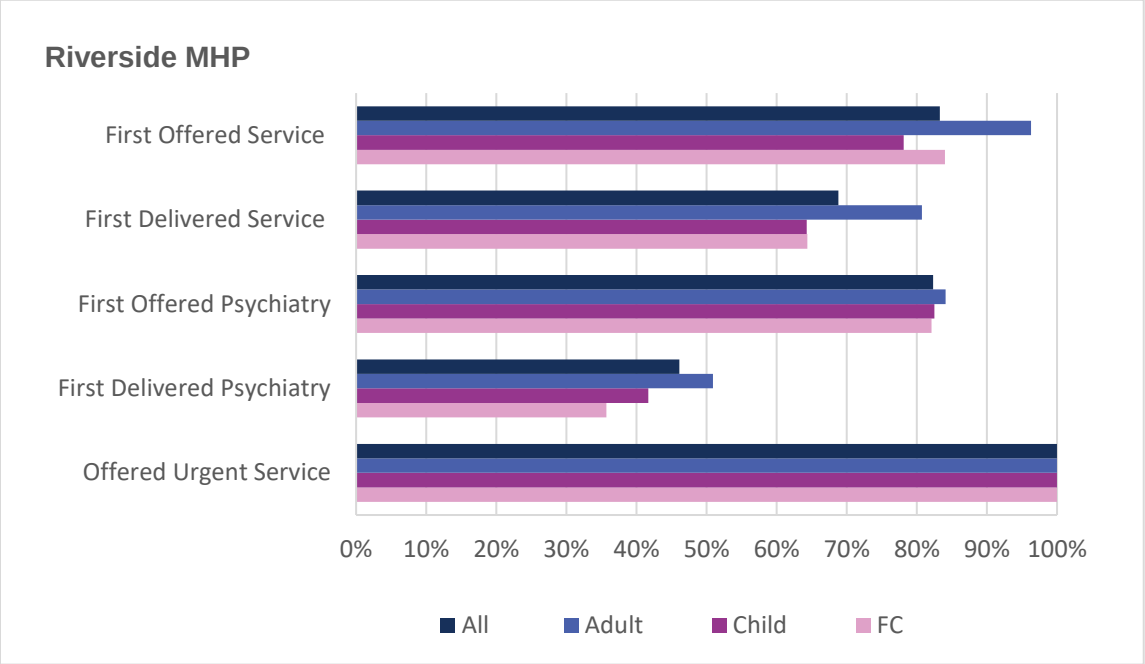


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned 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 13, represent scheduled assessments, unscheduled assessments, scheduled and unscheduled mental health services and targeted case management prior to completion of comprehensive assessment.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA as "…imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the beneficiary's life or health or could jeopardize their ability to regain maximum function." There were reportedly 73 of urgent service requests with a reported actual wait time to services for the overall population at zero hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the beneficiary's initial service request and limited to those circumstances wherein psychiatry was the first appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are representing a subset of directly-operated programs. The MHP reports an overall

psychiatry no-show rate of 14.3 percent, and an overall non-prescriber no-show rate of 6.5 percent.

IMPACT OF TIMELINESS FINDINGS

- The MHP's limitation of one lifetime first offered non-urgent event means that those who might episodically utilize SMHS would be excluded from timeliness tracking when they have experienced a significant hiatus in services. This would seem to result in under-reporting of first offered events.
- The limitation of first offered non-urgent psychiatry service, with a total of 391 events reported, is limited to when psychiatry is the first service delivered. When compared to similar sized MHPs, this would appear to be significantly under-reporting the potential events. Also, as defined, limitation to when psychiatry is the first service delivered would seem to skew towards urgent services, because psychiatry is not typically the first service delivered. This narrow definition of likely results in significant under-reporting.
- The MHP's reporting of urgent events, with a total of 73, seems quite small considering the scale of the MHP's operations and numbers of individuals served. In addition, the MHP reports no average time to urgent service, which is certainly a variance from the experiences of other MHPs in California. The comprehensiveness of this data is worthy of exploration by the MHP.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is located within the Quality and Research unit, under a deputy director, who oversees the Community Access, Referral, Evaluation and support (CARES) access line, Quality Management and Research and Technology. Compliance is located under the Admin & Finance unit, separately.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Improvement (QI) workplan, and the annual evaluation of the QI workplan. The QIC, comprised of leadership and staff involved in services to all populations served, the public guardian's office, regional program representation, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met nine times. Of the seven identified FY 2022-23 mental health QAPI workplan goals, the MHP deferred rating the two PIPs because of lack of data, and found of the five other goals, four were considered met and one was considered partial.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths, Pediatric Symptoms Checklist-35 (PSC-35), Child and Adolescent Trauma Screen, Eating Disorder Examination Questionnaire, and Eyberg Child Behavior Inventory (ECBI). However, it does not use dedicated LOC instruments, nor has it created a crosswalk from the outcome scores to specific levels of care.

The MHP utilizes the following outcomes tools: CANS, PSC-35, ECBI, State full-service partnership outcomes. The MHP is working towards remedying its lack of a universal adult outcome instrument.

Outcome reports are created and distributed to programs and are shared at QIC and provider meetings for discussion and follow-up.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture

that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Partially 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	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- 3A – Quality assessment and performance improvement (QAPI) is both a strength and a challenge area for this MHP. In support of innovative programs which enhance the overall system of care, there exist comprehensive reports that present a complete picture of program performance. But with the overall approach to presenting general quality improvement information, the MHP would benefit from reappraisal of the approach to QI Work Plan development, with the inclusion of longitudinal trend data elements along with the narrative conclusions. Because of this specific issue, this element is considered partially met.
- 3B – Use of data is an area of MHP strength, with various business intelligence reports, and use of data analytical reporting tools and software. The tracking and reporting on programs such as Wraparound, Crisis System of Care, each contain a data heavy focus on service activity and outcomes.
- 3D – The MHP demonstrates a strength at the development of extensive levels in its continuum of care, and also creates comprehensive data reports on the performance of these programs. While it has not implemented dedicated level of

care instruments it uses outcome tools to help evaluate progress and guide level of care selection. The MHP operates more than ten Full Service Partnership (FSP) programs, and also integrates the FSP level into its outpatient clinics. As of this review, the impact of unfilled positions reportedly makes it difficult for staff in outpatient programs to balance FSP requirements with routine outpatient-level caseloads.

- 3E – Overall medication monitoring is focused upon directly-operated programs. The MHP adheres to a general medication monitoring process that does not formally track HEDIS measures, except in the area of FC services (3F). The review summary results reflected fairly low compliance statistics, which likely merits a focused effort on education of prescribers to the documentation and practice requirements highlighted by this data. Because of these findings and the absence of HEDIS measure tracking for adults, this item is considered partially met.
- 3H – While the MHP summarizes and creates presentation material from the Consumer Perception Survey (CPS), none of the consumer focus group participants had been provided the results. The MHP's website contains a QI Work Plan from FY 2018-19, which emphasized the CPS collection process, but not results, nor trends over time. The MHP does not circulate results beyond its QIC and among program managers. The MHP does utilize an internally developed satisfaction survey that it finds more relevant to its served populations, which is summarized and circulated.
- The MHP does track the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): The MHP indicated a continuation phase follow-up rate of 88.89 percent, contrasted with the NCQA National Medicaid average of 50 percent. Initiation phase follow-up rate was 58.71 percent, whereas the Medicaid national average was 39.7 percent.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): The MHP states it tracks HEDIS APC, but there were no reports submitted reflecting results in this area.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): The MHP indicates it does not track HEDIS APM.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): The MHP reported HEDIS APP results of 67.81 percent, versus the NCQA National Medicaid average of 58.6 percent.

QUALITY PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions

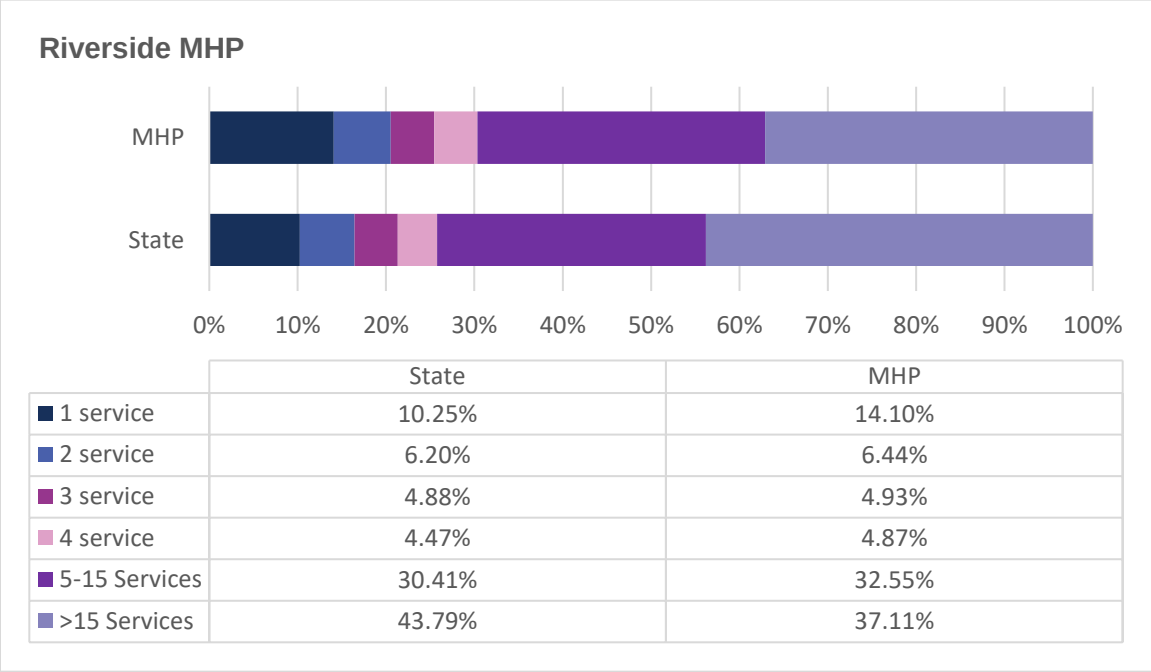
are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



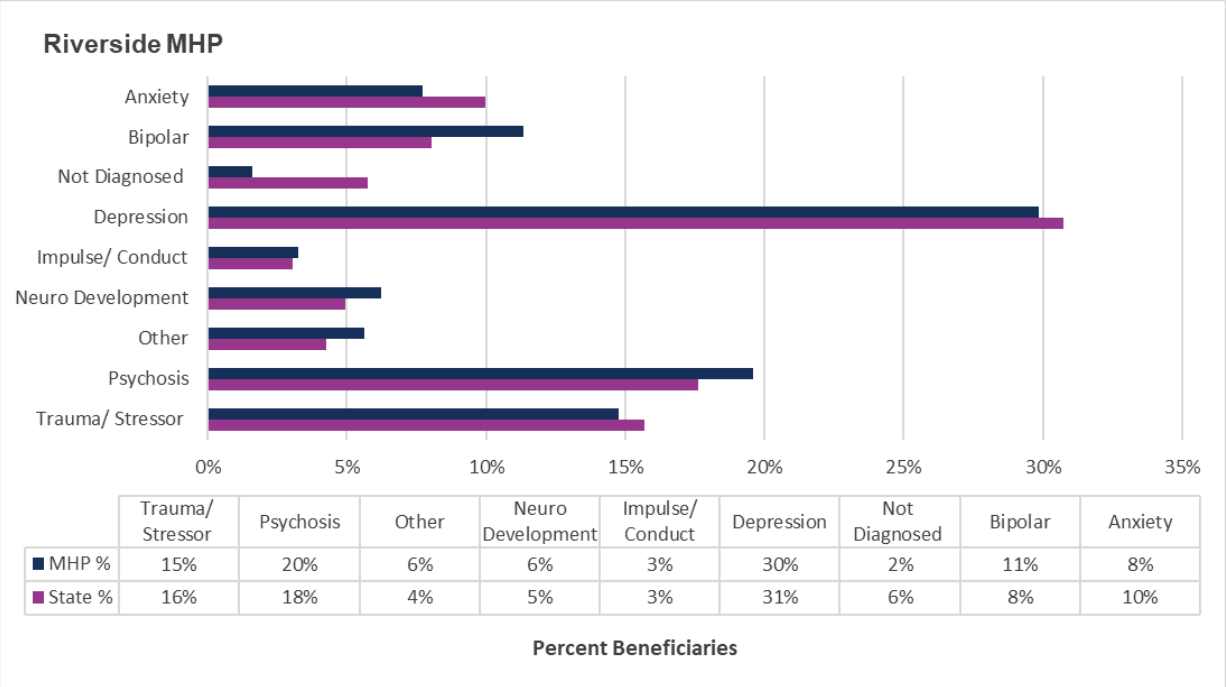
	State	MHP
1 service	10.25%	14.10%
2 service	6.20%	6.44%
3 service	4.88%	4.93%
4 service	4.47%	4.87%
5-15 Services	30.41%	32.55%
>15 Services	43.79%	37.11%

- The percentage of MHP's beneficiaries with a single service encounter in CY 2021 was 37.6 percent higher than the corresponding statewide percentage. At the high end of the service frequency categories, the MHP had a lower percentage of beneficiaries who received more than 15 service encounters, while in the middle frequency categories, the MHP's percentages were slightly higher than the statewide percentages.

Diagnosis of Beneficiaries Served

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

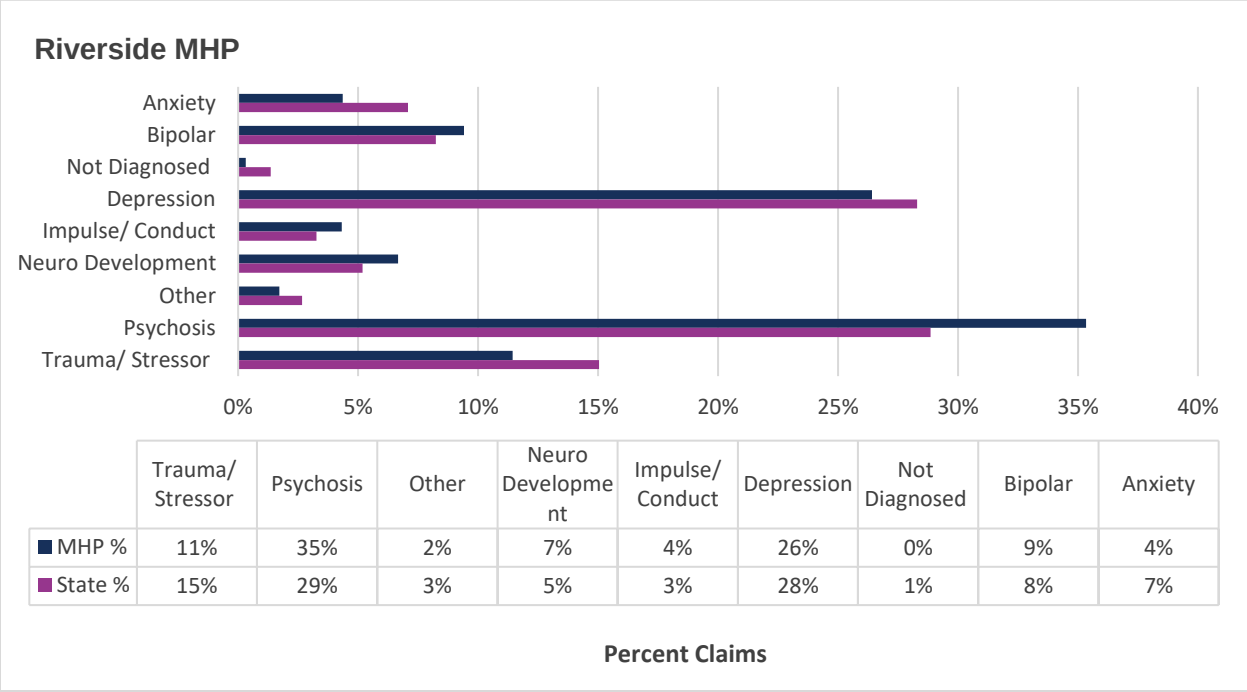
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	15%	20%	6%	6%	3%	30%	2%	11%	8%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP had higher percentages of bipolar and psychosis diagnoses than the corresponding statewide averages. It also had only about a third of the statewide percentage of not diagnosed beneficiaries.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	35%	2%	7%	4%	26%	0%	9%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The MHP's ratio of approved claims percentages by diagnostic categories more or less reflect its ratio of percentages of beneficiaries in those categories. Beneficiaries with psychosis (20 percent) accounted for a much higher percentage (35 percent) of the total approved claims.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	3,057	7,396	7.38	8.86	$14,823	$12,052	$45,313,846
CY 2020	2,198	4,708	6.93	8.68	$10,216	$11,814	$22,454,024
CY 2019	2,855	7,117	6.34	7.80	$9,943	$10,535	$28,387,472

- The MHP's inpatient utilization in terms of both the numbers of beneficiaries and admissions went down by a third in CY 2020 compared to CY 2019, and then went up by a similar margin in CY 2021.

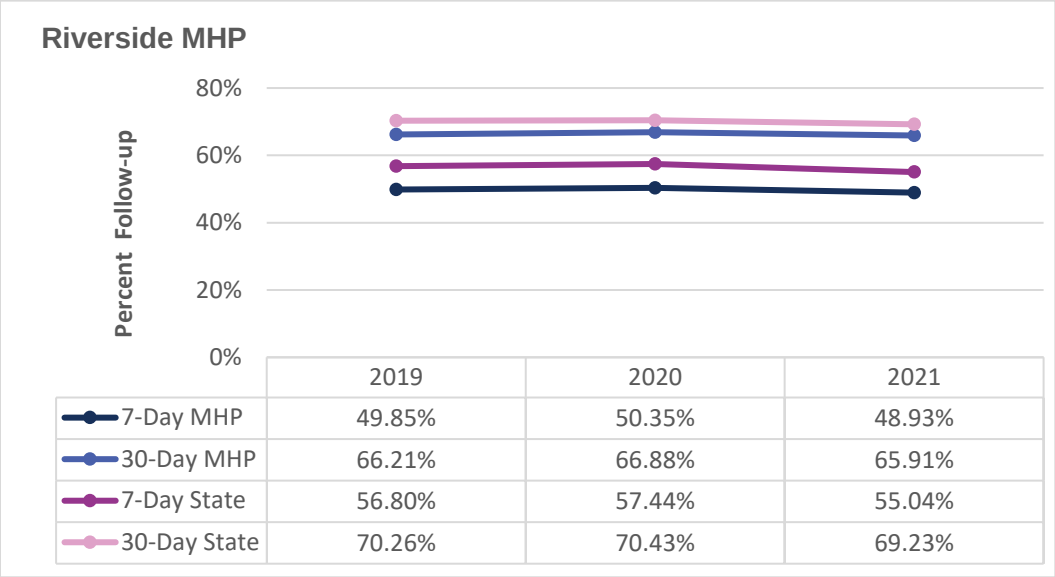
- Riverside's inpatient AACB went up by nearly 50 percent during CYs 2019 to 2021 without a big increase in its average inpatient LOS. The corresponding statewide AACB went up more modestly during the same period.

Follow-Up Post Hospital Discharge and Readmission Rates

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

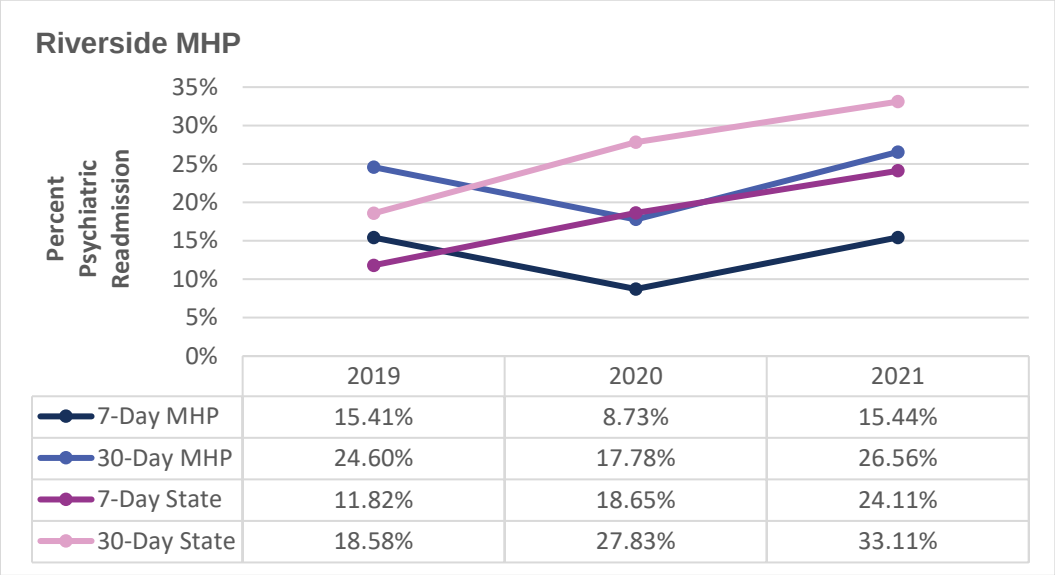
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	49.85%	50.35%	48.93%
30-Day MHP	66.21%	66.88%	65.91%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	15.41%	8.73%	15.44%
30-Day MHP	24.60%	17.78%	26.56%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Riverside had lower 7- and 30-day follow-up rates post-psychiatric inpatient discharge than the state. The 7-day follow-up rate was a little over 6 percentage points below the statewide average while the 30-day follow-up rate was 3.3 percentage points lower than the statewide average in CY 2021. This was also the same trend for three years between CYs 2019 and 2021.
- Despite a lower follow-up rate, the MHP was able to keep its 7- and 30-day psychiatric inpatient readmission rates well below the corresponding statewide averages in CYs 2020 and 2021. The MHP reported much lower 7- and 30-day readmission rates, 8.6 and 19.9 percents respectively for CY 2022 including all beneficiaries irrespective of the payer sources.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with

approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	925	2.81%	28.95%	$50,849,321	$54,972	$43,126
	CY 2020	576	1.77%	18.93%	$27,850,429	$48,351	$39,826
	CY 2019	784	2.34%	22.83%	$37,327,683	$47,612	$40,713

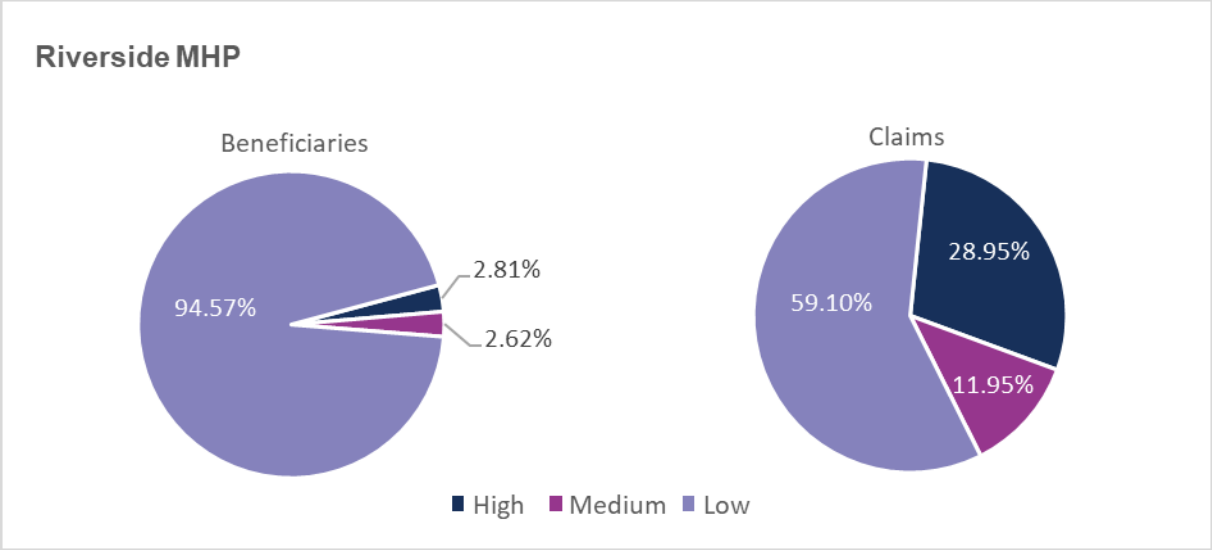
- The MHP’s lower AACB translates to a lower percentage of HCBs than the state. In CY 2021, this percentage was almost half that of the statewide average. However, its average approved claims per HCB was only slightly lower than the statewide average.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	864	2.62%	11.95%	$20,995,147	$24,300	$23,912
Low Cost (Less than $20K)	31,159	94.57%	59.10%	$103,794,055	$3,331	$1,729

- Almost 95 percent of the MHP’s beneficiaries were in the category of low-cost (<$20K) beneficiaries.

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



- 5.43 percent of Riverside's beneficiaries accounted for over 40 percent of the MHP's total approved claims. Just the HCBs (2.81 percent) alone accounted for 28.95 percent of the total approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP's submitted psychiatric inpatient readmission data for CY 2022 for all beneficiaries is significantly lower than CalEQRO's Medi-Cal only data for CY 2021. This calls for further examination by the MHP.
- The MHP's QI Work Plan would benefit from greater inclusion of metrics it is required to track, such as grievances, change of clinician, etc., and use of a format that includes both conclusions and trend data.
- The MHP's dedicated focus to improving high level of care resources, positions it to better serve the severely mentally ill population.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improve continuity of care and engagement in community outpatient services for detention mental health consumers when they are released.

Date Started: 07/2020

Date Completed: 03/2023

Aim Statement: Will enhanced discharge services improve the rate of transition from detention services to outpatient services within 90 days after release (from 16 to 30 percent); with 80 percent continuing engagement and receiving three or more services after the initial outpatient service with 45 days.

Target Population: The study population includes adults residing in Riverside County who have been incarcerated and discharged from the Presley correctional institution. These Adults must have had a mental health service within the detention institution as well as be classified as either moderately-severe, severe, or acute without very serious

[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

charges (i.e., murder, assault). The consumers leaving detention comprised mostly Men (78 percent) between the ages of 26 and 45 (62 percent). The majority of this population were either White (37 percent), Hispanic (34 percent) or Black (26 percent). The majority of these consumers were diagnosed with Schizophrenic or Psychotic disorders (33 percent).

Status of PIP: The MHP's clinical PIP was in the Other: Completed phase, and PIP concluded in March 2023. Due to time constraints the MHP decided to utilize the July through September 2022 to perform the final evaluation of effectiveness of this PIP.

Summary

The MHP recognized that individuals in jail custody (Presley Correctional Facility) and receiving mental health treatment while in custody tended to not follow-up with outpatient treatment. The goal of this PIP was to increase the rates of continued outpatient treatment post-release from 16 percent at baseline to 30 percent. An additional goal of having these individuals receive three or more services within 45 days of the initial outpatient service identified was sought through implementation of a number of strategies aimed at achieving follow-up. These interventions involved removing potential barriers by: obtaining a release of information for significant support persons who might act as an advocate for the individual; engagement of the family advocate to help reach out to support individuals; if history of substance use treatment existed, implement a SUD screening and develop a plan for an appropriate level of care upon release; involvement of homeless outreach if current homeless; connection to the New Life program and/or Forensic FSPs; identify a peer support individual; ensure 14-30 days of medications pre-release; prioritize transportation through Measure A staff. Discharge groups were re-started on June1, 2021, following relaxing of COVID-19 restrictions, which consists of an 8-week discharge planning group.

As to the results of this PIP, the MHP determined there was not a statistically significant difference between the baseline and PIP results (p=.203). The COVID-19 limitations on group activity early on dampened what could have been an effective group modality intervention of enhancing understanding and promoting follow-through at release.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: The reported results of this PIP did not have a statically significant impact. But these results were clouded by the inability to early on utilize a multi-session group approach that could have improved participant understanding of their illness and increase follow-through. The MHP also acknowledges staffing issues and challenges with matching participants from the jail health system with the MHP practice management system created other challenges to this improvement activity.

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

- At the time of this review, the PIP had recently been concluded, and the MHP had not had the opportunity to identify potential new PIP topics. Therefore, no recommendations were relevant or appropriate.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Milestone 3d, HEDIS FUM 7/30

Date Started: 09 /2022

Aim Statement: The aim of this performance improvement project is to increase the 7-and 30- day follow-up rates by 5 percent for all ages, and to decrease race/ethnic disparities by June 2024.

Target Population: The population affected by this problem are Riverside Medi-Cal beneficiaries with a mental illness diagnosis who visited the emergency department.

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

Summary

This HEDIS (FUM 7/30) measure PIP was identified by California DHCS based on the importance of follow-up of emergency department (ED) visits for self-harm or mental health conditions. Without timely follow-up there exists an increased likelihood of subsequent events and potentially a need for a high level of care. Therefore, DHCS has tasked each MHP with improving follow-up in this area, with an end goal of electronic data exchange and improvements to follow-up. While frequently MHPs have episodic contact with ED patients, the process is inconsistent and often narrowly focused on the most severe presentations and there has been no mechanism that ensures MHPs are aware of all such events.

The Riverside MHP's interventions include access to an expanded set of Medi-Cal ED visits in conjunction with the local MCP, Inland Empire Health Plan (IEHP), in order to obtain data. The MHP has performed an age, gender, ethnicity and diagnostic assessment of the relevant ED users.

The MHP's analysis indicates that EDs lack of detailed information about mental health follow-up. There is also a gap in data exchange between EDs and MHPs. Most often the interactions between an ED and the MHP is on the topic of finding acute hospital beds, not in coordinating mental health follow-up for those being discharged back to the community. Lastly establishment of an HIE for sharing this information is complicated and fraught with legal issues related to release of information.

The performance measures for this PIP are the 7- and 30-day post-ED follow-up rates. In addition, ED 7- and 30-day ED readmission rates will be tracked, as well as average

timeliness to first service post-ED visit. The interventions include: developing a data exchange between ED services and the MHP; building relationships with EDs to improve communication and coordination; develop outreach and educational materials for ED use in the promotion of follow-up; utilize the MHP's crisis system of care to coordinate services for high-risk individuals; utilize the Manifest Medex, an HIE, to convey critical information between systems.

The first six months of FY 2022-23 saw implementation of the DHCS data warehouse finder file, with MHP staff trained in how information is accessed, and information materials being vetted by various MHP groups, including cultural competence.

At the time of this review, there existed no new data runs that would support analysis of effectiveness of the MHP's targeted approaches to this issue.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: although lacking subsequent data runs, the basic format would appear to have a strong probability of improving ED follow-up rates for the 7- and 30-day periods.

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

- The MHP should consider development of an addendum sheet that contains the elements in the EQR PIP template that are not present in the DHCS format, such as: PIP start date, individual intervention start dates, sequential data run information, and the data presentation format (Table 8.1) used in the EQR PIP template 8.1.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart myAvatar, which has been in use for 11 years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 2.22 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 IS budget percentage was similar to the previous year.

The MHP has 1,886 named users with log-on authority to the EHR, including approximately 1,710 county staff and 176 contractor staff. Support for the users is provided by 24 full-time equivalent (FTE) IS technology positions. Currently all positions are filled and there was no change in FTEs from the previous year.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	70%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	15%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	15%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP provides PHR access through myHealthPointe, but reported that no beneficiaries accessed it last year.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with the following departments/agencies/ organizations: mental health and substance use disorder services' contract providers, federally qualified health centers, and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- By joining an HIE the MHP is well positioned for the necessary data exchange with the outside agencies. This will be helpful for healthcare and behavioral health integration as envisioned in CalAIM.
- Additionally, the MHP is developing a joint database with agencies that serve the homeless population but are not a part of the HIE such as the coroner's office. The MHP is planning to deploy artificial intelligence to conduct more predictive analysis and risk modeling.
- Another sequential query language-based database is bringing in the data from the different units of RUHS such as the medical center, public health, and behavioral health for more holistic tracking and reporting of beneficiary health indicators.
- The MHP has a seasoned team of fiscal and IS staff with little or no turnover who can efficiently facilitate the changes required by CalAIM.
- The MHP reported having a PHR system in place, but no beneficiary accessed it in the past year.
- The MHP continues to lack a BCP as was recommended by CalEQRO last year.
- The MHP website is a part of the overall RUHS website. While the behavioral health side has a wealth of information on the services and clinic locations, navigation is neither easy nor intuitive. It also lacks any highlighting or embedding of crisis or access call numbers throughout the website structure.
- The MHP noted that the contract providers need to do double data entry for historical reasons; however, it tries to mitigate the situation by requiring only the minimum required fields to be reported on.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

The timing of Medi-Cal claiming is shown in Table 18. This table appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	61,511	$13,599,462	$54,027	0.40%	$12,897,588
Feb	62,162	$13,457,420	$55,726	0.41%	$12,734,411
Mar	74,421	$16,384,621	$86,156	0.53%	$15,496,575
April	68,645	$15,229,849	$115,392	0.76%	$14,560,877
May	62,734	$14,665,510	$114,353	0.78%	$13,948,312
June	66,745	$15,183,179	$159,789	1.05%	$14,503,153
July	58,681	$13,855,516	$157,503	1.14%	$13,379,685
Aug	62,402	$14,306,226	$195,606	1.37%	$13,776,340
Sept	62,008	$14,205,301	$267,923	1.89%	$13,642,872
Oct	57,746	$13,685,150	$266,530	1.95%	$13,209,047
Nov	58,550	$13,469,231	$326,164	2.42%	$13,024,097
Dec	57,569	$13,012,099	$350,631	2.69%	$12,578,814
Total	**753,174**	**$171,053,564**	**$2,149,800**	**1.26%**	**$163,751,771**

- Riverside MHP's claim volume and billed amounts were stable throughout CY 2021; however, it's denied claim percentage started going up toward the end of the year.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	1,264	$688,932	32.05%
Late claim	311	$541,633	25.19%
Other healthcare coverage must be billed before submission of claim	1,444	$425,734	19.80%
Medicare Part B must be billed before submission of claim	831	$265,678	12.36%
Service line is a duplicate and a repeat service procedure code modifier not present	399	$135,458	6.30%
Place of service incomplete or invalid	22	$38,720	1.80%
Service location NPI issue	41	$35,239	1.64%
Deactivated NPI	124	$10,609	0.49%
Other	48	$7,797	0.36%
Total Denied Claims	**4,484**	**$2,149,800**	**100.00%**
Overall Denied Claims Rate	**1.26%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- Despite the MHP's trend of increasing denied claims in the second half of CY 2021, its average denied claims remained below the statewide rate. Beneficiary not eligible or non-covered charges, and late claims accounted for 57 percent of the denied claims.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Between HIE and other joint databases, the MHP is well-positioned to track and trend beneficiary health indicators and other social determinants more comprehensively. This will allow better risk modeling and mitigation for a vulnerable population including prevention of adverse outcomes.
- The MHP's stable EHR environment, coupled with seasoned fiscal, IS and analytical staff, allow it to implement the CalAIM changes in a timely manner.
- With a functional PHR in place, getting the beneficiaries the information and training on using it will benefit the beneficiaries in keeping track of their appointments, medications, and other available information on the PHR.
- Tracking the website user experience and satisfaction will be key to continuous improvement of the website structure.
- The MHP needs to monitor its denial rates for any untoward increasing trend.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP discusses CPS results in the QIC, and then shares specific results with program administrators. The results are not posted to the MHP's website because the responses tend to remain static between administrations, and the MHP believes beneficiaries are not interested. Overall, the MHP believes the survey itself confuses beneficiaries and is not often useful to in providing direction to MHP improvement activities. In response to these issues, the MHP developed and runs its own in-house quarterly survey.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers the majority of whom initiated services in the preceding 12 months. The focus group was held at the Rustin Building, Riverside, CA, and included eight participants. All consumers participating receive clinical services from the MHP.

Only one participant started services within the prior 12 months.

When asked about appointment reminders, cards, reminder calls, and voice mail messages were mentioned. While not needing interpreting assistance, these participants mentioned an awareness for the availability of linguistic support. Various supportive transportation options were identified. These options include: Lyft, Uber,

CarCall, with two-day notice required for IEHP support to come. Others options were peers and program supported rides.

If desired, family participation is reportedly welcomed.

Physical health is addressed as part of the treatment, including self-care, whole health, lab work, exercise and physical activity.

Psychiatry and communication with primary care physicians varies, with some bidirectionally communicating. One participant's psychiatrist referred him to a neurologist, which was experienced as a positive.

If a worker or clinician was not a good fit, several understood how to express their concerns and obtain a different therapist. As to how services are received, telephone and video services in addition to in-person care are available options.

Frequency of psychiatry services are currently six weeks apart, extended from monthly due to lack of psychiatry staffing. Another receives psychiatry every two months. Other clinician services were reported as weekly, and as needed.

Missed clinical appointments can be rescheduled or obtained via Zoom. If a psychiatry appointment is missed it can take three weeks to re-book at times.

Crisis and after-hours options include: peer support services, an after-hours line, the CARES line, a triage center at Perris Behavioral Health, urgent care, or calling the therapist directly. Peer staff are considered a valuable resource, with some participants feeling "less judged" by them. Not all programs currently have peers on staff. One participant was aware of the Take My Hand peer chat, but has not used it.

Participants mentioned completing the CPS survey, but none had seen the results. All would be interested in learning the survey results. Changes in the services available can be found in posted clinic calendars, from peer support staff, word of mouth, and from their psychiatrist.

A very small number of these participants knew of the MHP's website. One individual had tried unsuccessfully to use the personal health record, My Health Pointe. A few felt they had been able to share their input to the mental health system. In some instances, the feedback was implemented.

Beneficiaries report a sense of hope and that they can recover. This occurs more frequently with the newer staff. They all feel involved in their own care planning.

Recommendations from focus group participants included:

- More supportive services.
- Develop a gift card incentive program.

- Emphasize the development of online and telehealth options for groups, particularly useful for those who work.
- More and/or longer therapy sessions.
- More employment readiness programs.
- More alcohol and drug services.
- More volunteer work opportunities.
- More groups and other programs.
- More school services.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of caregivers of children and youth. The focus group was held at the RUHS-BH Rustin Building, Riverside, CA, and included nine participants; a Spanish language interpreter was used for this focus group, with five participants preferring a language other than English. All family members participating have a family member who receives clinical services from the MHP.

Six of the nine participants initiated services within the past 12 months.

For the majority of participants, initial access was described as relatively quick and easy. The frequency of psychiatry is most often monthly, and for a smaller element every two weeks. Psychosocial therapy for most occurs weekly, with a few reporting monthly. Other services reported include weekly support groups, and peer support. One individual's son feels he needs more medications and group treatment. Once a week is not sufficient.

One participant's daughter receives services four times per week, in-home services and the caregiver receives parenting classes. Others mentioned receiving family therapy, and Zoom classes.

These caregivers report having options in how services are provided. Options like Zoom are well-received. They appreciate having a choice. As with how services are received, participants report options in appointment reminders – phone calls, texts, and reminder cards.

Missed appointments are easily rescheduled for the next day or next week.

As to linguistic needs, some report interpreting is always available, and several others state their clinic lacks interpreters. Transportation assistance exists in the form of bus passes and rides. Some programs directly provide transportation. Car Call, through the MCP IEHP, is another transportation resource.

Family involvement with treatment is common among these caregivers, but requires a release of information (for TAY). Several caregivers described situations wherein their

child refused to allow information sharing when such was important to proper treatment. In general, caregivers have been provided with support information, such as a Family Advocate resource sheet.

Many reported completing the state-required satisfaction survey but none have seen the results. None could recall being invited to provide input on services in other venues.

The changes in the last year that have been most impactful have been in psychiatry and therapist changes, with special emphasis on interns rapidly turning over.

Recommendations from focus group participants included:

- Reduce the turnover in all personnel, clinicians and psychiatrists.
- Provide the family with more education regarding medications, so they know what to therapeutic and side effects to expect.
- Provide more support to caregivers of adult beneficiaries.
- Help with homelessness.
- Reduce the high turnover of interns, which is disruptive to treatment and trust.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The most common and critical need reported from these focus groups is in staffing capacity, and resultant turnover of staff being disruptive to treatment and trust. Caregivers with seriously mentally ill children face challenges regarding release of information and continuing to share information with parents, while living at the parental home. The importance of a family advocate to help navigate these circumstances is underscored by these participants.

Not only is turnover effecting the therapeutic relationship, but the amount of treatment is impacted when staff leave and the process of recruitment and hiring takes time to navigate. This can result in reluctance to engage in treatment when it is very important.

The use of telehealth as a way of delivering groups and other services to those who work or have transportation barriers was often mentioned. The MHP may wish to expand some of the services provided into the video support area.

CONCLUSIONS

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

STRENGTHS

1. The MHP has a strong internal focus on the development of specialized programs that enhance available levels of care for beneficiaries, such as recovery villages and FSPs, and the subsequent development of extensive performance reports evident for the Crisis System of Care, Adult FSP, and Wraparound programs. (Access, Quality)
2. The MHP's recovery and peer services are an MHP strength, including a new Peer Deputy position. Lived experience staff include peers, parent partners, and family advocates. Programs include TakemyHand, a peer-run chat support, the Rustin Gym Peer services, and an array of wellness and recovery programs dispersed throughout the county, including three which target the TAY population. There are approximately 450 peer positions, with a career ladder and integration with all service teams. (Access, Quality)
3. The depth of knowledge of leadership team members and their collaborative efforts in the implementation of system changes was evident during this review. (Quality)
4. Between HIE and other joint databases, the MHP is well-positioned to track and trend beneficiary health indicators and other social determinants more comprehensively. This will allow better risk modeling and mitigation for a vulnerable population including prevention of adverse outcomes. (IS)
5. The MHP's stable EHR environment, coupled with seasoned fiscal, IS and analytical staff, allow it to implement the CalAIM changes in a timely manner. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Development of clinical and technical guidance is important for telehealth implementation, including guidance for the provision of groups, psychosocial treatment and psychiatry services. Additionally, there should be guidance on determining clinical appropriateness and consumer choice. (Access, Timeliness, Quality)
2. The combined factors of higher than anticipated referrals from MCP use of the DHCS screening tools and the position vacancy rates (approximately 30 percent clinical positions, 38 percent of psychiatry positions) have resulted in the

implementation of various strategies such as wait lists, partial services, and the use of urgent care centers/crisis stabilization units as default due to routine appointment unavailability. (Access, Timeliness, Quality)

3. The MHP's process and structure for tracking non-urgent psychiatry, urgent services, and initial access is resulting in under-reporting of events and limiting the MHP's understanding of existing access issues. (Access, Timeliness, Quality, IS)
4. The MHP's integrated MHP/SUD QI Work Plan would benefit from the identification of a greater number of tracked goals and objectives, and inclusion of trend data in each element, enabling the viewer to both access conclusions and view the actual data. (Quality, IS)
5. The MHP website is a part of the overall RUHS health system website. While the behavioral health side has a wealth of information on services and clinic locations, navigation is neither easy nor intuitive. It also lacks any highlighting or embedding of crisis or access call numbers throughout the website structure. (Access, Quality, IS)

RECOMMENDATIONS

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

1. Develop a clinical telehealth policy that clearly describes the criteria for approval or denial of telehealth requests, with an included appeal process, and also highlights clinical and technical aspects to be considered in approval or denial of these requests. (Access, Quality, IS)

   (This recommendation is a carry-over from FY 2021-22.)
2. The MHP should research, implement, and improve recruitment and retention success to lower the vacancy rates and improve availability of capacity to serve its large beneficiary pool. The priorities of job applicants, such as flexible and hybrid work schedules with some work from home, merits consideration for broad implementation. (Access, Quality)
3. The MHP should research and implement improved timeliness tracking protocols, particularly focused on the areas of first non-urgent psychiatry service and urgent care. This could involve consultation with DHCS and/or collaboration with neighboring and similar-sized MHPs that would assist in validating its protocols. Timeliness information is most useful when event capture is more complete. (Timeliness, Quality, IS)
4. The MHP's integrated MHP/SUD QI Work Plan would benefit from the identification of a greater number of tracked objectives and goals, and inclusion of trend data with each element, enabling the viewer to both access narrative conclusions and view the supporting data. (Quality, IS)

5. Implement website navigational improvements, testing changes with beneficiaries and caregivers and local access experts before implementation. (Access, Quality, IS)

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

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a California public health emergency (PHE) was in place until February 28, 2023 and a national PHE was scheduled to end May 11, 2023. EQR activities were conducted in a hybrid format of virtual video sessions, and onsite session that focused on consumer focus groups, and wellness center visitations. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Riverside MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
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 Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Information Systems Billing and Fiscal Interview
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Robert Walton, QR
Sandra Sinz, QR
Saumitra SenGupta, ISR
Pamela Roach, CFMR

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.

RUHS-BH Rustin Campus, Riverside, California

MHP County Sites

Riverside
9990 County Farm Road
Suite 5
Riverside, CA 92503

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Arnold	Maria	Parent Partner Manager	RUHS-BH
Ayon	Brenda	Clinical Therapist, Mobile Crisis Management Team	RUHS-BH
Barajas	Karla	BHS II, San Jacinto New Life AB109	RUHS-BH
Barton	Myesha	Performance & Service Excellence Prog. Administration	RUHS-Medical Center
Blalock	Michael	Admin. Services Asst. SAPT	RUHS-BH
Brenneman	Bill	Deputy Director-Adult Programs	RUHS-BH
Brown	William	CT II, Temecula Adult BH Clinic	RUHS-BH
Cannon	Marcus	Deputy Director-Forensics	RUHS-BH
Chang	Matthew	Director	RUHS-BH
Chung	Nancy	Admin. Services Manager	RUHS-BH
Curran	Julie	Supervising Behavioral Health Specialist	RUHS-BH
Del Rio	Elizabeth	BH Services Manager-CARES	RUHS-BH
DeShields	Miranda	Central Children's Administrator	RUHS-BH
Dopson	Maureen	QI Administrator	RUHS-BH
Downs	Michelle	BH Services Manager	RUHS-BH
Duffy	Kristen	Peer Services Manager	RUHS-BH
Edwards	Nichol	BH Supervisor-Technology	RUHS-BH

Last Name	First Name	Position	County or Contracted Agency
Flournoy	Belinda	Bus. Process Analyst III	RUHS-BH
Gonzalez	Danielle	Sr. PSS, Crisis Support West	RUHS-BH
Grisham	Jim	Desert Region Adult Services Administrator	RUHS-BH
Hemani	Heena	BH Services Manager-BHI	RUHS-BH
Hildebrand	Candice	BH Services Supervisor	RUHS-BH
Inzunza	Klarysa	CT I, Indio Adult Outpatient	RUHS-BH
Jacobs	Brandon	Deputy Director-Quality Management	RUHS-BH
Jimenez	Lauren	BHS II, Mobile Crisis Response	RUHS-BH
Johnson	Deborah	Director of Innovation/Integration	RUHS-BH
Juarez-Williamson	Suzanna	Admin. Services Manager-Evaluation	RUHS-BH
McCann	Amy	BH and CHC Comptroller	RUHS-BH
McCleerey-Hooper	Shannon	Deputy Director-Peer Programs	RUHS-BH
Miller	Rhyan	Deputy Director-Integrated Programs	RUHS-BH
Miller	Kristin	Crisis Services Administrator	RUHS-BH
Moore	Janine	Deputy Director-Children's Programs	RUHS-BH
Moore	Janine	Deputy Director-Children's Programs	RUHS-BH
Moreno	Maria	BH Services Manager Tech Suite	RUHS-BH
Nava	Kimberly	BHS II, New Life	RUHS-BH
Noone	Melissa	Admin. Services Manager	RUHS-BH

Last Name	First Name	Position	County or Contracted Agency
Orozco	Angelica	BH Services Administrator- HHOPE	RUHS-BH
Ramirez	Christina	BHS II	RUHS-BH
Robinson	Toni	BH Mid-County Administrator	RUHS-BH
Rodriguez	Antonio	CT II, CalWorks	RUHS-BH
Ruiz	Jacob	Deputy Director-Finance	RUHS-BH
Sanchez	Aaron	PSS, Rustin Resource Center	RUHS-BH
Sewani	Peggy M.	BHSII, Wellness and Recovery Clinic	RUHS-BH
Summers	Ronena	Sr. Clinical Therapist, Mature Adult Clinic	RUHS-BH
Torres	Ryan	Business System Analyst III	RUHS-BH
Torres	Lindsay	LMFT	Riverside County Latino Commission
Trevino-Kwong	Ashley	Admin. Services Manager	RUHS-BH
Twohey-Jacobs	Joan	Admin. Services Manager-Research	RUHS-BH
Vivanco	Refujio	Family Advocate, Hemet Adult Clinic	RUHS-BH
Watson	Robby	IT Manager	RUHS-BH
Wynn	Williard	Family Advocate Manager	RUHS-BH
Xayarath	Novanh	Western Children's Administrator	RUHS-BH
Yarbrough	Rich	PSS, Jefferson Wellness	RUHS-BH
Youssef	Robert	Sr. Public Info. Specialist	RUHS-BH

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 determined there was not a statistically significant difference between the baseline and PIP results (p=.203). The COVID-19 limitations on group activity dampened what could have been an effective group modality intervention, although possibly enhancing understanding among the target group and promoting follow-through at release.
General PIP Information	
MHP/DMC-ODS Name: RUHS-BH	
PIP Title: Improve continuity of care and engagement in community outpatient services for detention mental health consumers when they are released.	
PIP Aim Statement: Will enhanced discharge services improve the rate of transition from detention services to outpatient services within 90 days after release (from 16 percent to 30 percent); with 80% continuing engagement and receiving three or more services after the initial outpatient service with 45 days.	
Date Started: 07/2020	
Date Completed: 03/2023	
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): The study population includes adults residing in Riverside County who have been incarcerated and discharged from the Presley correctional institution. These adults must have had a mental health service within the detention institution as well as be classified as either moderately-severe, severe, or acute without very serious charges (i.e., Murder, Assault). The consumers leaving detention comprised mostly Men (78 percent) between the ages of 26 and 45 (62 percent). The majority of this population were either White (37 percent), Hispanic (34 percent) or Black (26 percent). The majority of these consumers were diagnosed with Schizophrenic or Psychotic disorders (33 percent).
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): 1. Obtaining a release of information to speak with anyone the consumer considers part of their social support and probation officer when applicable; 2. Family advocacy - reaching out to consumers social support system when listed on the ROI; 3. Substance use disorder (SUD) treatment when identified engage consumer is SUD screening, work with SUD CARES to arrange any Detox, Outpatient, or Residential Placement upon release; 4. Housing - When required contact Housing and Homeless Outreach to plan for housing upon release; 5. Community Mental Health services link to New Life program and Forensic FSPs; 6. Peer support - Request a peer support be assigned to consumer pre-release from custody for support and engagement; 7. Ensure timely release of psychotropic medications with 14-30 day supply prior to release; 8. Prioritize transportation for the most vulnerable consumers through Measure A staff.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The proportion of detention mental health consumers that access services following release from the detention facility.	July of 2019 to March of 2021	The transition rate for consumers who were released from jail was at 16%	Oct 2022- Dec 2022	15%	☐ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
The proportion of consumers who continue engagement in ongoing services after initial service post detention discharge.	Of those who had an initial transition service 66% continued on to receive 3 or more services within 45 days.	July, 2019 to March, 2021	July –Sept 2022	During intervention 66% continued on to receive 3 or more services in under 45 days	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): 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: This PIP has ended and would not be appropriate for recommendations at this time.

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	At this time, confidence is based on the structure of this PIP, not on subsequent data reports and analysis. Thus far, the approaches taken by the MHP show the promise of moderate confidence. They have undertaken changes that should increase their awareness of ED visits which are appropriate for a HEDIS FUM 7/30 follow-up contact.

General PIP Information
MHP/DMC-ODS Name: RUHS-BH MHP
PIP Title: HEDIS FUM 7/30 Post-ED Follow-Up Clinical PIP
PIP Aim Statement: The aim of this performance improvement project is to increase the 7- and 30- day follow-up rates by 5 percent for all ages, and to decrease race/ethnic disparities by June 2024.
Date Started: 07/2020
Date Completed: 03/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Individuals who have had an ED visit for self-harm or a mental health condition.

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): Identification and outreach to individuals who present to an ED with a mental health need, to educate and encourage follow-up care.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Use of crisis services to contact and link individuals to follow-up.
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): Development of a data exchange process between the MHP and EDs.

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 rates to behavioral health treatment after emergency department discharge (ED) for people with a mental illness diagnosis Goal: 5% improvement	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	n/a	n/a	n/a
. • 30-Day follow-up rates to behavioral health treatment after emergency department discharge (ED) for people with a mental illness diagnosis	n/a	n/a	☒ Not applicable—PIP is in Planning or implementation phase, results not available	n/a	n/a	n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
• ED 7-day re-admission rates.	n/a	n/a	n/a	n/a	n/a	n/a
• ED 30-day re-admission rates.	n/a	n/a	n/a	n/a	n/a	n/a
• Timeliness with average time to first service from the ED discharge date.	n/a	n/a	n/a	n/a	n/a	n/a

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: For improving this PIP, the MHP should consider tracking some of the elements missing from this format that are customarily required of a PIP, such as the PIP start date, the start dates for each intervention, and regular, recurring production of results data. In addition, while the MHP has provided analysis based on age and ethnicity and specified the 5 percent improvement expected, the data is not presented in a format that supports trend over time analysis. While the basic intent of this PIP is positive and will likely be successful, it is important to routinely produce and include the data elements that are to be tracked in regular updates.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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