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

SAN BENITO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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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, “San Benito” may be used to identify the San Benito County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — March 22,2023

MHP Size — Small

MHP Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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
5	2	1	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	0	6	0
Quality of Care	10	0	8	2
Information Systems (IS)	6	4	1	1
TOTAL	**26**	**8**	**15**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Coordination of Care to Reduce Crisis and Inpatient Services"	Clinical	07/2021	Second Remeasurement	Moderate
"Text Appointment Reminders"	Non-Clinical	01/2021	Other: Completed	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	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has identified two dedicated intake days a week to reduce no-show and increase first appointment scheduling.
- Staff utilizes both the Children and Adolescent Needs and Strengths (CANS) and Risk Resiliency Factors (RRF) outcome tools when working with beneficiaries on identified goals.
- The MHP has a low rate of inpatient hospital readmissions.
- The MHP has increased their use of data dashboards to evaluate data.
- MHP utilizes case managers to provide transportation for beneficiaries who are unable obtain other services, and intensive case management with clients in between clinical appointments.

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

- The MHP does not include new initiatives or review impact of outcomes on the beneficiary experience within the Quality Improvement Workplan (QIWP). (Carry-over recommendation 1 and 2 from FY 2021-22.)
- Key informants identified higher no-show rates than the data provided on the Assessment of Timeliness Access (ATA), and the percentage standards set by the MHP lack staff understanding when standards are not met, or data is incomplete.
- The MHP lacks beneficiary participation in the Quality Leadership Committee (QLC), and beneficiaries have limited opportunities for employment.

- Key informants have identified low staff morale, resulting in high clinical turnover rates which is impacting the beneficiary experience.
- The MHP limits their receipt of federal and state funds by not ensuring that all billable services are submitted.

Recommendations for improvement based upon this review include:

- Include new initiatives, outcomes, and goals and report the impact on beneficiaries, when compliance percentage goals are achieved within the QIWP.

  (This is a carry-over recommendation from FY 2021-22 with a combined recommendation for goals 1 and 2.)
- Identify realistic no show percentage standards within the ATA; train staff on input expectation; and investigate impact on beneficiary care when dedicating two intake days.
- Engage beneficiary voice by holding a QLC meeting at the Esperanza Center; and identify additional areas peers can become involved in paid and/or non-paid positions within the system of care.
- Initiate a line staff satisfaction survey and report outcomes to staff; engage line staff in a focus group to determine areas of improvement and a timeline to address staffing needs, to stabilize the workforce and beneficiary care..
- Identify and implement training and oversight activities to ensure that all billable services are submitted accurately and billed.

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 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for San Benito County MHP by BHC, conducted as a virtual review on March 22,2023.

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 quality improvement (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 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 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 during the Coronavirus Disease 2019 (COVID-19) pandemic, which is scheduled to end on May 11, 2023. The MHP is dealing with an overall county clinical staff vacancy rate of 60 percent and currently the MHP has a vacant director position. In addition, the MHP dealt with a number of floods that prevented staff and beneficiaries from reaching county facilities due to road closures and evacuation warnings. CalEQRO worked with the MHP to design an alternative 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.

- The MHP increased contracts with Community Based Organizations to increase outreach to bilingual children in rural areas.
- Due to high vacancy rate and staffing turnover, the MHP created therapy and rehabilitation groups.
- The MHP created two dedicated intake days a week to prevent no show appointments and assist in first appointment scheduling. These days do not offer clinical treatment services.
- The MHP is implementing the California Mental Health Services Authority (CalMHSA) SmartCare Electronic Health Record (EHR) Solution for Multi-County Behavioral Health Initiative in California. They are scheduled to begin using the EHR in July 2023.
- The population in San Benito County has been increasing steadily in recent years, contributing to challenges meeting the needs of all Medi-Cal beneficiaries with reduced clinical staffing.

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: Expand outcome goals within the QIWP, to include the impact on beneficiaries when compliance percentage goals are achieved.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Due to conflicting initiatives and multiple regulatory requests in addition to the depletion of staff, the MHP did not address Recommendation 1.
- The MHP plans to expand on incorporating outcome goals within the QIWP to establish ongoing monitoring and tracking of the impact of the SMHS on the beneficiaries and their families.
- This recommendation will carry over and be combined with Recommendation 2.

Recommendation 2: Update the QIWP to include goals and outcomes for new initiatives. Consider reporting on new initiative impacts on beneficiaries' experience.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Due to conflicting initiatives and multiple regulatory requests in addition to the depletion of staff, the MHP did not address Recommendation 2.
- MHP's intends to develop the QIWP goals with a focus to measure beneficiary outcomes on a regular and consistent basis.
- This recommendation will carry over and be combined with Recommendation 1.

Recommendation 3: Track, monitor and report urgent services separately and not aggregated for adults, TAY, children, and FC youth.

(This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Raw data for urgent services timeliness data included age and Child Protective Services status to break out reports by adults, children, TAY, and FC youth.
- Of note, the MHP did not have FC services to report, though they did break out FC services as requested.

Recommendation 4: Engage mono-lingual Spanish speaking beneficiaries to determine interest and need for Spanish speaking support groups and activities. Create a plan to implement changes that includes utilizing Spanish speaking staff verses interpreters when possible.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Established two Spanish speaking case managers to engage with beneficiaries and conduct focus groups at the Esperanza Center.
- Established interpretation support two days a week.
- Case managers play an active part in creating the monthly Wellness Center calendar with input from English and Spanish speaking participating beneficiaries.

Recommendation 5: Update the MH website for ease of use and information gathering. Include a suicide prevention number and information on how to access services. Explore oversight for both the website and Facebook media outlets with a web and social media expert.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Both 988 for Suicide and Crisis and the 24-hour Access Line are prominently displayed on the county behavioral health landing page.
- There is a predominate Hispanic/Latino population in the county and Spanish captions for each number are not on that page. The Guide to County Mental Health Services and other documents, in both English and Spanish, can be found lower down on the page. The Calendar, News/Media, and Newsletter pages are not up to date.
- The MHP is identifying staff to develop the website and social media platforms.
- To fully meet this recommendation, the MHP will ensure that critical information is available in both English and Spanish and keep time sensitive information such

as calendars up to date. For this reason, the recommendation will not be carried forward.

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 primarily by county-operated providers in the MHP. Regardless of payment source, approximately 88 percent of services were delivered by county-operated/staffed clinics and sites, and 12 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 80 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 and contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: Prevention and Early Intervention programs, high school wellness centers or the Support, Awareness, Follow-Up, and Engagement (S.A.F.E.) team. The MHP recently enacted two days a week dedicated to walk in and/or scheduled intake services. After-hours access is provided by Crisis Support Services of Alameda County. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. With a rotating on-call clinician, once a beneficiary calls, they will be assessed for appropriate services at the time of the call, an initial nursing assessment strives to ensure psychiatrist consultation within the same day.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 361 adult beneficiaries, 48 youth beneficiaries, and 56 older adult beneficiaries across 2 county-operated sites and 1 contractor-operated sites. Among those served, 41 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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[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 NA Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For San Benito County, the time and distance requirements are 60 miles and 90 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 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	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- Case managers provide transportation for MH services when needed.
- The MHP has issued two Requests for Proposal to augment county clinical staff with contract clinicians.
- The MHP expanded group therapy services to meet capacity needs, although some beneficiaries reported that they would prefer continuing with individual services.
- Crisis services are delivered over the phone unless the call comes from the emergency room, jail, or probation.
- The MHP has not implemented the new screening tool.
- The MHP has dedicated two days a week for walk-in and/or scheduled intakes.

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, with a 5.46 percent PR, continues to demonstrate better access to care than the state.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	19,946	1,089	5.46%	$4,257,463	$3,910
CY 2020	18,258	1,008	5.52%	$3,723,438	$3,694
CY 2019	18,108	1,087	6.00%	$3,411,078	$3,138

- The annual number of beneficiaries in San Benito County increased every year between CY 2019 and CY 2021, increasing 9 percent between CY 2020 and CY 2021. The PR decreased slightly in that same period.
- Although the AACB has gone up every year between CY 2019 and CY 2021, the AACB of $3,910 in CY 2021 is 52 percent of the state $7,478 average. The MHP reported that some Medi-Cal billable services are entered into the EHR as non-billable codes, contributing to the relatively low AACB.

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	2,409	19	0.79%	1.27%	1.96%
Ages 6-17	5,255	308	5.86%	5.74%	5.93%
Ages 18-20	1,178	58	4.92%	4.89%	4.41%
Ages 21-64	9,560	661	6.91%	4.73%	4.56%
Ages 65+	1,545	43	2.78%	2.45%	1.95%
Total	**19,946**	**1,089**	**5.46%**	**4.39%**	**4.34%**

- The MHP's PR is higher than other small counties in all age categories other than 0-5. It is relatively close in the other youth and older adults age groups. The 6.91 percent PR for ages 21-64 is the primary factor for the overall high PR in the county.
- Although the MHP's overall PR is higher than the statewide average, the PR for children aged 0-5 and 6-17 is lower than the statewide average.

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	207	19.01%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language in the MHP. In CY 2021, almost one out of every five beneficiaries served identify 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	5,473	384	7.02%	$1,413,120	$3,680
Small	199,673	7,709	3.86%	$45,313,502	$5,878
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.
- The MHP's ACA PR is much higher than the statewide and small county rates. The MHP's 7.02 percent ACA PR is also higher than the county's 5.46 percent overall PR. The $3,680 ACA AACB is lower than the $3,910 county overall AACB. While the PR is higher than the county overall, the ACA population received fewer or less costly services than the non-ACA population in San Benito County.

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.

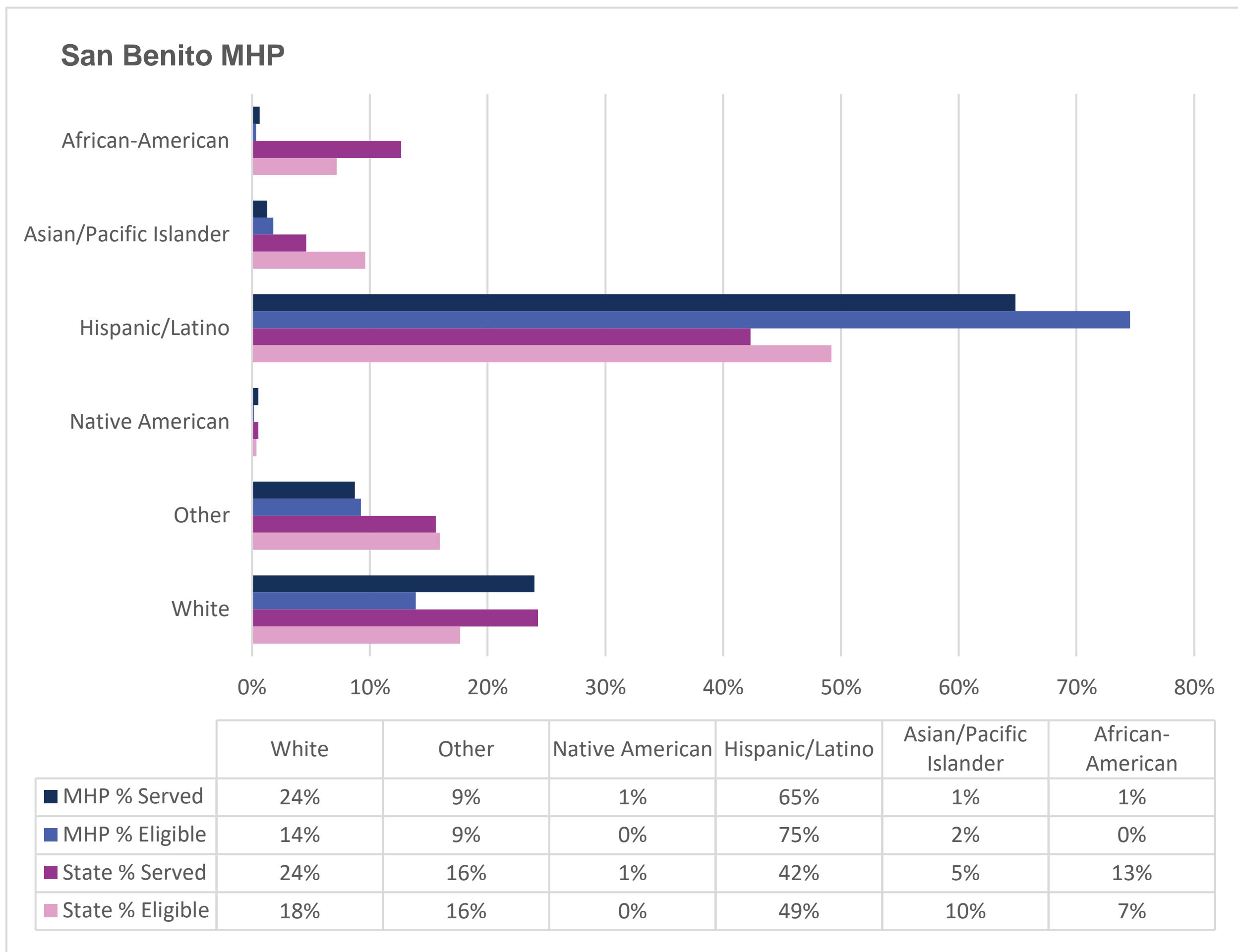
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	70	<11	-	7.64%
Asian/Pacific Islander	360	14	3.89%	2.08%
Hispanic/Latino	14,872	706	4.75%	3.74%
Native American	33	<11	-	6.33%
Other	1,842	95	5.16%	4.25%
White	2,772	261	9.42%	5.96%
Total	**19,949***	**1,089**	**5.46%**	**4.34%**

* *Differences in totals from Table 3 and Table 4 are due to rounding of averages across different variables.*

- The PR is higher than the state rate for every race/ethnicity where there is sufficient data to report.
- Within the county, the only PR that is higher than the 5.46 percent overall PR is for white beneficiaries. Services to white beneficiaries contribute greatly to the overall high PR in San Benito County.

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

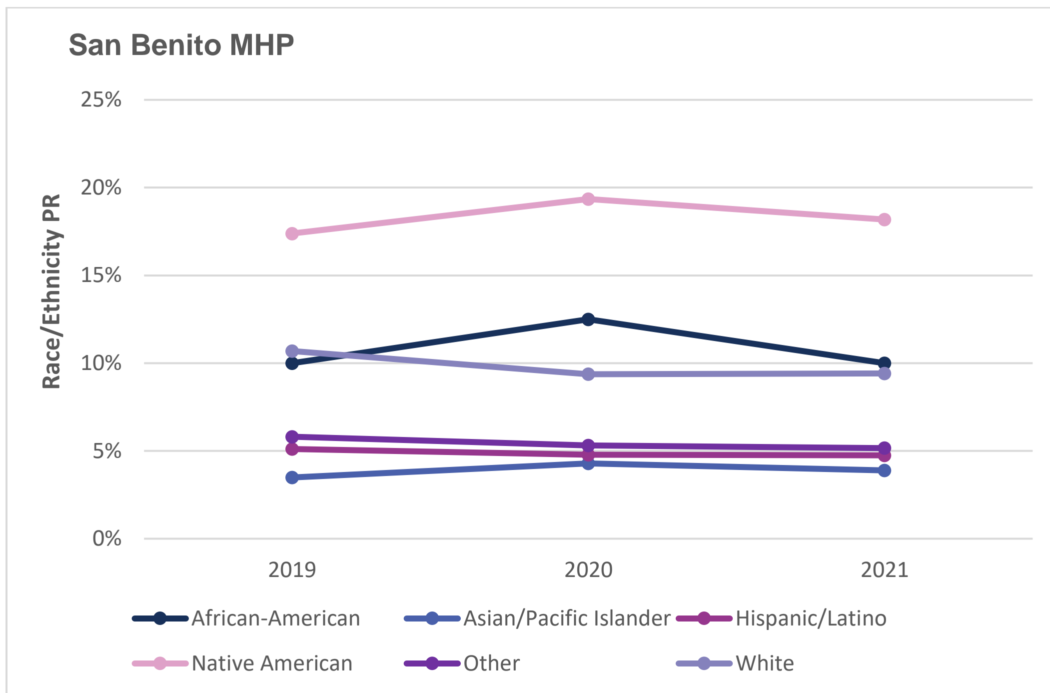


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	24%	9%	1%	65%	1%	1%
MHP % Eligible	14%	9%	0%	75%	2%	0%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The MHP has a higher proportion of Hispanic/Latino eligibles (75 percent) than statewide (49 percent), and a lower proportion of White and Other eligibles (14 and 9 percent, respectively) than statewide (18 and 16 percent, respectively).
- Hispanic/Latino beneficiaries represented 65 percent of the population receiving services, while they are 75 percent of Medi-Cal eligibles in the county. Conversely, 24 percent of services were provided to White beneficiaries while they are only 14 percent of the eligible population.

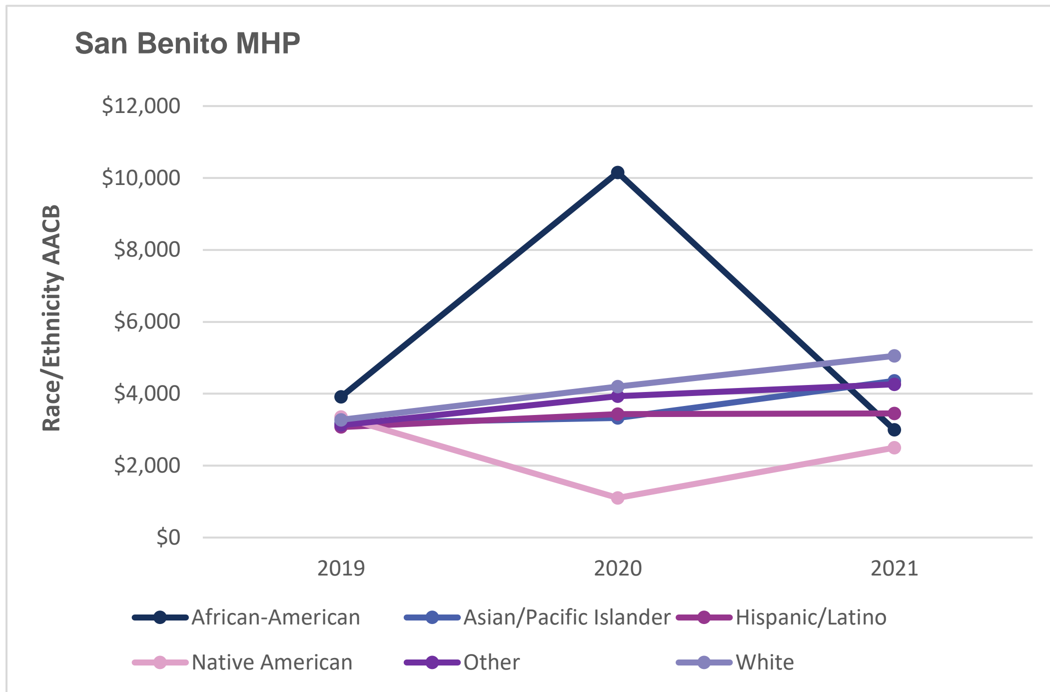
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



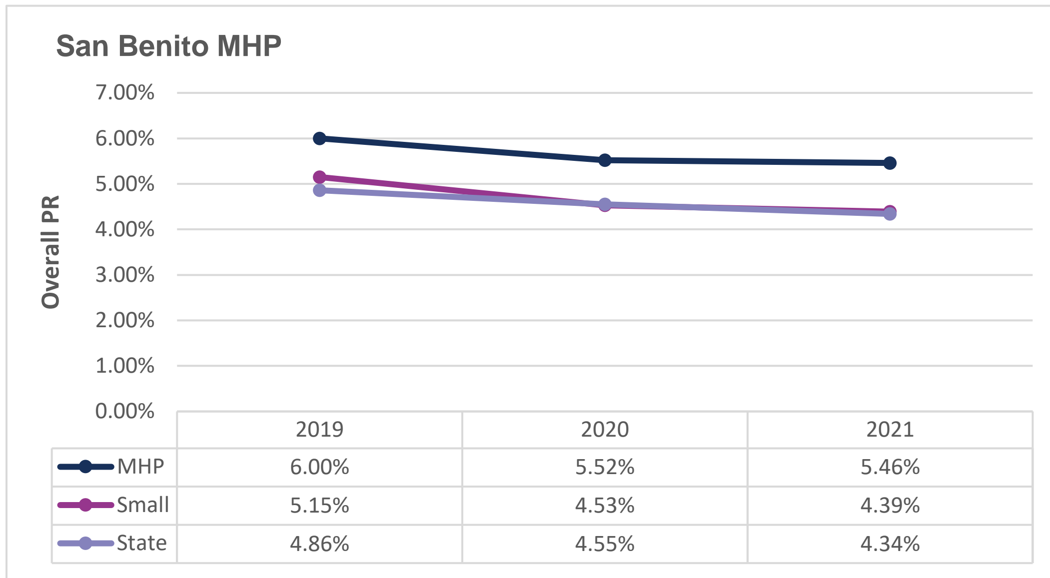
- Between CYs 2019 to 2021, Hispanic/Latino, Asian/Pacific Islander and Other PRs have been consistently lower than other race/ethnicities. The White PR has been consistently higher at close to 10 percent. Native American and African-American PRs, each with a low number of beneficiaries served, have also had consistently higher PRs.

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



- Excluding the African-American and Native American outliers, there has been a general pattern in CYs 2019 to 2021 that White beneficiaries have highest AACB and Hispanic/Latinos have the lowest AACB.
- White, Other, Asian/Pacific Islander and Hispanic/Latino AACBs have been increasing from CYs 2019 to 2021. The African-American AACB increased substantially in CY 2020 and then came down substantially in CY 2021. The Native American AACB dipped in CY 2020 and came back up in CY 2021. The variation in the African-American and Native American PRs in the 3-year period, could be due to the low number of African-American and Native American beneficiaries served.

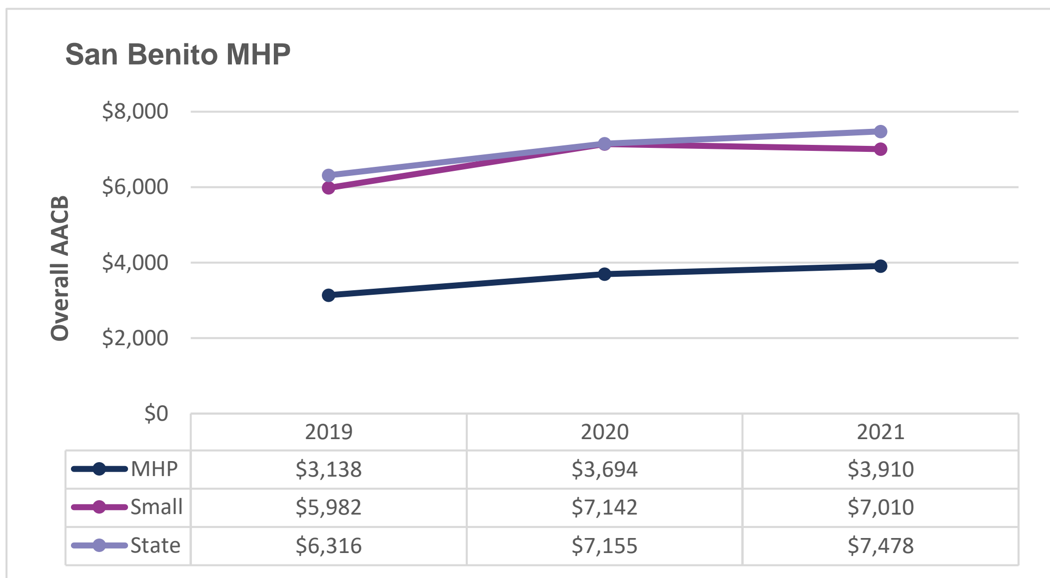
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.00%	5.52%	5.46%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

- The MHP's PR has been consistently above the state and small county average between CY 2019 and CY 2021.

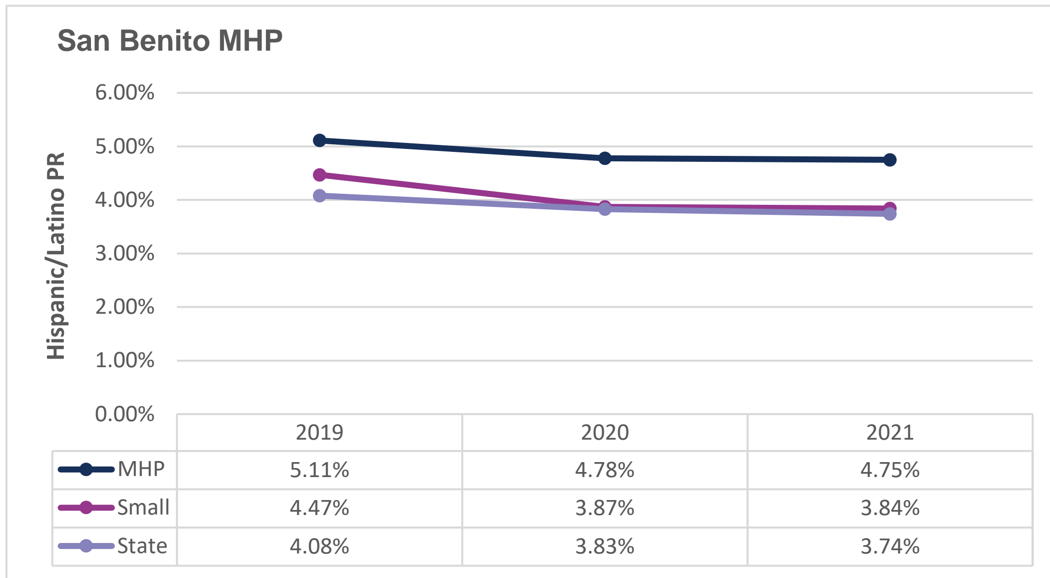
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$3,138	$3,694	$3,910
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

- Although the MHP's AACB has increased each year between CY 2019 and CY 2021, the AACB is consistently lower than the state and small county averages during those years. The MHP reported that not all billable services are claimed to DHCS, contributing to the relatively low AACB.

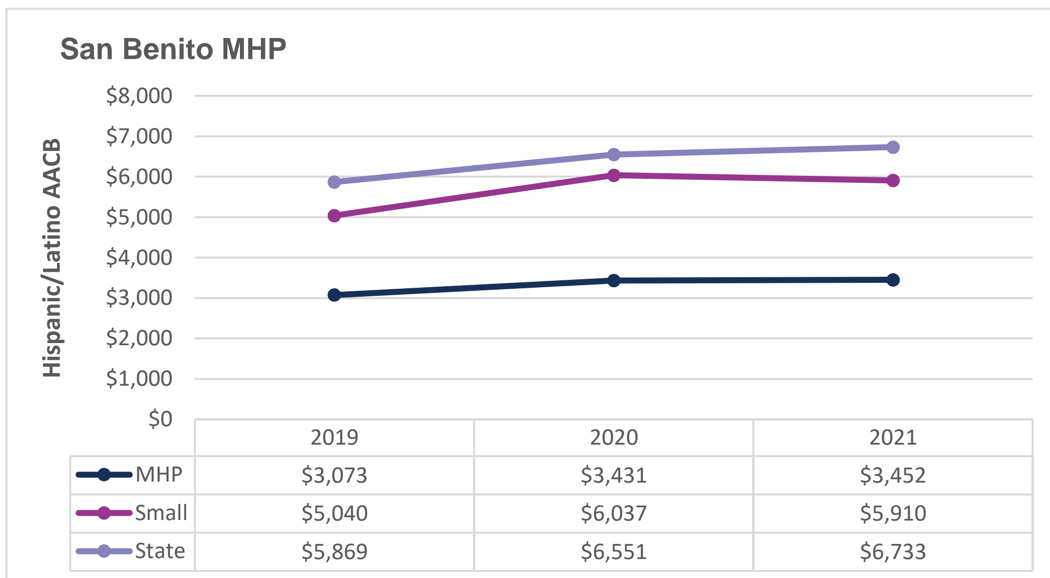
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	5.11%	4.78%	4.75%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

- The Hispanic/Latino PR remains consistently higher than other small counties and statewide.

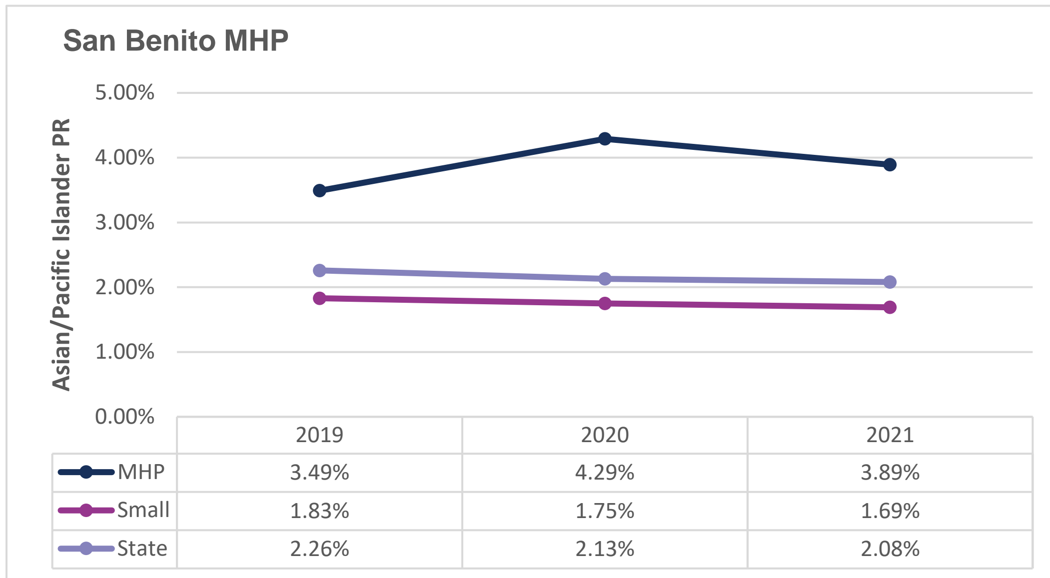
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$3,073	$3,431	$3,452
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

- The Hispanic/Latino AACB is consistently lower than seen in other small counties and statewide. Also, while the MHP's overall AACB went up almost 6 percent in CY 2021, the Hispanic/Latino AACB only increased marginally.

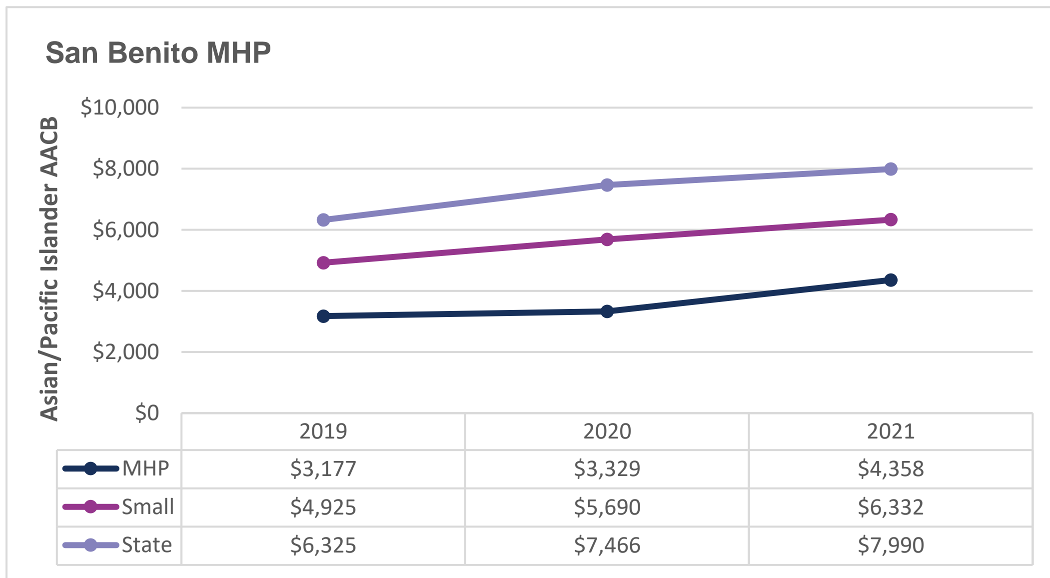
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	3.49%	4.29%	3.89%
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

- While only 14 Asian/Pacific Islander beneficiaries were served in CY 2021 they do represent a higher PR than seen in other small counties. In CYs 2020 and 2021, the rate is more than twice the small county PRs.

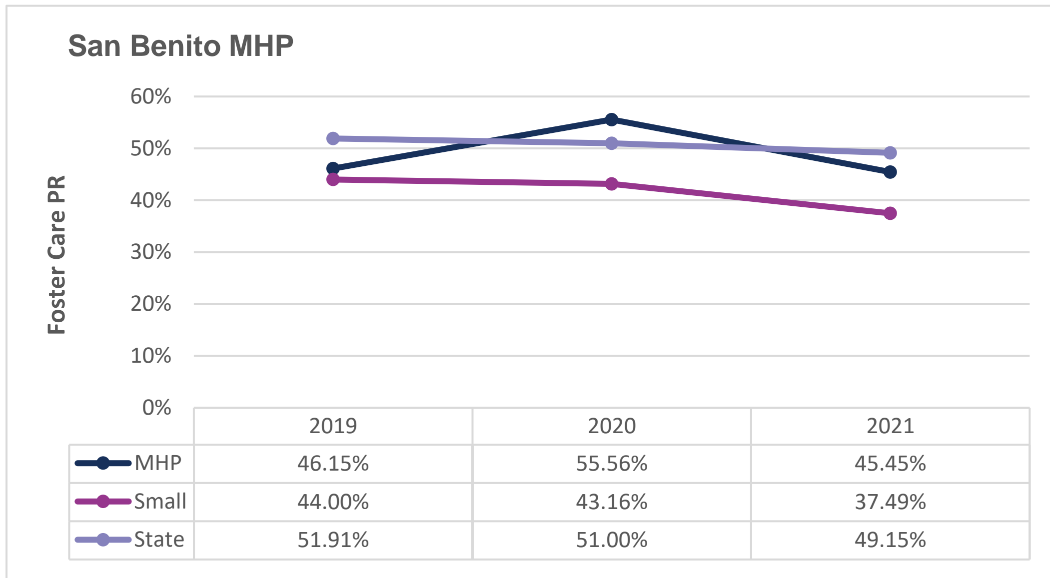
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$3,177	$3,329	$4,358
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

- The Asian/Pacific Islander AACB is consistently lower than seen in other small counties and statewide.
- In CY 2021 the 14 Asian/Pacific Islanders receiving services had a higher AACB than the $3,910 county average.

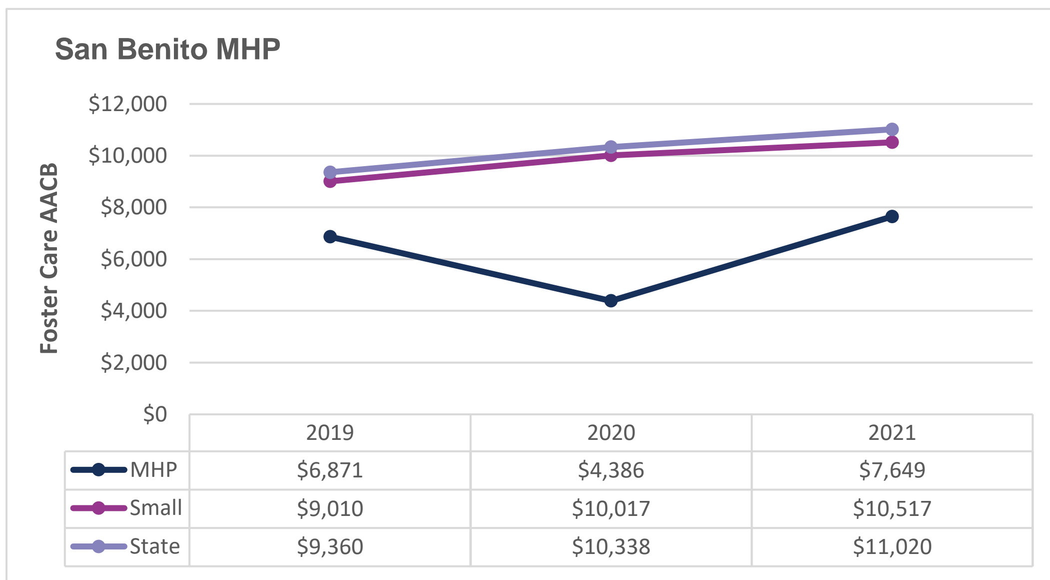
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	46.15%	55.56%	45.45%
Small	44.00%	43.16%	37.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed. The MHP's FC PR has ranged between 45 and 56 percent. It went up to 55.56 percent in CY 2020 and came down to 45.45 percent in CY 2021.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,871	$4,386	$7,649
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year. The MHP's FC AACB is consistently lower than the state averages. The MHP FC AACB went down in CY 2020 and came back up in CY 2021. In CY 2021 the MHP's FC AACB is 69 percent of the state average.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 762				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	20	2.6%	10	6	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	0	0.0%	0	0	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	28	35	2.2%	21	14
Per Minute Services							
Crisis Stabilization	19	2.5%	1,096	1,140	13.0%	1,546	1,200
Crisis Intervention	93	12.2%	325	205	12.8%	248	150
Medication Support	420	55.1%	281	253	60.1%	311	204
Mental Health Services	504	66.1%	450	255	65.1%	868	353
Targeted Case Management	228	29.9%	531	253	36.5%	434	137

- Similar proportions of San Benito adult beneficiaries served received crisis intervention and MH services compared to statewide. MHP beneficiaries received more crisis intervention and fewer MH units on average than statewide. MHP beneficiaries received an average of 450 units of MH services which is about 52 percent of the state average of 868 minutes billed.
- The MHP had lower utilization rates of medication support (55.1 percent) and targeted case management (29.9 percent) services than seen statewide (60.1 and 36.5 percent respectively). It provided a lower average of medication support units and a higher average of targeted case management units compared to statewide. Key informants indicated they were very satisfied with the services provided by case managers.
- The MHP has lower rates of adult inpatient and crisis stabilization utilization than statewide.

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

Service Category	MHP N = 24				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	18	18	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,404	1,200
Crisis Intervention	<11	-	272	272	7.5%	406	199
Medication Support	<11	-	282	252	28.2%	396	273
Therapeutic Behavioral Services	<11	-	6,821	6,821	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	457	438	40.2%	1,354	473
Intensive Home Based Services	<11	-	915	580	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	21	87.5%	1,169	832	96.3%	1,854	1,108
Targeted Case Management	16	66.7%	468	239	35.0%	342	120

- Among the 24 FC youth served, fewer than 11 FC beneficiaries received inpatient, crisis intervention, medication support, therapeutic behavioral, intensive home based and intensive care coordination services.
- As in the adult population, FC youth received a lower average number of MH services than seen statewide. The MHP's average number of MH services (1,124 minutes) is 61 percent of the state average.
- Targeted Case Management (TCM) is delivered to 64.0 percent of MHP FC youth compared to 35.0 percent statewide. The average and median units

delivered are also higher than seen statewide. It is possible that ICC services are not being fully delivered or that some are being billed as TCM.

IMPACT OF ACCESS FINDINGS

- While the MHP's PRs are consistently higher than like-sized county MHP and statewide averages, there are some notable differences between beneficiary populations that suggest disparity in access among beneficiary groups. The following warrants closer analysis and potential action:
  - Latino/Hispanics, making up 75 percent of the MHP's beneficiaries, have one of the lowest PRs in the county.
  - White beneficiaries, while only representing 14 percent of eligibles, comprise 24 percent of beneficiaries served.
  - Adults aged 21-64 and the ACA population have PRs substantially higher than the overall MHP PR.
- The MHP has a consistently low AACB which could be influenced by a number of factors, including staffing vacancies, creating capacity issues and operational issues that result in not claiming all billable services.
- The high average crisis intervention and targeted case management units, coupled with the low average MH services units, suggests that staffing vacancies are most significant with clinicians who provide therapy.

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	Partially met
2E	Psychiatric Readmission Rates	Partially met
2F	No-Shows/Cancellations	Partially met

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

- The MHP has implemented two dedicated intake days a week which has decreased the time for beneficiaries to receive clinical services and psychiatric assessments. The dedicated intake days have been particularly effective with Spanish speaking beneficiaries. However, the implementation of dedicated intake

days limits the available days for ongoing clinical services. Key informants report a high turnover in clinicians and a higher no-show rate when a beneficiary has a change in clinical staff.

- The MHP has implemented a text appointment reminder system which has improved communication to the beneficiary but did not significantly impact the no show rate.
- While 83.3 percent of first offered non-urgent appointments met the 10-day standard, approximately 30 percent of offered appointments did not result in an assessment and are not included in the percentages meeting the standards. The MHP implements a protocol to contact beneficiaries at least three times if they do not show up for an assessment.

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 ATA, representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The MHP defines urgent services as crisis calls and sets a 2-hour standard to meet the goal.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.1 Business Days	10 Business Days*	83.3%
First Non-Urgent Service Rendered	8.4 Business Days	10 Business Days**	72.8%
First Non-Urgent Psychiatry Appointment Offered	6.9 Business Days	15 Business Days*	100.0%
First Non-Urgent Psychiatry Service Rendered	7.6 Business Days	15 Business Days**	94.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.89 Hours	2 Hours**	86.0%
Follow-Up Appointments after Psychiatric Hospitalization	6.9 Days	7 Days**	74.2%
No-Show Rate – Psychiatry	10.3%	8%**	n/a
No-Show Rate – Clinicians	12.8%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

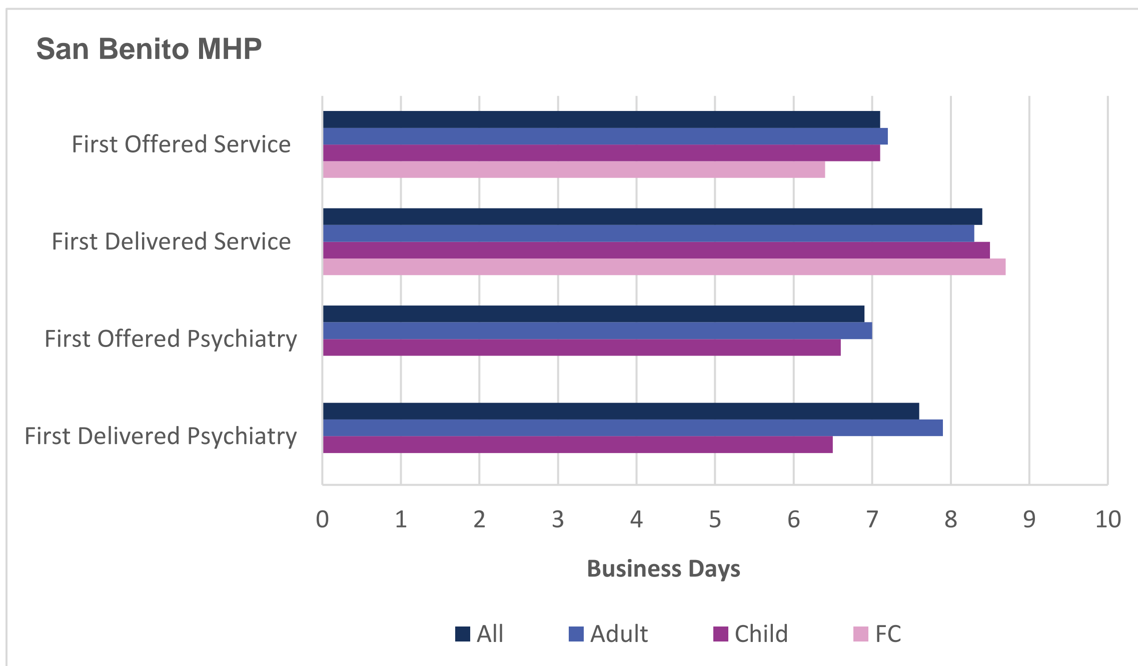


Figure 13: Wait Times for Urgent Services

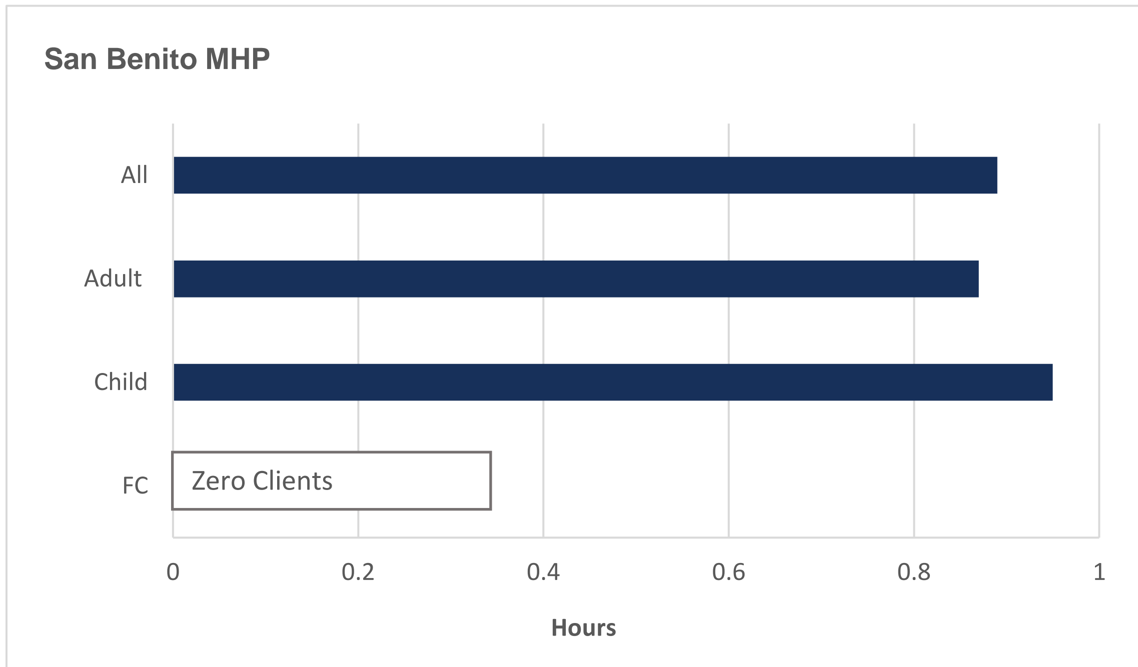
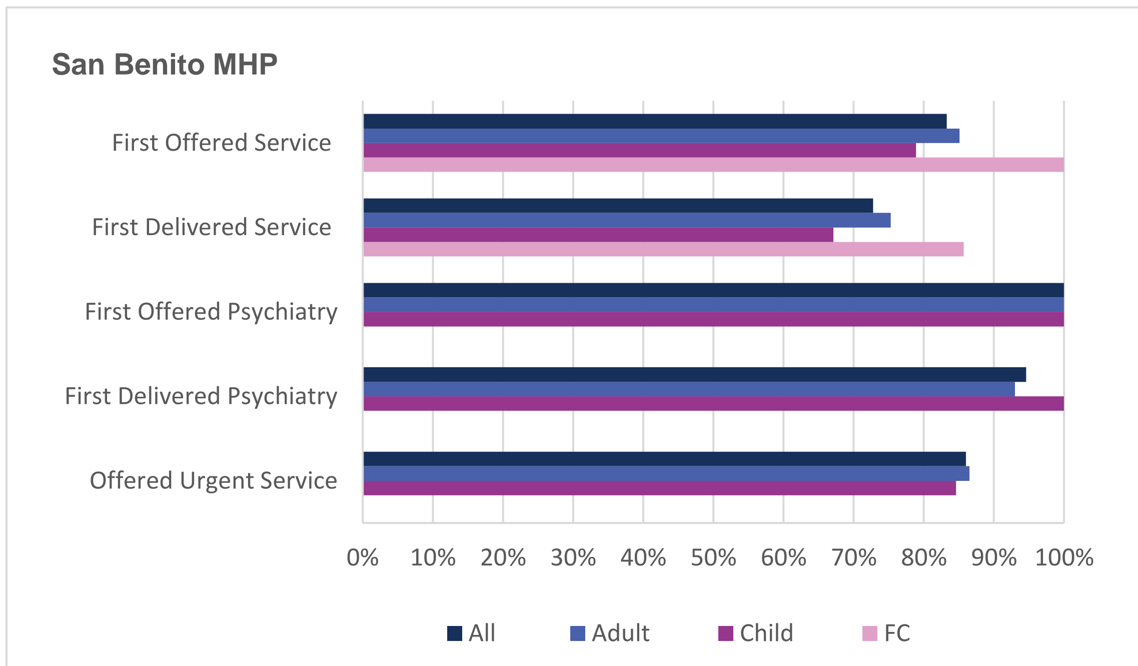


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned MH 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 beneficiaries who received an 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 services that came through crisis calls. There were reportedly 143 urgent service requests with a reported actual wait time to services for the overall population of 0.89 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 first clinical determination of need.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 10.3 percent for psychiatrists and 12.8 percent for non-psychiatry clinical staff.
- There were no FC first requests for non-urgent psychiatry, urgent appointments, psychiatric hospitalizations or readmissions during the reporting period.

IMPACT OF TIMELINESS FINDINGS

- The MHP should evaluate how dedicated intake days impact the delivery of ongoing services. While they do increase access to initial appointments there is a related loss of time for continued services which could decrease engagement.
- The MHP should analyze the approximately 30 percent of offered appointments that do not result in an assessment, and psychiatric discharges that did not have a follow-up appointment. Further exploration and possible modification of practices is warranted to ensure the needs of these beneficiaries are addressed.
- The MHP reports on data that does not meet standards they identify. Key informants cannot explain the purpose of certain data parameters. Knowing why standards are created and identifying goals to meet those parameters will aid the MHP in improving potential service delivery gaps.
- No-show data is not consistent across data collection platforms. Provided data shows multiple clinicians with a quarter to one-third no-shows, 28 beneficiaries requested a change in clinicians and the ATA data does not meet standards set by the MHP. Identifying discrepancy could aid the MHP in an understanding of accurate no-show data and potential causes.

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 responsible for the overall quality of services. It is designed to address QI and quality management to ensure beneficiaries receive fair, efficient, and cost-effective services. The QI lies within one team. The team has been reduced to four positions with one current vacancy.

The MHP monitors its quality processes through the QLC, QIWP, and the annual evaluation of the QIWP. The QLC, comprised of MHP Assistant Director; QI Supervisors; the Staff Analyst; representatives from MH, SUD, Access Team, Crisis, Medication Support, Administrative Services, and Fiscal staff, is scheduled to meet monthly. Since the previous EQR, the MHP QLC met eight times. Due to high vacancy rates and impacts of California Advancing and Innovating Medi-Cal (CalAIM) requirements, the MHP was unable to evaluate the FY 2021-22 QWIP report.

The MHP utilizes the following level of care (LOC) tools: Pediatric Symptoms Checklist (PSC-35), CANS, BECKs Depression Inventory (BDI), and a local tool called RRF used in adult services. The adult tools are used to determine the appropriate program a beneficiary should be seen in and access progress, though there is no aggregate analysis of the results. The MHP is working with Child Welfare and Probation departments on how to incorporate the CANS into the treatment process.

The MHP utilizes the following outcomes tools: PSC-35, CANS, BDI, and RRF.

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	Partially met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially met
3E	Medication Monitoring	Partially met
3F	Psychotropic Medication Monitoring for Youth	Partially met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Not met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Not met

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

- The MHP uses dashboards for tracking timeliness, crisis utilization, NA, and a dashboard designed for one of their PIPs.
- The MHP has added a tracking process to verify that clinicians are attending evidence-based practice trainings.
- While the MHP staffs a 24-hour crisis line, key informants reported that they felt the services were rushed and unsympathetic.
- The MHP does not use data from the Consumer Perception Survey (CPS) to improve services. Key informants reported the desire to have the CPS posted for review.
- The Esperanza Center employs peers with a limited number of hours. Key informants reported wanting more opportunities for paid and/or non-paid employment.
- The MHP does track but does not trend 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).
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

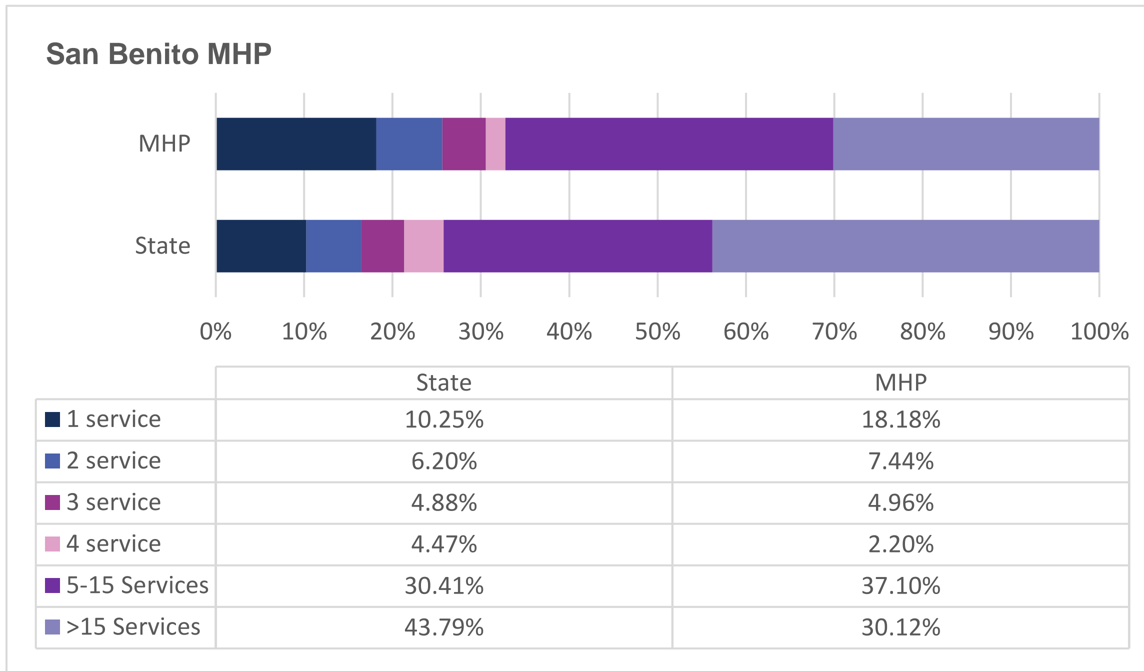
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



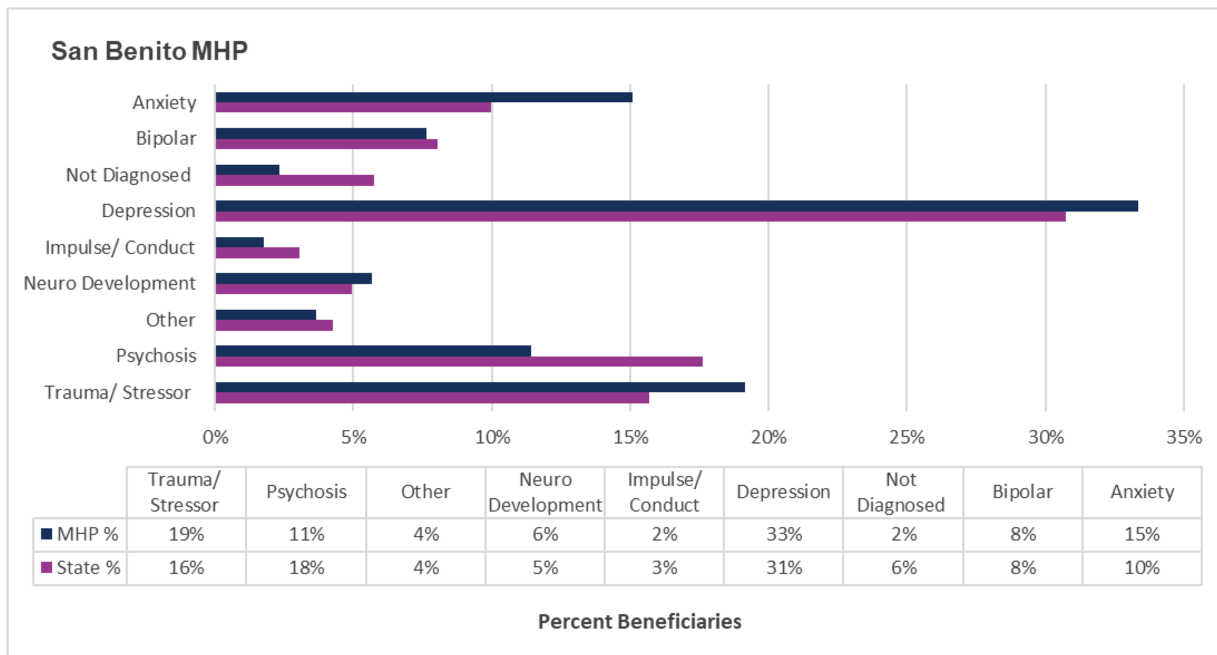
	State	MHP
1 service	10.25%	18.18%
2 service	6.20%	7.44%
3 service	4.88%	4.96%
4 service	4.47%	2.20%
5-15 Services	30.41%	37.10%
>15 Services	43.79%	30.12%

- Overall MHP beneficiaries were retained for fewer services than statewide. About one in four beneficiaries received one or two services. A larger percentage, 37.10 compared to 30.41 percent statewide, received 5-15 services. A smaller percentage, 30.12 versus 43.79 percent statewide, received more than 15 services.

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.

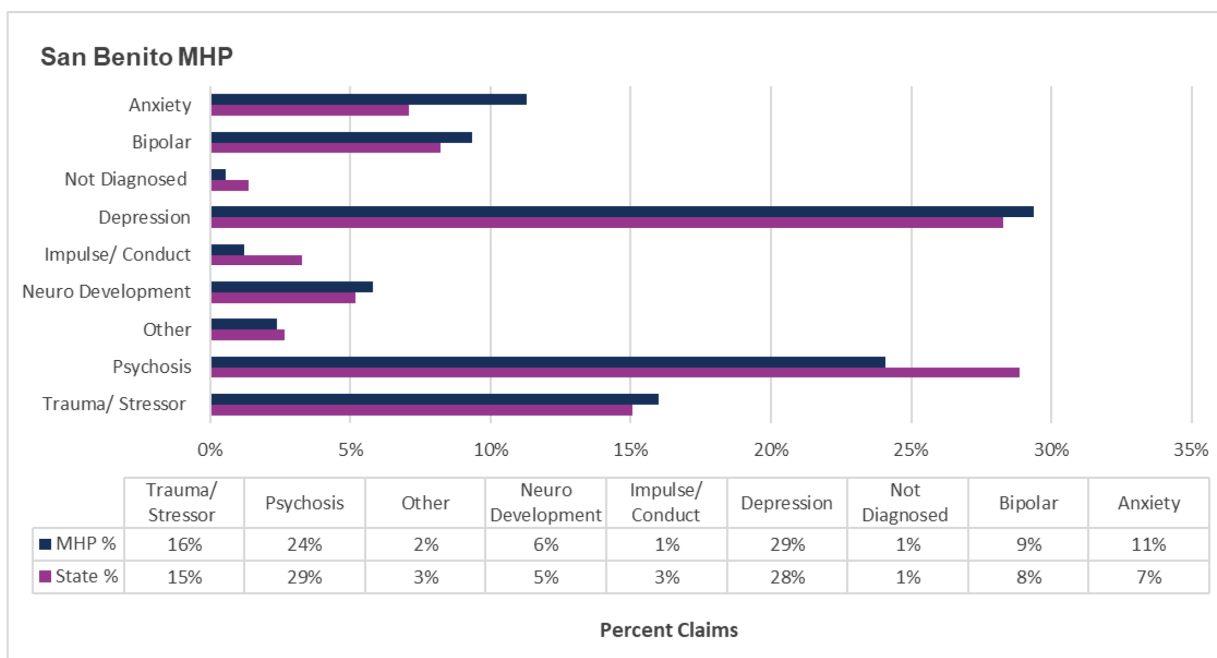
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	11%	4%	6%	2%	33%	2%	8%	15%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Two thirds of beneficiaries have one of three diagnoses: Depression (33 percent), trauma/stressor related disorders (19 percent) and anxiety (15 percent). The MHP has a higher proportion of beneficiaries with these diagnoses, and a lower proportion of psychosis, than seen statewide.

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 %	16%	24%	2%	6%	1%	29%	1%	9%	11%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Psychosis is responsible for a higher proportion (24 percent) of claims than beneficiaries (11 percent). Both diagnoses and claims are lower than the statewide proportions for psychosis.
- Similar to the diagnostic breakdown by beneficiary, the MHP has a higher proportion of approved claims for depression, trauma/stressor and anxiety diagnoses than seen statewide.

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	37	53	9.86	8.86	$13,820	$12,052	$511,340
CY 2020	45	58	7.02	8.68	$8,970	$11,814	$403,640
CY 2019	39	50	6.66	7.80	$8,069	$10,535	$314,684

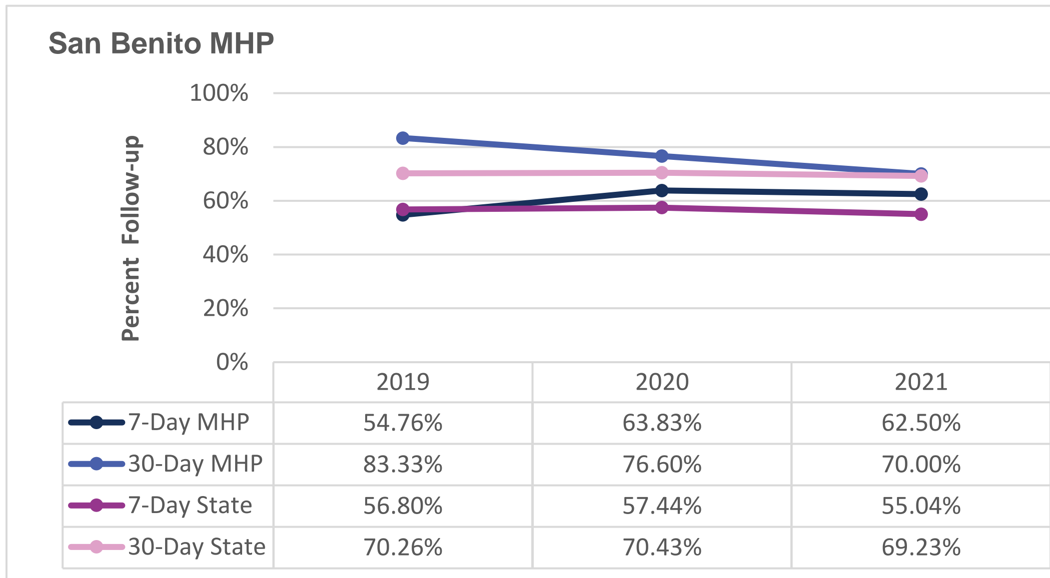
- The MHP's average LOS has been increasing each year from CY 2019 to CY 2021, while the unique beneficiary count went down in CY 2021. The MHP reported that there were some legitimate extended stays from a few beneficiaries that impacted the increase. The MHP also has a higher number of admissions per beneficiary in CY 2021 compared to the previous two years. Though the AACB rates have been traditionally lower than the statewide average, increased LOS and inpatient admissions per beneficiary contribute to the increasing psychiatric inpatient AACB in the county in CY 2021.

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.

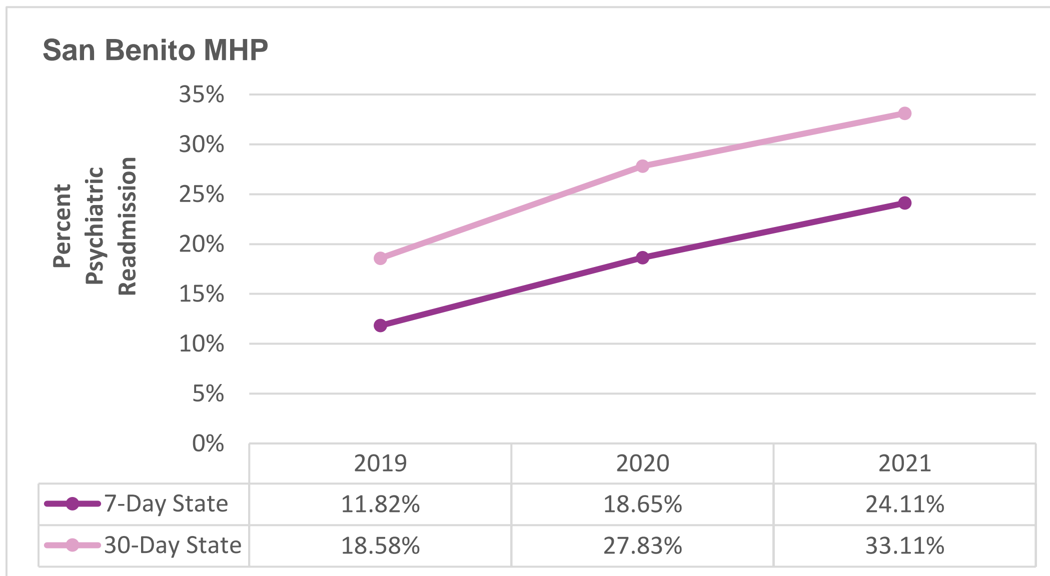
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	54.76%	63.83%	62.50%
30-Day MHP	83.33%	76.60%	70.00%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

- The MHP's inpatient follow-up rates tend to be higher than the state rates, although the 30-day MHP rate has gone down every year between CYs 2019 and 2021.

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



	2019	2020	2021
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Due to small numbers, the MHP's readmission data is not displayed in the figure above.

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 beneficiaries, 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

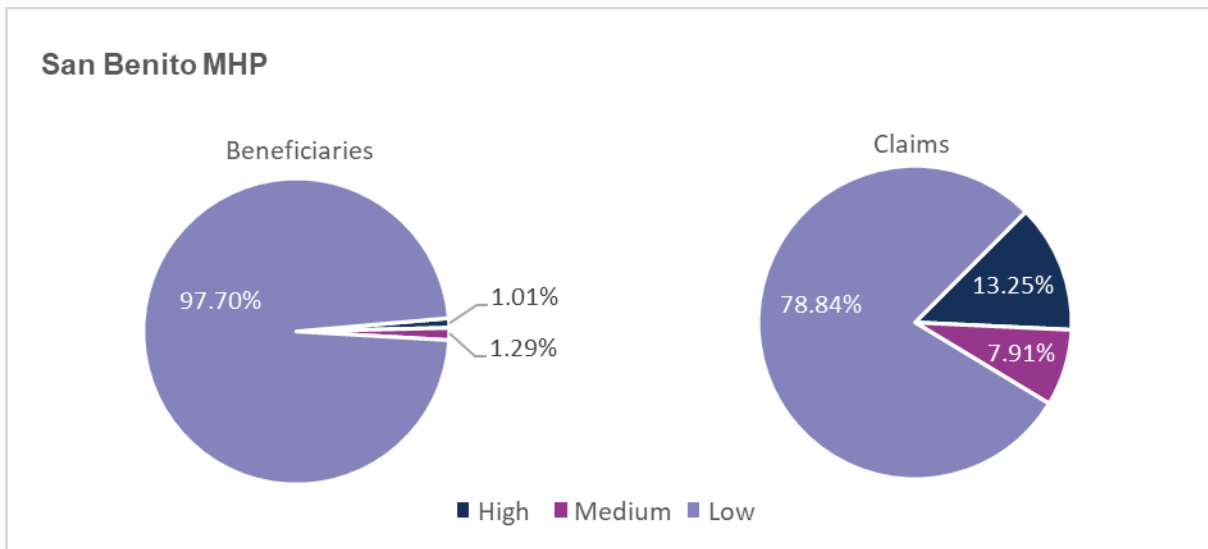
Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	11	1.01%	13.25%	$564,111	$51,283	$40,952
	CY 2020	<11	-	7.24%	$269,719	$44,953	$44,442
	CY 2019	<11	-	3.74%	$127,563	$63,781	$63,781

- The MHP has a low percentage of beneficiaries and claims that are in the HCB category.

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)	14	1.29%	7.91%	$336,808	$24,058	$23,098
Low Cost (Less than $20K)	1,064	97.70%	78.84%	$3,356,544	$3,155	$2,036

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



- Almost all beneficiaries (97.70 percent) and over three out of four approved claims are for low-cost beneficiaries. This is consistent with the low AACB and number of services provided in the county.

IMPACT OF QUALITY FINDINGS

- The low retention rates in the county, combined with a low AACB despite high PRs, and lower units of MH services, may reflect a service delivery system focused on initial contacts and challenged by providing ongoing services.
- The MHP tracks data across the delivery system but does not aggregate or identify needed improvements or specific training opportunities. Data can be used to inform the system of care.
- Key informants have identified a lack of peer paid/non-paid positions as well as the impact on clinical services when there is a high rate of clinical turnover.

Peers, beneficiaries, and family members are under utilized in both employment opportunities and system improvement conversations. Peer beneficiary/family partner staff can be an asset to the MHP when clinical vacancy rates are high.

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: "Coordination of Care to Reduce Crisis and Inpatient Services"

Date Started: 07/2021

Aim Statement: "Will the use of our S.A.F.E. team in the community, Warm Room drop-in services, and ongoing outpatient mental health services post-inpatient/ crisis help reduce the number of crisis and inpatient services over the next 24 months?"

Target Population: "The population includes all SBCBH beneficiaries who receive mental health crisis and/or psychiatric inpatient services."

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

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

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

Summary

Case management will be provided to all beneficiaries and their families/significant others, following a crisis evaluation that results in inpatient diversion. While in inpatient or crisis services, a team decision meeting (TDM) will be implemented to discuss client services to ensure proper level of care. Peer mentor intervention will be provided at the Esperanza Center's Warm Room.

PMs include percent of crisis beneficiaries who go into psychiatric inpatient following the crisis; percent of inpatient beneficiaries who are admitted to the hospital again; percent of inpatient/ crisis beneficiaries who receive a follow-up outpatient service; and the average number of outpatient services receiving within the first month following inpatient/ crisis.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the MHP provides a safety plan and follow-up outpatient services upon being released from inpatient care. Along with case management, text reminders, and the ability to participate in the Warm room to avoid additional crisis situations, allows the beneficiary to be successful in outpatient care. There are those, as reported, that will continue to relapse and be hospitalized.

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

- CalEQRO provided TA after the previous review on 05/18/22, to assist the MHP in discussion around the ongoing PIP and PMs.
- The S.A.F.E. team in the community may contribute to the decreased inpatient readmission rates. The Warm Room drop-in is only for stable and currently enrolled beneficiaries. Identifying in the final measurement the impact of both the S.A.F.E and Warm Room interventions to the reduction of readmission would assist in knowing if this PIP truly made the expected impact.
- The MHP is encouraged to engage in TA when formulating their next clinical PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Text Appointment Reminders"

Date Started: 01/2021

Date Completed: 01/2023

Aim Statement: "Will utilizing text appointment reminders help reduce the overall no-show rate for mental health outpatient appointments to 10 percent over the next 24 months?"

Target Population: "The population includes all beneficiaries who receive mental health outpatient services with SBCBH mental health treatment staff."

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

Summary

Text appointment reminders utilizing GoReminder.com and assigning staff to follow-up on cancellations and no-shows to reschedule missed appointment; will reduce the rate of the no-show visits, ensuring beneficiaries are accessing services, and staff do not lose productivity time.

PMs include percentage of no-shows/cancellations for routine outpatient and assessment appointments; percentage of beneficiaries who received a text message and responded, confirmed, or cancelled; and percentage of beneficiaries who rated the app as excellent or very good. Initial measurements for no-shows/cancellations for routine outpatient MH appointments were decreased to 15.6 percent but then increased in the last measurement by .08 percent, remaining just above the target goal of 15 percent.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the text reminders decreased no-show and cancelled appointments. Though beneficiaries did not always respond to the text, they did cancel appointments more often than simply being a no-show. Overall beneficiaries responded that it was easier to confirm appointments.

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

- CalEQRO provided TA after the previous review on 05/18/22, to assist the MHP in discussion around the ongoing PIP and PMs.
- The MHP has a high rate of clinical staff turnover and is advised to review the number of beneficiaries that acknowledge receipt of a text reminder that no-show based on the lack of ability to see the same clinician.
- The MHP is actively working on a BHQIP-PIP and will continue working with their local MCP as their next non-clinical PIP. They are encouraged to seek TA as necessary, though the MHP utilizes a paid consultant who aids in the PIP write-up and outcomes.

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 Cerner Community Behavioral Health, which has been in use for 16 years. Currently, the MHP plans to implement the CalMHSA Streamline SmartCare semi-statewide EHR in July 2023.

Approximately 2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The MHP is exploring adding an analytic position to their QI staff to provide more independence in report writing and analysis when they've converted to the SmartCare EHR.

The MHP has 49 named users with log-on authority to the EHR. All are county staff. Support for the users is provided by 0.2 full-time equivalent (FTE) IS technology positions. Because the ASP support system relies on a distributed staffing model, the MHP was not able to provide an estimated FTE for the ASP support. However, the MHP appears to receive adequate support from the ASP. Currently all positions are filled.

As of the FY 2022-23 EQR, no 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	0%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	100%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		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 plans to implement the SmartCare PHR within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff have access to secure email but exchange clinical data primarily through facsimile. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: 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	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Not Met

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

- The MHP utilizes both electronic prescribing and laboratory orders.
- The MHP implemented training on dashboards to increase utilization of the tools.
- The MHP relies on the ASP vendor and an outside consulting firm to generate all reports from the current EHR. They plan to generate some of their own reports, possibly allocating a new business analyst, after they convert to the SmartCare EHR which will provide more flexibility towards producing and analyzing data.
- The MHP has limited tablets and laptops for field-based services. Only crises reported from the emergency room, jail, and probation are responded to in person. The staff use computers in those locations to document their services.
- The MHP reported that some billable services are entered into the current EHR in a way that they cannot be billed. This is one of the factors of a low AACB and retention rate.
- The MHP is not a member of an HIE and has limited electronic exchange of data with other departments and agencies. They rely on facsimiles rather than secure email for most exchange of clinical data.
- The MHP has not determined how contract provider information will be entered into the new EHR. Currently clinical documents are sent to the MHP and uploaded into its EHR. The Fiscal Unit enters services so they can be billed to Medi-Cal.

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.

This chart 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	1,452	$336,261	$0	0.00%	$322,363
Feb	1,518	$323,506	$0	0.00%	$313,591
Mar	1,608	$353,158	$0	0.00%	$345,521
April	1,488	$345,929	$0	0.00%	$331,354
May	1,405	$332,399	$832	0.25%	$314,073
June	1,147	$274,719	$0	0.00%	$262,778
July	1,227	$336,336	$920	0.27%	$319,697
Aug	1,354	$340,947	$2,488	0.73%	$325,798
Sept	1,350	$377,415	$10,436	2.77%	$359,707
Oct	1,323	$334,995	$3,663	1.09%	$323,122
Nov	1,172	$288,743	$4,018	1.39%	$282,447
Dec	975	$234,862	$3,213	1.37%	$228,818
Total	**16,019**	**$3,879,270**	**$25,570**	**0.66%**	**$3,729,269**

- The MHP has a low claims denial rate and consistent claims volume.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	59	$13,516	52.86%
Beneficiary not eligible or non-covered charges	20	$9,530	37.27%
Other healthcare coverage must be billed before submission of claim	6	$1,994	7.80%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$531	2.08%
Total Denied Claims	**87**	**$25,571**	**100.00%**
Overall Denied Claims Rate	**0.66%**		
Statewide Overall Denied Claims Rate	**1.43%**		

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has reported that not all billable services are claimed to DHCS. As a result, performance measure data understates the services delivered and leaves the county responsible for a higher share of the cost of services. Implementation of a new EHR and CalAIM payment reform provide opportunities for new training to ensure billable services can be submitted to DHCS.
- Currently the MHP relies on their vendors for all reporting needs. The SmartCare EHR will give them better, quicker, and less expensive access to their data. They are encouraged to train analysts in report writing and explore adding a business analyst to their staff to develop internal data expertise.
- As there are requirements to expand mobile crisis services this year, the MHP should consider purchasing more tablets and laptops for field-based services.
- The MHP is not a member of an HIE. The local hospital is facing internal challenges and is unable to be an optimal partner for beginning a data exchange project. As a result, the EQRO is not making an interoperability project recommendation. The MHP should explore additional training on the use of secure email to reduce the use of facsimiles for exchanging clinical data.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The 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 collects the CPS. The MHP did not identify data to address any areas of improvement. Key informants have requested the results of the CPS be posted for review.

CONSUMER FAMILY MEMBER FOCUS GROUP

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 one 90-minute focus group 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 who initiated services in the preceding 12 months. The focus group was held virtually with consumers located at the Esperanza Center and included seven participants. All consumers participating receive clinical services from the MHP.

The beneficiaries reported receiving text reminder calls, feeling comfortable asking for a provider change, and participating in telehealth appointments. If they missed an appointment, they often had to wait a month for their next appointment. Many described not having the same clinician from appointment to appointment or having an appointment cancelled due to their clinician being on the crisis call rotation and having to attend to a crisis situation. Beneficiaries would like more information on paid and/or non-paid roles within the department and Esperanza Center. All praised the work of the case managers. Even crediting their case managers with aiding in their recovery and giving them a sense of hope.

Recommendations from focus group participants included:

- “More youth group services.”
- “Expansion of the Esperanza Center hours.”
- “Better staff communication at the main clinic between front office staff and providers.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiaries are being impacted by the high vacancy rates. They have frequent clinician changes and often feel a lack of connection with the clinician they are meeting with. Beneficiaries want to work and provide support for other peers. Providing peer opportunities could ease the pressure of the case managers who seem to be working most consistently with the beneficiaries.

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 identified two dedicated intake days and as a result have reduced their no-show rate for intakes and first appointment scheduling. (Access, Timeliness, Quality)
2. Staff utilize CANS and RRF outcomes in both supervision and when speaking with the beneficiary on goals and client care. (Quality)
3. The MHP has a low rate of inpatient hospital readmission which can be attributed to early identification of beneficiaries exiting care and intensive case management services. (Access, Timeliness, Quality)
4. The MHP increased their use of data dashboards in the last year to begin utilizing data from Timeliness and LOC tools. (IS)
5. MHP utilizes case managers to provide transportation for beneficiaries who are unable obtain other services, and intensive case management with beneficiaries in between clinical appointments. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP, having a high staff vacancy in key quality positions, was unable to address Recommendations 1 and 2, FY 2021-22. The goals will be carried over but combined as they address similar items within the QIWP. The MHP does not include new initiatives nor review impact of outcomes on the beneficiary experience within the QIWP. (Quality)
2. No show data reported on the ATA and the percentage standards set by the MHP either lack staff understanding when standards are not met or the submitted data is incomplete. Key informants report high no-show rates due to the lack of consistent clinician care. Source data delivered confirms higher no-show rates for some clinicians, which does not match the ATA data provided. The MHP is transitioning to a new EHR and will need staff training and understanding of data submitted and identified percentage standards. (Timeliness, IS)
3. The MHP includes beneficiary voice when completing the annual CPS. However, CPS results are not discussed or disseminated back to the beneficiaries. Beneficiaries are not regularly included in the QLC meetings and beneficiaries

have limited opportunities for paid or non-paid employment within the MHP. (Quality)

4. Key informants have identified a division between staff and management resulting in a high turnover rate, which has been reported to impact beneficiary care due to lack of consistency in clinicians. Though management has attempted to address this concern by enlisting a consultant to work on communication within the department, key Informants expressed the lack of inclusion in staff morale decisions and the inability to express dissatisfactions. (Quality)
5. The MHP limits their receipt of federal and state funds by not ensuring that all billable services are submitted. (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. Include new initiative outcomes and goals, and report on impact to beneficiaries, when compliance percentage goals are achieved within the QIWP. (Quality) (This is a carry-over recommendation from FY 2021-22 with a combined recommendation for goals 1 and 2.)
2. Identify realistic percentage standards when reporting on no show Timeliness data; train staff on input expectations and review outcome data quarterly to address data input barriers; and investigate the impact on beneficiary clinical retention and engagement when dedicating two days a week for intakes. (Access, Timeliness, Quality)
3. Display and post CPS results; engage beneficiary voice by holding a QLC meeting at the Esperanza Center; and identify additional areas peers can become involved in paid and/or non-paid positions within the system of care. (Quality)
4. To improve recruitment and retention, provide a line staff satisfaction survey and report outcomes to staff; engage line staff in a focus group to determine areas of improvement and a timeline to address staffing needs, to stabilize the workforce and beneficiary care. (Quality)
5. Identify and implement training and oversight activities to ensure that all billable services are submitted accurately and billed. (IS)

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, California public health emergency (PHE) was in place until February 28, 2023, and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. 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 – San Benito MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's NA
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Inclusion/Peer Employees within the System of Care
Information Systems Billing and Fiscal Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Quality Reviewer
Zena Jacobi, Information Systems Reviewer
Walter Shwe, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Abellera	Nancy	Case Management Services Manager	SBCBH
Callahan	Nancy	Consultant	IDEA
Campoy	Vanissia	MH Clinician I	SBCBH
Cendana	Maxe	QI Supervisor I	SBCBH
Clark	Wayne	Consultant	SBCBH
Coombes	Louise	Staff Analyst	SBCBH
Garfield	Lindsay	QI Sup	SBCBH
Gomez	Shannon	Clinical Supervisor Children/TAY	SBCBH
Ham	Tyler	Case Manager	SBCBH
Kendall	Regina	QI Supervisor II	SBCBH
Perez	Mark	Clinical Supervisor Adults	SBCBH
Ramer	Molly	Admin Services Manager	SBCBH
Romero	Sandra	MH Clinician II	SBCBH
Saikia	Rumi	QI Supervisor II	SBCBH
Sanchez	Maria	Case Management Services Manager	SBCBH
Wallace	Aryn	MH Nurse	SBCBH
White	Rachel	Assistant Director	SBCBH

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	MHP provides a safety plan and follow-up outpatient services upon being released from inpatient care. Along with case management, text reminders, and the ability to participate in the Warm Room to avoid additional crisis situations, allows the beneficiary to be successful in outpatient care. There are those, as reported, that will continue to relapse and be hospitalized.

General PIP Information
MHP/DMC-ODS Name: San Benito
PIP Title: "Coordination of Care to Reduce Crisis and Inpatient Services"
PIP Aim Statement:
Date Started: 07/2021
Date Completed: n/a
PIP Aim Statement: "Will the use of our S.A.F.E. team in the community, Warm Room drop-in services, and ongoing outpatient mental health services post-inpatient/ crisis help reduce the number of crisis and inpatient services over the next 24 months?"
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: The population includes all SBCBH beneficiaries who receive mental health crisis and/or psychiatric inpatient services.

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) Interact and participate with S.A.F.E team and/or Warm Room.
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) S.A.F.E. team to create a safety plan, hold TDM, provide family support services and input data into the EHR. Administration front office staff will keep a crisis log.

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
PM 1. Percent of inpatient beneficiaries who receive a follow-up outpatient service after inpatient discharge	FY 2020-21	N = 110 inpatient discharges 60 / 110 = 54.5%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 87 inpatient discharges 62 / 87 = 71.3%	☐ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Percent of crisis beneficiaries who receive a follow-up outpatient service after crisis intervention	FY 2020-21	N = 304 crisis beneficiaries 141 / 304 = 46.4%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 294 crisis beneficiaries 212 / 294 = 72.1%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
PM 3. Percent of inpatient beneficiaries with a re-admission within 6 months	FY 2020-21	N = 110 inpatient discharges 17 / 110 = 15.5%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 87 inpatient discharges 20 / 87 = 23.0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4. Average number of outpatient services received within 1 month after a crisis service	FY 2020-21	N = 141 crisis beneficiaries with followup outpatient services 752 / 141 = 5.3 services	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 212 crisis beneficiaries with follow-up outpatient services 968 / 212 = 4.6 services	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 5. Average number of outpatient services received within 1 month after an inpatient admission	FY 2020-21	N = 58 inpatient beneficiaries with outpatient services 363 / 58 = 6.3 services	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 47 inpatient beneficiaries with outpatient services 320 / 47 = 6.8 services	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 6. Percent of crisis beneficiaries who are admitted to inpatient after the crisis	FY 2020-21	N = 304 crisis beneficiaries 69 / 304 = 22.7%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	N = 294 crisis beneficiaries 48 / 294 = 16.3%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • CalEQRO provided TA after the previous review on 05/18/22, to assist the MHP in discussion around the ongoing PIP and PMs. • The S.A.F.E. team in the community may contribute to the decreased inpatient readmission rates. The Warm Room drop-in is only for stable and currently enrolled beneficiaries. Identifying in the final measurement the impact of both the S.A.F.E and Warm Room interventions to the reduction of readmission would assist in knowing if this PIP truly made the expected impact. • The MHP is encouraged to engage in TA when formulating their next clinical PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The text reminders decreased no-show and cancelled appointments. Though beneficiaries did not always respond to the text, they did cancel appointments more often than simply being a no-show. Overall beneficiaries responded that it was easier to confirm appointments.

General PIP Information
MHP/DMC-ODS Name: San Benito
PIP Title: “Text Appointment Reminders”
PIP Aim Statement: “Will utilizing text appointment reminders help reduce the overall no show rate for mental health outpatient appointments to 10% over the next 24 months?”
Date Started: 01/2021
Date Completed: 01/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): “The population will be all beneficiaries who receive routine outpatient mental health services.”

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Beneficiaries will receive text appointment reminders utilizing GoReminder.Com. Staff will be assigned to follow-up with the client when they cancel, giving them the opportunity to reschedule their appointment, as well as to reschedule beneficiaries who no-show.
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) Staff will use GoReminders.com to assign a text reminder to each outpatient client of their upcoming appointment.

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
PM 1. Percentage of noshows/ cancellations for routine outpatient MH appointments	FY 2019- 20	N = 17,113 routine outpatient appointments 3,236 / 17,113 = 18.9%	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N = 17,264 routine outpatient appts. 2,776 / 17,264 = 16.1%	☒ Yes ☐ No	☒ Yes ☐ No P-value: ☐ <.01 ☒ <.05 Other:

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
PM 2. Percentage of noshows/ cancellations for assessment appointments.	FY 2019- 20	N = 1,446 assessment appointments 27 / 1,446 = 1.9%	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N = 1,446 assessment appts. 22 / 1,446 = 1.5%	☒ Yes ☐ No	☐ Yes ☒ No P-value: ☐ <.01 ☐ <.05 Other:
PM 3. Percentage of beneficiaries who were sent a text reminder and responded.	n/a	n/a	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=2,181 texts received 420 / 2,181 = 19.3%	☐ Yes ☒ No	☐ Yes ☐ No P-value: ☐ <.01 ☐ <.05 Other:
PM 4. Percentage of beneficiaries who responded to the text reminder and confirmed the appointment.	n/a	n/a	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=420 text responses 355 / 420 = 84.5%	☐ Yes ☒ No	☐ Yes ☐ No P-value: ☐ <.01 ☐ <.05 Other:
PM 5. Percentage of beneficiaries who responded to the text reminder and canceled the appointment.	n/a	n/a	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=420 text responses 65 / 420 = 15.5%	☐ Yes ☒ No	☐ Yes ☐ No P-value: ☐ <.01 ☐ <.05 Other:

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
PM 6. Percentage of beneficiaries who rated the app. "excellent" or "very good"	n/a	n/a	☐ Not applicable—PIP is in Planning or implementation phase, results not available	N=12 surveys 12 / 12 = 100%	☒ Yes ☐ No	☒ Yes ☐ No P-value: ☐ <.01 ☒ <.05 Other:

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed

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

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

EQRO recommendations for improvement of PIP:

- CalEQRO provided TA after the previous review on 05/18/22, to assist the MHP in discussion around the ongoing PIP and PMs.
- The MHP has a high rate of clinical staff turnover and is advised to review the number of beneficiaries that acknowledge receipt of a text reminder that no-show based on the lack of ability to see the same clinician.
- The MHP is actively working on a BHQIP-PIP and will continue working with their local MCP as their next non-clinical PIP. They are encouraged to seek TA as necessary, though the MHP utilizes a paid consultant who aids in the PIP write-up and outcomes.

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.