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

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

SAN BERNARDINO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 6
MHP INFORMATION 6
SUMMARY OF FINDINGS 6
SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS 7
INTRODUCTION 9
BASIS OF THE EXTERNAL QUALITY REVIEW 9
REVIEW METHODOLOGY 9
HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE 11
MHP CHANGES AND INITIATIVES 12
ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS 12
SIGNIFICANT CHANGES AND INITIATIVES 12
RESPONSE TO FY 2021-22 RECOMMENDATIONS 14
ACCESS TO CARE 18
ACCESSING SERVICES FROM THE MHP 18
NETWORK ADEQUACY 19
ACCESS KEY COMPONENTS 19
ACCESS PERFORMANCE MEASURES 20
IMPACT OF ACCESS FINDINGS 31
TIMELINESS OF CARE 33
TIMELINESS KEY COMPONENTS 33
TIMELINESS PERFORMANCE MEASURES 34
IMPACT OF TIMELINESS FINDINGS 38
QUALITY OF CARE 39
QUALITY IN THE MHP 39
QUALITY KEY COMPONENTS 40
QUALITY PERFORMANCE MEASURES 42
IMPACT OF QUALITY FINDINGS 49
PERFORMANCE IMPROVEMENT PROJECT VALIDATION 51
CLINICAL PIP 51
NON-CLINICAL PIP 52
INFORMATION SYSTEMS 54
INFORMATION SYSTEMS IN THE MHP 54

INFORMATION SYSTEMS KEY COMPONENTS 55
INFORMATION SYSTEMS PERFORMANCE MEASURES 57
IMPACT OF INFORMATION SYSTEMS FINDINGS 58
VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE 60
CONSUMER PERCEPTION SURVEYS 60
CONSUMER FAMILY MEMBER FOCUS GROUP 60
SUMMARY OF BENEFICIARY FEEDBACK FINDINGS 62
CONCLUSIONS 64
STRENGTHS 64
OPPORTUNITIES FOR IMPROVEMENT 64
RECOMMENDATIONS 65
EXTERNAL QUALITY REVIEW BARRIERS 66
ATTACHMENTS 67
ATTACHMENT A: REVIEW AGENDA 68
ATTACHMENT B: REVIEW PARTICIPANTS 70
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY 75
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE 83
ATTACHMENT E: LETTER FROM THE DIRECTOR 84

LIST OF FIGURES

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021 23
Figure 2: MHP PR by Race/Ethnicity CY 2019-21 24
Figure 3: MHP AACB by Race/Ethnicity CY 2019-21 25
Figure 4: Overall PR CY 2019-21 25
Figure 5: Overall AACB CY 2019-21 26
Figure 6: Hispanic/Latino PR CY 2019-21 26
Figure 7: Hispanic/Latino AACB CY 2019-21 27
Figure 8: Asian/Pacific Islander PR CY 2019-21 27
Figure 9: Asian/Pacific Islander AACB CY 2019-21 28
Figure 10: Foster Care PR CY 2019-21 28
Figure 11: Foster Care AACB CY 2019-21 29
Figure 12: Wait Times to First Service and First Psychiatry Service 36
Figure 13: Wait Times for Urgent Services 36
Figure 14: Percent of Services that Met Timeliness Standards 37
Figure 15: Retention of Beneficiaries CY 2021 43
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021 44
Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021 45
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21 46
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21 47
Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021 49

LIST OF TABLES

Table A: Summary of Response to Recommendations 6
Table B: Summary of Key Components 6
Table C: Summary of PIP Submissions 7
Table D: Summary of Consumer/Family Focus Groups 7
Table 1A: MHP Alternative Access Standards, FY 2021-22 19
Table 1B: MHP Out-of-Network Access, FY 2021-22 19
Table 2: Access Key Components 20
Table 3: MHP Annual Beneficiaries Served and Total Approved Claim 21
Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021 21
Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021 22
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021 22
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021 23
Table 8: Services Delivered by the MHP to Adults 30
Table 9: Services Delivered by the MHP to Youth in Foster Care 31
Table 10: Timeliness Key Components 33
Table 11: FY 2021-22 MHP Assessment of Timely Access 35
Table 12: Quality Key Components 40
Table 13: Psychiatric Inpatient Utilization CY 2019-21 45
Table 14: HCB (Greater than $30,000) CY 2019-21 48
Table 15: Medium- and Low-Cost Beneficiaries CY 2021 48

Table 16: Contract Provider Transmission of Information to MHP EHR 55
Table 17: IS Infrastructure Key Components 56
Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims 57
Table 19: Summary of Denied Claims by Reason Code CY 2021 58
Table A1: CalEQRO Review Agenda 68
Table B1: Participants Representing the MHP and its Partners 71
Table C1: Overall Validation and Reporting of Clinical PIP Results 75
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results 78

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

MHP INFORMATION

Review Type — Virtual

Date of Review — April 4-6, 2023

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	2	4	0

Table B: Summary of Key Components

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

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Clinical	09/22	Implementation	Moderate
Optimizing the Waiting Room Experience	Non-Clinical	03/22	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
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	2

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Ongoing communication and collaboration with local Managed Care Plans (MCPs).
- Strong stakeholder communication efforts, including a structured communication plan that includes contractors, MHP staff, and beneficiaries.
- Development of children's outcome dashboards from Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) aggregate results.
- The MHP's clubhouse programs are situated throughout its major population centers, including three transitional age youth (TAY) programs, providing social and other support to beneficiaries.
- The San Bernardino County Department of Behavioral Health (DBH) has supported the creation of the Consumer Evaluation Council (CEC), which is engaged in providing feedback and advocacy regarding all matters that relate to the beneficiary experience.

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

- Continued challenges in recruitment and retaining clinical staff and psychiatry, and losses of bilingual personnel.
- Challenges in maintaining comprehensiveness and accuracy of timeliness data collection.

- Identification and resolution of issues related to return referrals between the MCPs and the MHP.
- The MHP currently has 15 of 49 Peer and Family Advocate positions vacant.
- Hospital liaison and discharge planning collaboration between the MHP and acute hospitals is not supported after-hours and weekends.

Recommendations for improvement based upon this review include:

- Consider broad implementation of non-financial benefits such as flexible schedules that target employee priorities to improve recruitment and retention efforts.
- Develop and implement a timeliness data validation process that informs MHP staff whether the data collection is comprehensive and accurate.
- Track and trend MHP/MCP bidirectional referrals for identification of potential improvement areas.
- Resolve career ladder policy decisions related to certified and non-certified peers, and determine and communicate whether new peer hires will be require certification; and proceed to rapidly recruit for and fill existing vacancies to assist with the staffing shortage.
- Expand the acute hospital/MHP liaison and discharge planning activities to include weekends and after-hours coordination.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for San Bernardino County MHP by BHC, conducted as a virtual review on April 4-6, 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 network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the Quality Assessment and Performance Improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has experienced loss of staff and difficulties with recruitment and retention. 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.

- California Advancing and Innovating Medi-Cal (CalAIM): This includes Implementation of CalAIM which incorporates numerous initiatives, including no wrong door, documentation simplification, implementation of screening and transition tools, performance improvement initiatives, payment reform and others. The MHP desires more interactive discussions with the DHCS to be able to correctly implement related changes.
- San Bernardino MHP hired new personnel into core leadership positions, including: Deputy Director for the Forensics Division, three Associate Medical Directors hired into Children's Services, Substance Use Disorder and Recovery Services, and Forensic Services.
- Non-CalAIM changes introduced by the DHCS have stretched the MHP's ability to support continual changes across the system. This includes the new Annual County Monitoring Activities (ACMA) which was created to streamline county submissions from triennially to annually, avoiding duplication but increasing the frequency this reporting must occur. The MHP has found that the 274 submission process has increased the work involved with Network Adequacy, rather than reducing the involved work as originally envisioned.
- The MHP is involved in the process of training and certification of peers, with 194 CalMHSA training scholarships, assisting 30 individuals in completing the 80-hour training, and supporting 5 in becoming fully certified. San Bernardino DBH was first in the state to certify a peer specialist.
- The MHP has expanded their enhanced care management (ECM) into four regional teams. This includes a whole person approach to physical and mental

health care and involves a focus on social supports. There are plans to extend ECM to forensic outpatient clinics to support those released from incarceration.

- The MHP has created the Revenue Cycle Unit, which will address the processing of all claims, separating technical staff from fiscal staff, with anticipation of greater efficiency.
- Family Urgent Response Services (FURS): A collaborate effort by Child and Family Services, Probation and DBH, the local FURS implementation has been utilized less than anticipated. DBH and partners are looking at strategies that result in increased utilization of this resource.
- Qualified Individual (QI) Assessment: The MHP has completed 45 to 60 assessments per month, all within the required time-frame of 30 calendar days from QI referral or date of placement in a Short-Term Residential Therapeutic Program (STRTP), for determination if a STRTP is appropriate to a child’s needs.

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: Include in the development of recruitment and retention strategies a focus on bilingual/bicultural personnel to develop a workforce that can better engage and serve the Latino/Hispanic and Spanish-speaking beneficiaries.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is collaborating with Human Resources regarding the needs for all types of staff, particularly those bilingual in English and Spanish. In addition, the desired qualifications of those fluent in American Sign Language, Arabic, Korean, Mandarin, and Vietnamese are encouraged to apply.
- The MHP intends to conduct stakeholder meetings that could improve recruitment efforts through various important contacts such as the Mexican Consulate, Latino, Asian Pacific Islander, and Native American Awareness Committees. Through this input the MHP anticipates identification of key communication channels that will attract qualified staff, including partnerships with local higher education institutions.
- From September 2021 to September 2022, Spanish speaking service provider numbers decreased by 15 percent (117 to 88), which highlights the importance of this recommendation. Current strategies have yet to significantly impact the current personnel status and requires more attention and consideration of innovative solutions. This could include development of paid internships for individuals engaged in master's and doctoral programs.

- This recommendation will be modified and continued for the coming period, with the anticipation of additional innovative recruitment and retention strategies that provide more results.

Recommendation 2: Incorporate the Consumer Perception Survey (CPS) results as a tracked item in the QAPI plan; and, develop a mechanism to periodically share results with stakeholders via website postings once the analysis has been performed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has included the CPS results in the Quality Improvement Performance Plan (QIPP).
- The MHP added goals to the FY 2022-23 QIPP to be used in trend identification and discussion during Quality Management Action Committee (QMAC).
- Discussion about posting CPS results to the website occurred, as were other methods of sharing this information with stakeholders. More action is anticipated in this area during the coming year.

Recommendation 3: Prominently include the clubhouse participation policy with website information that describes and identifies clubhouse locations, ensuring that there is broader comprehension of participation requirements.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP included in the website description of clubhouse services: "Individuals may or may not be accessing clinical services." This clarifies that involvement in treatment is not a requirement.

Recommendation 4: Develop a clinical telehealth policy that details the clinical guidelines for approval or denial, as well as describes the process for review or appeal of rendered decisions and assures consistency in decision making.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has developed a draft clinical telehealth policy that provides guidance for approval or denial of these requests. Policy completion is anticipated by June 2023.
- The draft clinical telehealth policy constitutes sufficient progress to consider this recommendation as partially addressed. Continuation of this recommendation is not needed for this current review period due to planned finalization by summer 2023.

Recommendation 5: Consider alternative options to address the 25 percent psychiatry vacancy rate and associated extended wait times, such as through contract hires of

psychiatrists who provide 100 percent telehealth services as an interim solution to in-person coverage.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP cited a number of remedies to see improved stability of psychiatry/prescriber coverage. These include posting physician recruitment advertising in social media, locum tenens temporary coverage, a MHP sponsored psychiatry hiring fair, and outreach through residents in training.
- The MHP also notes that it met the 2022 NACT standards and was in compliance with both adult and child/youth psychiatry ratios.
- Wherever possible, the MHP advocates for in-person psychiatry services, believing this approach is the higher standard of care. There is also internal redistribution of psychiatry coverage through telehealth when required.
- The need in this area is highlighted by the MHP's self-report of first non-urgent psychiatry service delivered, which in FY 2021-22 overall had a 41.0-day average for this review period for both adults and children/youth.
- This recommendation is partially addressed by the MHP efforts at improved recruitments and incentives and will be continued in a modified form for this review period.

Recommendation 6: Develop actions to address and improve the self-reported MHP's FY2020-21 results of adult post-hospital 30-day follow-up (30.19 percent) and readmission rates (29.68 percent).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP created a workgroup with participants from Quality Management (QM), outpatient clinics, and 24-hour emergency services to address hospital discharge processes. The intent is to promote opportunities for discharge planning coordination and follow-up/post discharge contact. This is intended to improve and standardize hospital discharge coordination procedures.
- The MHP is also starting a "Top 50 Hospital Readmissions Workgroup," to focus on those who utilize the emergency department as their routine medical provider. This will address readmissions for both those who have an existing connection to MHP services as well as those yet unlinked to services.
- In reference to the self-reported data that served as the foundation of this recommendation in the FY 2021-22 review period, for the current review period of FY 2022-23 (MHP self-report data from FY 2021-22), the 30-day post-hospital discharge follow-up for adults was 27.8 percent, and the 30-day readmission rate for adults was 30 percent.
- This recommendation will be continued in modified form, encouraging the development of a hospital liaison process that ensures all hospital discharges

receive active coordination with MHP and/or contract provider team that assures discharge coordination.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 40.1 percent of services were delivered by county-operated/staffed clinics and sites, and 59.9 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 72.7 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; with after-hours coverage provided by MHP clinic volunteers. Beneficiaries may request services through the Access Line as well as direct presentation to MHP clinics, whereby an assessment is performed and services provided until step-down to MCP appears appropriate and the DHCS transition tool is utilized. The MHP's centralized access team is responsible for linking beneficiaries to appropriate, medically necessary services, using the DHCS screening tool. Beneficiaries are referred to the MCP if scoring five or below on the DHCS screening tool, or to an appropriate regional MHP clinic if six or above, wherein a clinical assessment occurs and needed services are provided.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 2,858 adult beneficiaries, 10,027 youth beneficiaries, and 74 older adult beneficiaries across 28 county-operated sites and 87 contractor-operated sites. Among those served, 1,327 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

For San Bernardino County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

- 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
OON Details	

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

ACCESS KEY COMPONENTS

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

the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

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

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

- As with many of its MHP peers, DBH faces challenges with recruitment and retention of staff, particularly of licensed clinicians and psychiatrists/other prescribers. While the MHP identified a number of strategies for improving results of recruitment efforts, options such as work-from-home and other flexible work schedules show promise for improving stability in critical staffing areas. The development of a clinical telehealth policy that provides decision support for telehealth service requests may offer another avenue to increase options for flexible work schedules.
- Collaboration is a strength for this MHP on multiple levels. Collaboration with MCPs is an area of strong collaboration for the MHP, including regular recurring meetings and a presence in several sessions during this review.

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, the MHP's PR of 3.53 percent was 18.7 percent lower than the statewide average, and the average claim amount of $6,137 was 17.9 percent less than the statewide average.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	929,179	32,787	3.53%	$201,229,529	$6,137
CY 2020	870,276	31,028	3.57%	$150,019,660	$4,835
CY 2019	860,693	35,583	4.13%	$177,317,171	$4,983

- While declining from CY 2019 to CY 2020, annual eligibles and AACB increased from CY 2020 to CY 2021. The PR was stable from CY 2020 to CY 2021.

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	106,962	2,439	2.28%	1.69%	1.96%
Ages 6-17	243,208	11,483	4.72%	5.40%	5.93%
Ages 18-20	51,705	1,636	3.16%	4.06%	4.41%
Ages 21-64	457,477	16,309	3.56%	4.24%	4.56%
Ages 65+	69,828	920	1.32%	1.69%	1.95%
Total	**929,179**	**32,787**	**3.53%**	**3.99%**	**4.34%**

- While PR was higher than similar sized counties and the statewide average for those aged 0-5, PRs for all other age groups were lower than both similar sized counties and 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	2,973	9.07%
Vietnamese	54	0.16%
Mandarin	23	0.07%
Total Threshold Languages	**3,050**	**9.30%**
Threshold language source: Open Data per BHIN 20-070		

- San Bernardino had three threshold languages other than English in CY 2021, Spanish, Vietnamese, and Mandarin. There were 3,050 beneficiaries served and 9.07 percent identified Spanish as a preferred language. The MHP served 54 beneficiaries, 0.16 percent of the total served, who identified Vietnamese as a preferred language and 23 beneficiaries, 0.07 percent of the total served, who identified Mandarin as a preferred 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	267,916	7,880	2.94%	$46,633,840	$5,918
Large	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. While the MHP's CY 2021 overall PR was 3.53 percent, the ACA PR was 2.94 percent, mirroring the statewide trend of a lower ACA penetration rate.
- The ACA PR was 22.8 percent lower than the statewide rate (2.94 percent vs. 3.81 percent) and the AACB was 7.3 percent less than the statewide average ($5,918 vs. $6,383).

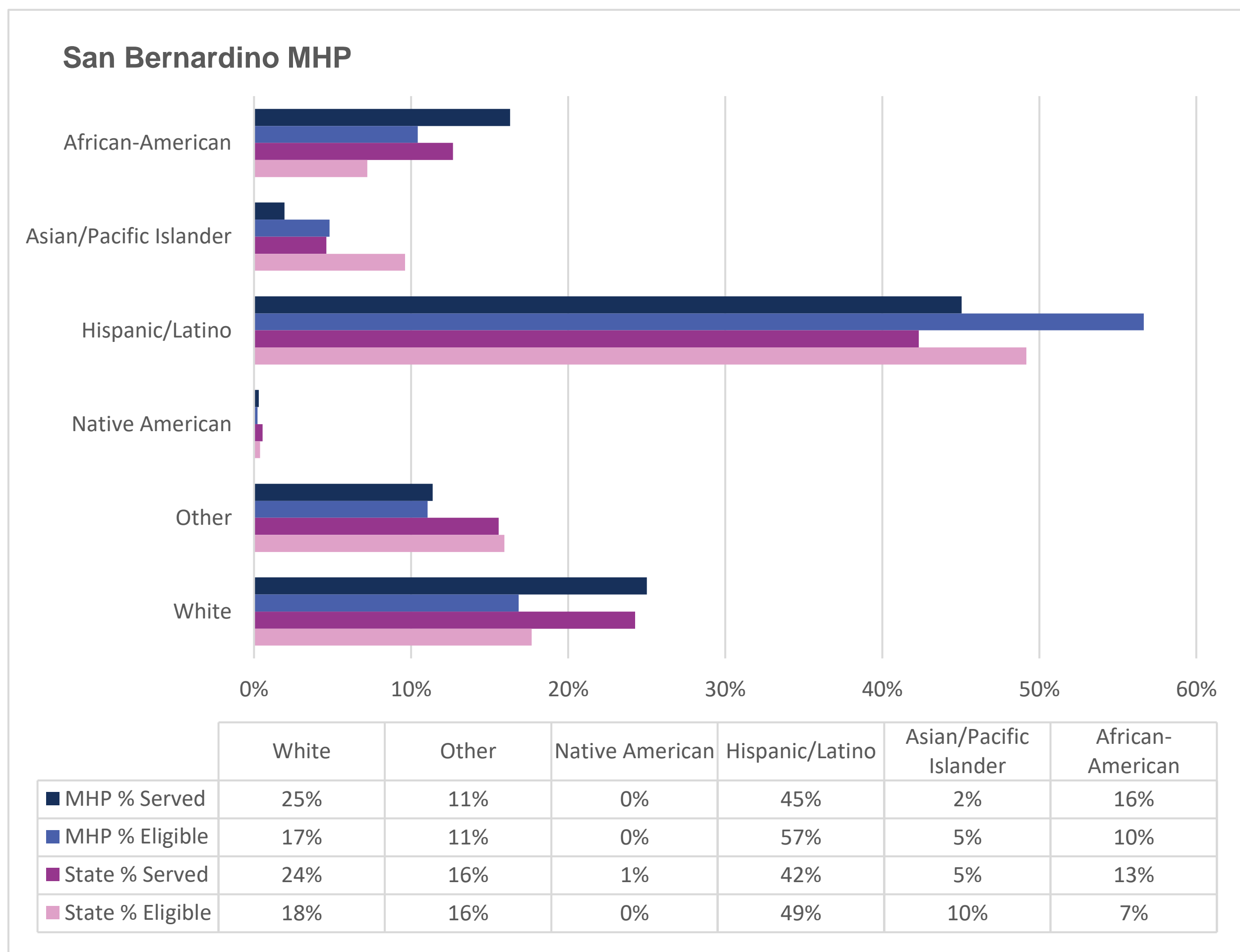
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	96,803	5,345	5.52%	7.64%
Asian/Pacific Islander	44,619	637	1.43%	2.08%
Hispanic/Latino	526,408	14,774	2.81%	3.74%
Native American	2,112	102	4.83%	6.33%
Other	102,754	3,730	3.63%	4.25%
White	156,486	8,199	5.24%	5.96%
Total	**929,182**	**32,787**	**3.53%**	**4.34%**

- San Bernardino served 32,787 beneficiaries in CY 2021. The eligible population was largely comprised of Hispanic/Latinos, who represented 57 percent of all eligibles. PRs for all race/ethnicity groups were lower than corresponding statewide rates.

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

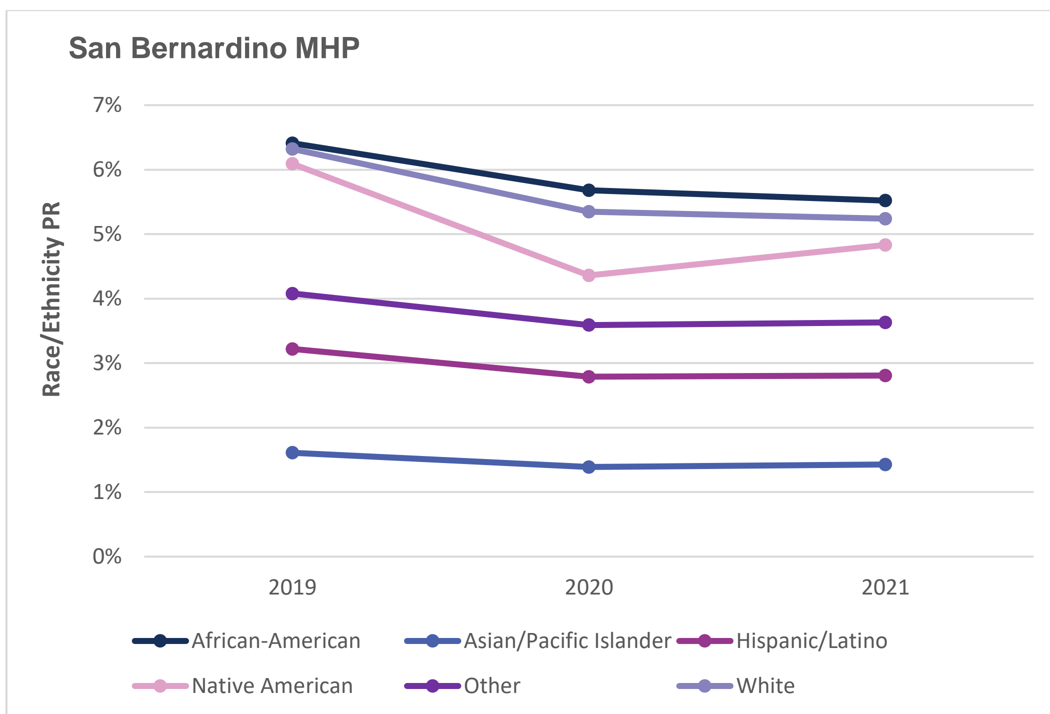


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	25%	11%	0%	45%	2%	16%
MHP % Eligible	17%	11%	0%	57%	5%	10%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- While the Hispanic/Latino population comprised 57 percent of the eligible population, 45 percent of those served were Hispanic/Latino. Whites comprised the next largest race/ethnicity group, compromising 17 percent of the eligible population and 25 percent of those served. The lower percent of Hispanic/Latinos served compared to the eligible population indicates that this population may be underserved.

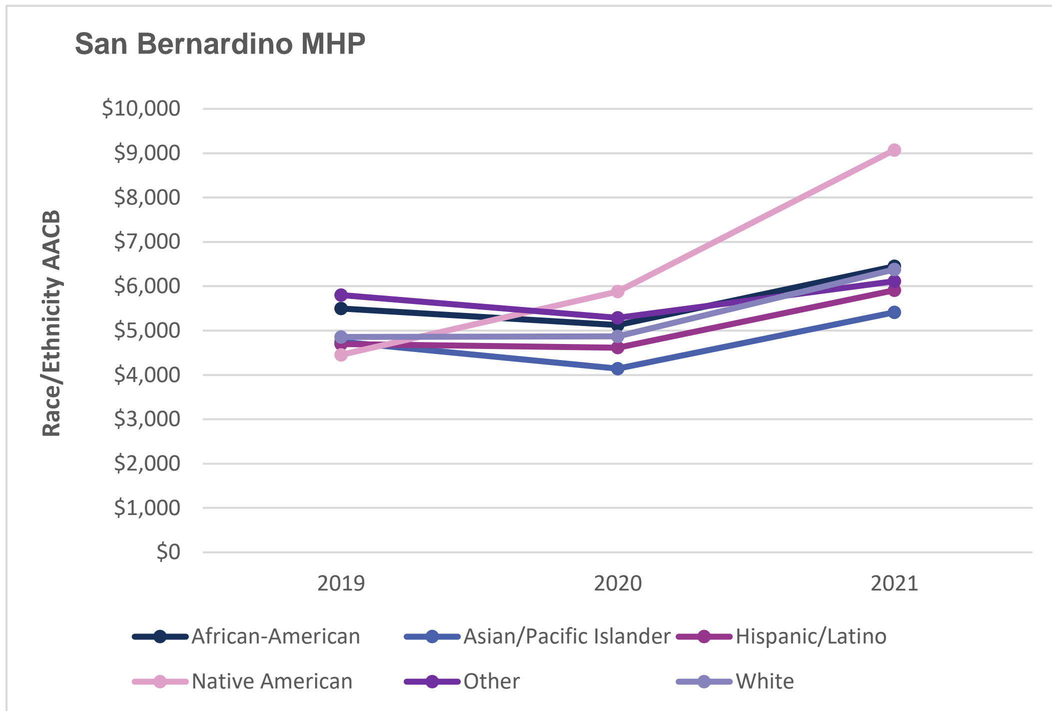
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



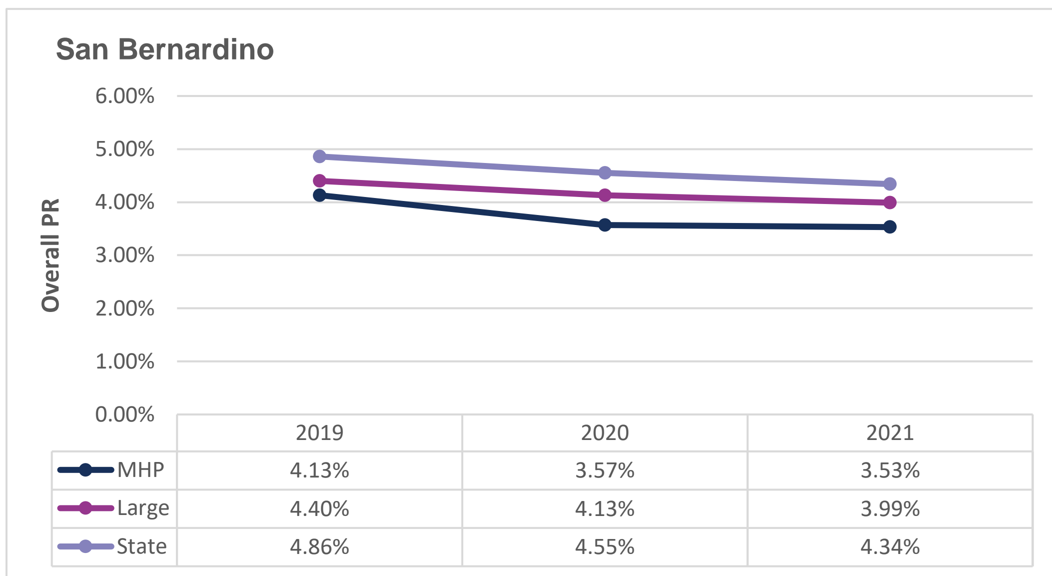
- From CY 2019 to CY 2021, Hispanic/Latino and Asian/Pacific Islander PRs were consistently the lowest while White, Native American, and African American had the highest PRs. While the Native American PR increased from CY 2020 to CY 2021, African American and White PRs declined and Asian/Pacific Islander, Latino/Hispanic and Other were stable. It should be noted that 102 Native Americans were served, and lower beneficiary counts can cause greater year over year variations in the data.

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



- AACB for all race/ethnicity groups increased from CY 2020 to CY 2021, with Native American having the greatest increase. It should be noted that 102 Native Americans were served, and lower beneficiary counts can cause greater year over year variations in the percentage data.

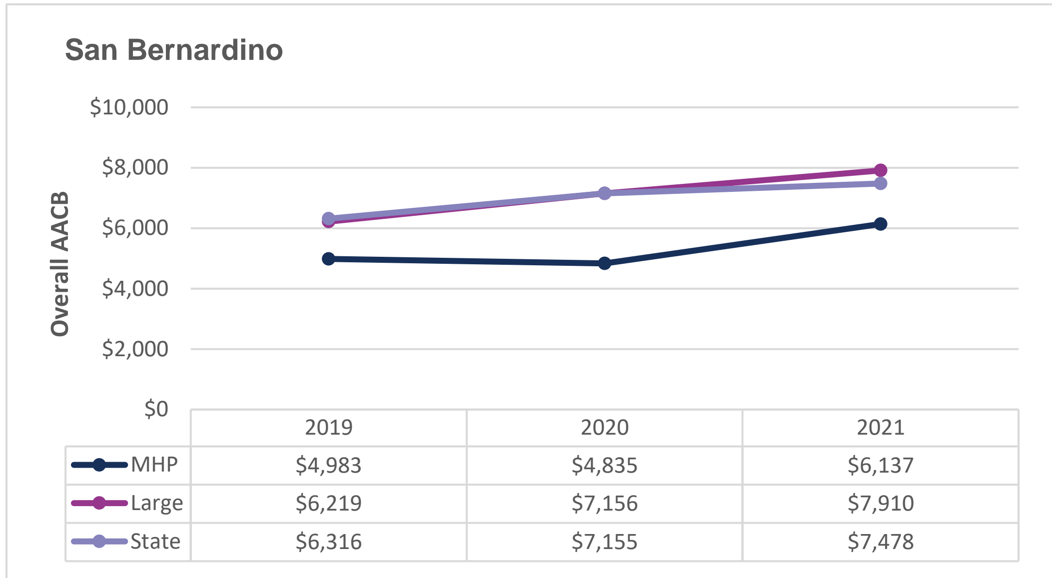
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.13%	3.57%	3.53%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

- While the overall PR declined from CY 2019 to CY 2020, it was stable from CY 2020 to CY 2021 (3.57 percent vs. 3.53 percent). PR was lower than that of large and statewide rates from CY 2019 to CY 2021.

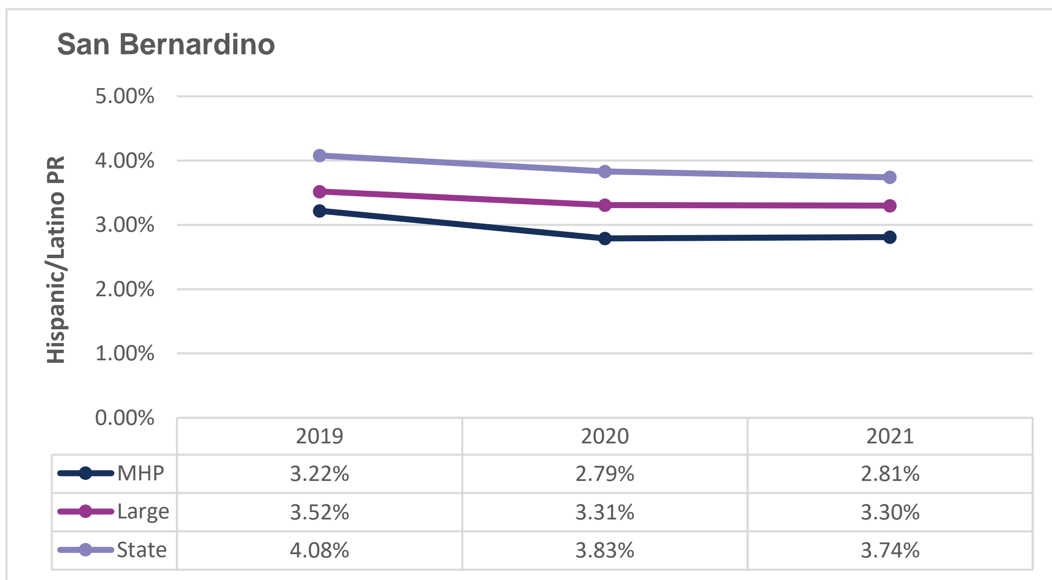
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,983	$4,835	$6,137
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

- While the overall AACB increased 26.9 percent from CY 2020 to CY 2021 ($4,835 vs. $6,137), AACB remained below that of large county and statewide averages in CY 2021.

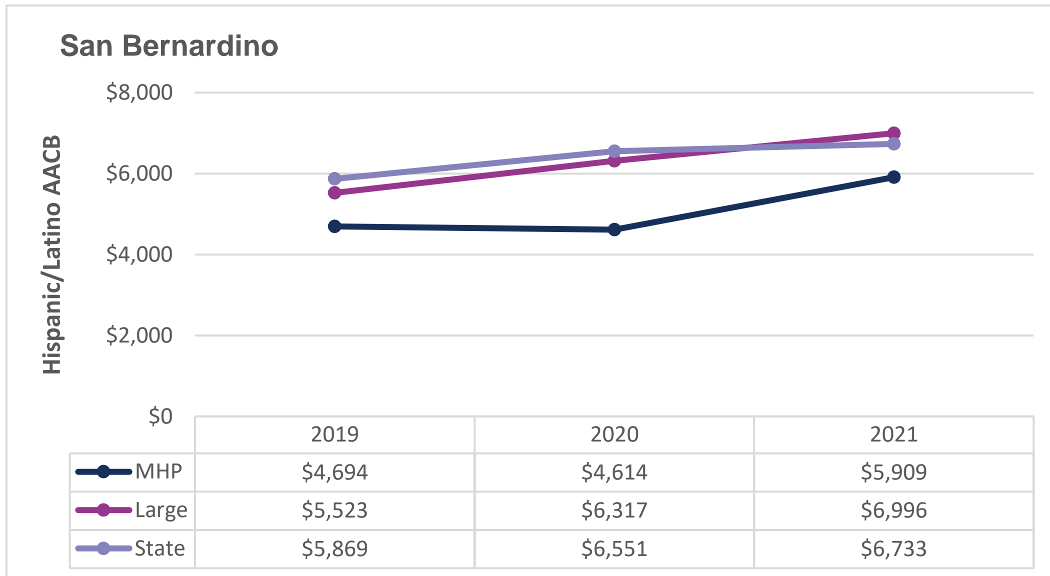
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.22%	2.79%	2.81%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

- The Hispanic/Latino PR was lower than large county and statewide rates from CY 2019 to CY 2021.

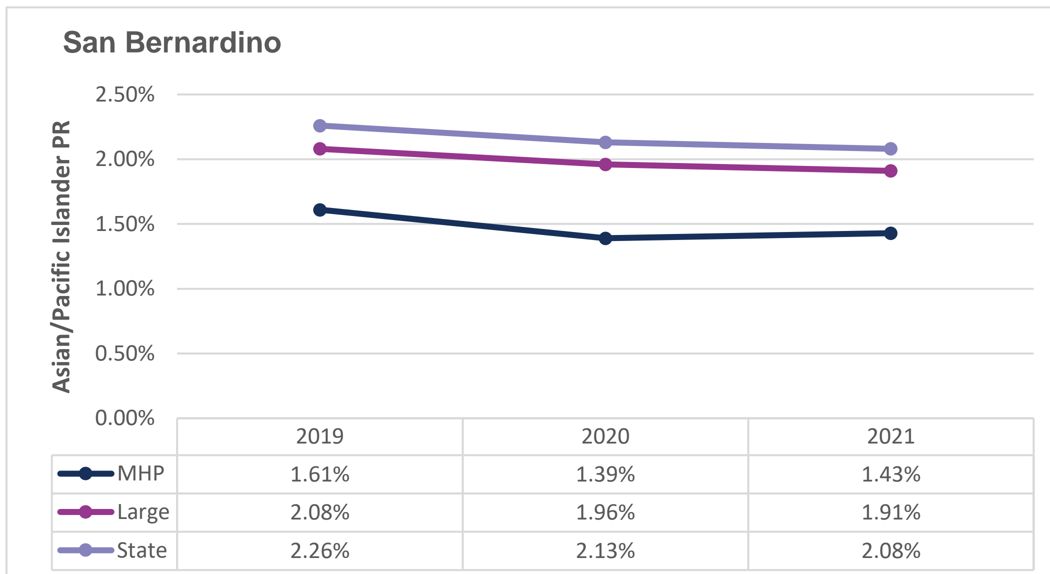
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,694	$4,614	$5,909
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

- While the MHP's Hispanic/Latino AACB increased 28.1 percent from CY 2020 to CY 2021 ($4,614 vs. $5,909), their AACB remained below that of large county and statewide averages in CY 2021.

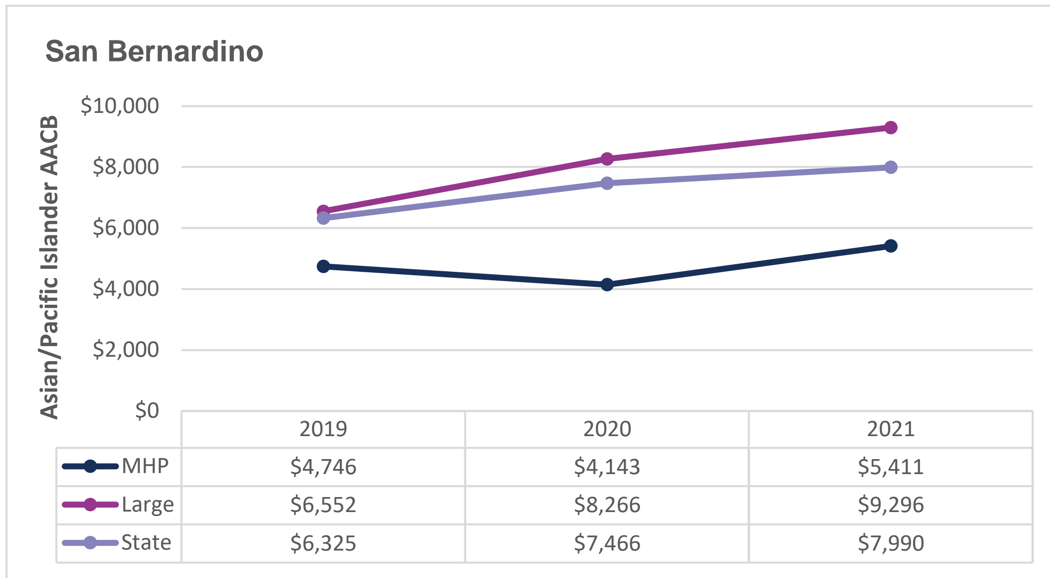
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.61%	1.39%	1.43%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

- The Asian/Pacific Islander PR was lower than both large county and statewide rates from CY 2019 to CY 2021.

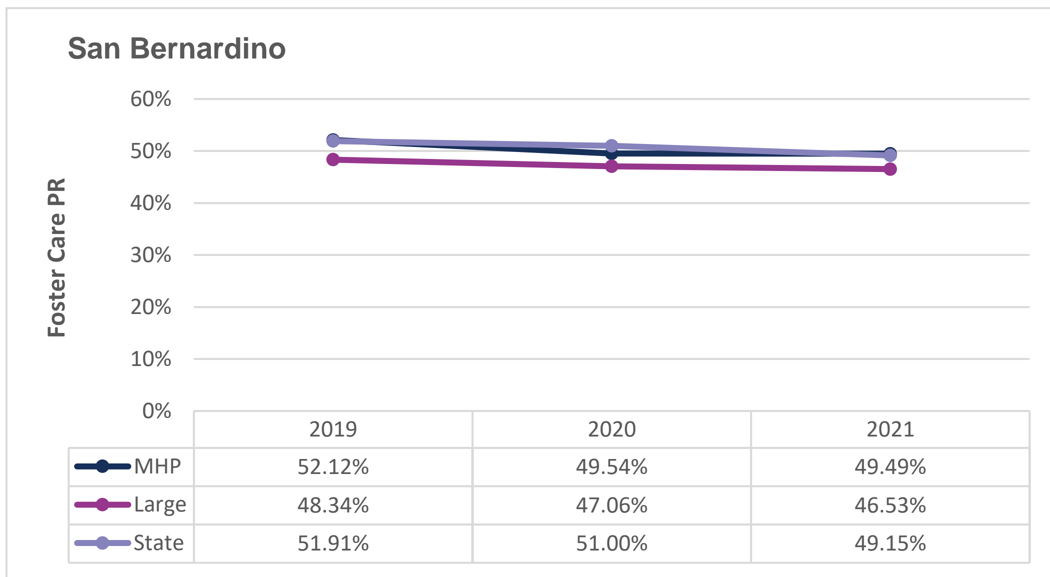
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$4,746	$4,143	$5,411
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

- While the Asian/Pacific Islander AACB increased 30.6 percent from CY 2020 to CY 2021 ($4,143 vs. $5,411), AACB remained below that of large county and statewide averages in CY 2021.

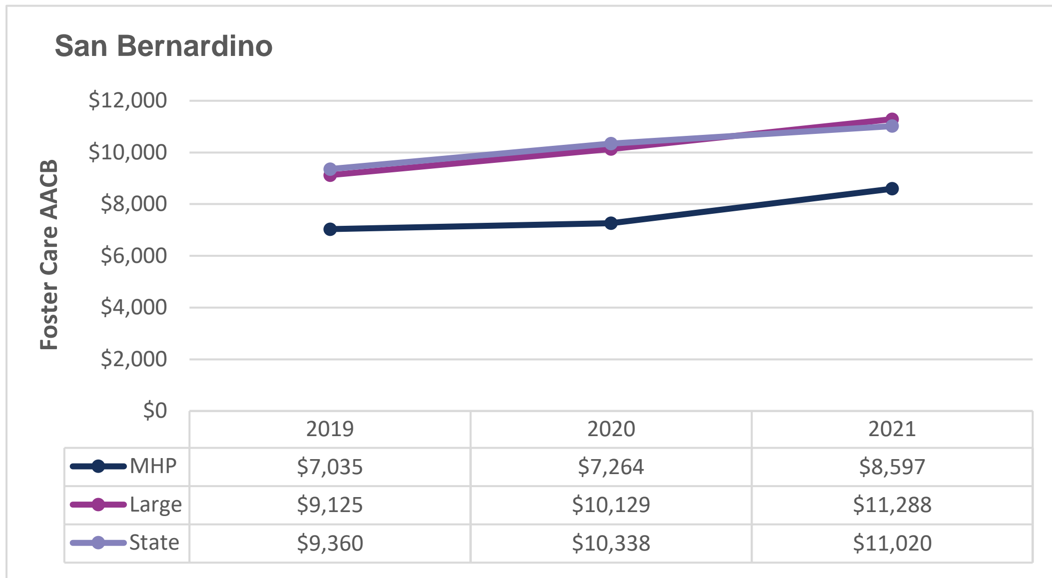
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	52.12%	49.54%	49.49%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- FC PR was stable from CY 2020 to CY 2021 (49.54 percent vs. 49.49 percent), and in CY 2021 exceeded the large county rate (49.49 percent vs 46.53 percent) while being comparable to the statewide rate (49.49 percent vs. 49.15 percent).

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,035	$7,264	$8,597
Large	$9,125	$10,129	$11,288
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- Statewide, large county, and the MHP's FC AACB has increased each year from CY 2019 to CY 2021. While the MHP's AACB increased 18.4 percent from CY 2020 to CY 2021 ($7,264 vs. $8,597), it was lower than both the large county and statewide CY 2021 rates.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 18,869				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	2,826	15.0%	7	4	11.6%	16	8
Inpatient Admin	53	0.3%	39	12	0.5%	23	7
Psychiatric Health Facility	15	0.1%	8	5	1.3%	15	7
Residential	85	0.5%	168	151	0.4%	107	79
Crisis Residential	432	2.3%	47	38	2.2%	21	14
Per Minute Services							
Crisis Stabilization	3,740	19.8%	1,212	780	13.0%	1,546	1,200
Crisis Intervention	3,397	18.0%	144	90	12.8%	248	150
Medication Support	11,439	60.6%	272	199	60.1%	311	204
Mental Health Services	10,729	56.9%	730	270	65.1%	868	353
Targeted Case Management	2,340	12.4%	258	95	36.5%	434	137

- Compared to statewide rates, San Bernardino had a notably lower percentage of beneficiaries receiving psychiatric health facility and targeted case management services.
- A higher percentage of beneficiaries received crisis stabilization and crisis intervention services compared to statewide rates.

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

Service Category	MHP N = 4,086				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	159	3.9%	10	6	4.5%	14	9
Inpatient Admin	<11	-	2	1	0.0%	5	4
Psychiatric Health Facility	<11	-	24	22	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	26	17	0.1%	18	13
Full Day Intensive	<11	-	180	180	0.2%	582	441
Full Day Rehab	12	0.3%	34	36	0.5%	97	78
Per Minute Services							
Crisis Stabilization	129	3.2%	1,315	900	3.1%	1,404	1,200
Crisis Intervention	188	4.6%	250	151	7.5%	406	199
Medication Support	1,208	29.6%	339	270	28.2%	396	273
TBS	181	4.4%	3,626	2,193	4.0%	4,020	2,373
Therapeutic FC	<11	-	165	165	0.1%	1,030	420
Intensive Care Coordination	2,062	50.5%	940	326	40.2%	1,354	473
Intensive Home Based Services	586	14.3%	1,600	877	20.4%	2,260	1,275
Katie-A-Like	<11	-	1,043	1,020	0.2%	640	148
Mental Health Services	3,918	95.9%	1,821	1,093	96.3%	1,854	1,108
Targeted Case Management	499	12.2%	249	88	35.0%	342	120

- Compared to statewide rates, San Bernardino FC youth had a notably lower percentage of beneficiaries receiving targeted case management but more receiving intensive care coordination.
- A lower percentage of MHP FC youth received intensive home based services, and those who received it received fewer units of service on average.

IMPACT OF ACCESS FINDINGS

- San Bernardino had three threshold languages other than English in CY 2021, Spanish, Vietnamese, and Mandarin. There were 3,050 beneficiaries served and

9.07 percent identified Spanish as a preferred language. From September 2021 to September 2022, the decline of Spanish speaking service provider staff was reported by the MH to be approximately 15% (117 staff to 99 staff). The MHP may consider assessing the adequacy of Spanish speaking service providers to establish if beneficiary need is being met.

- While the Hispanic/Latino population comprised 57 percent of the eligible population, 45 percent of those served were Hispanic/Latino. The lower percent of Hispanic/Latinos served compared to the eligible population indicates that this population may be underserved.
- All non-White populations served by the MHP are served at a rate much lower than their presence in the eligible population, and lower that the statewide average and large MHP average. This reinforces the notion that the MHP should apply itself to the diverse recruitment of clinical staff, which is one aspect of improving services to these populations. Evaluation of outreach and stigma-fighting efforts should also be considered.

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	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Met

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

- The MHP reports the use of a custom Initial Contact Log (ICL) form located within the EHR. The MHP reports discovery of issues that impact the use of the form and usability of the data. The form and users guide were revised, and the

MHP looks forward to improved results as this form is implemented, and staff training is provided.

- The MHP's first non-urgent request to first offered psychiatry appointment results has an overall average of 8.5 days, and of the subpopulations Children's Services are longest at 12.9 days on average. However, the total events reported are 399, which is quite low when considered against the backdrop of other MHPs. Most stakeholders directly involved in care suggested that wait time for psychiatry can range from days to weeks, to as much as one to two months, depending upon program. The MHP might wish to develop a mechanism to compare its total timeliness events with the new beneficiaries registered over a period who received a first psychiatry visit in order to validate the completeness of their event capture process. The MHP also mentioned finding that there has been an issue with the accuracy of the event capture process, which it is seeking to correct and improve. Because of the variance between key stakeholder feedback and MHP's data, plus the strong likelihood that these events are currently under-reported when comparisons with other MHPs are performed, this key component is considered partially met.
- While the overall average is 71 hours for the 48-hour urgent standard, Children's comes closest of all groups to attaining the standard at 50.9 hours. With revisions to the ICL form, the MHP anticipates improvements in accuracy as the form comes online and the training occurs.
- Follow-up services after psychiatry hospitalization are measured at 7- and 30-days post discharge. The MHP's FY2021-22 Assessment of Timely Access (ATA) 7/30-day self-report data 21.2/35.1 percent, including all clients, differs significantly from the BHC CY21 7/30-day results of 55.62/69.23 percent. The managed care unit tracks admissions and may assist in discharge coordination during business hours. The creation of a weekend response and 24/7 liaison to these facilities could improve follow-up rates and reduce re-hospitalizations.
- Psychiatric readmission rates are considered partially met, due to the need for the MHP to engage in a performance improvement process that offers support to after-hours and weekends. The MHP's FY21-22 ATA data show 7/30-day readmissions at 14/28 percent, which the BHC approved claims CY21 performance data indicate 10.7/19.5 percent, for a slightly offset period. A transitional care team is often utilized by MHPs to provide support to hospital discharges and particularly to those who are not receiving services at the time of hospitalization. These teams can improve engagement with services and reduce re-hospitalizations.

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.

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	8.7 Business Days	10 Business Days*	74.2%
First Non-Urgent Service Rendered	14.84 Business Days	10 Days**	69.6.0%
First Non-Urgent Psychiatry Appointment Offered	8.5 Business Days	15 Business Days*	84.0%
First Non-Urgent Psychiatry Service Rendered	41 Business Days	15 Business Days**	36.8%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	71 Hours	48 Hours**	76.5%
Follow-Up Appointments after Psychiatric Hospitalization	12.1 Days	7 Days**	21.2%
No-Show Rate – Psychiatry	14.6%	25%**	n/a
No-Show Rate – Clinicians	6.0%	15%**	n/a

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

** MHP-defined timeliness standards

*** The MHP did not report data for this measure

For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.

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

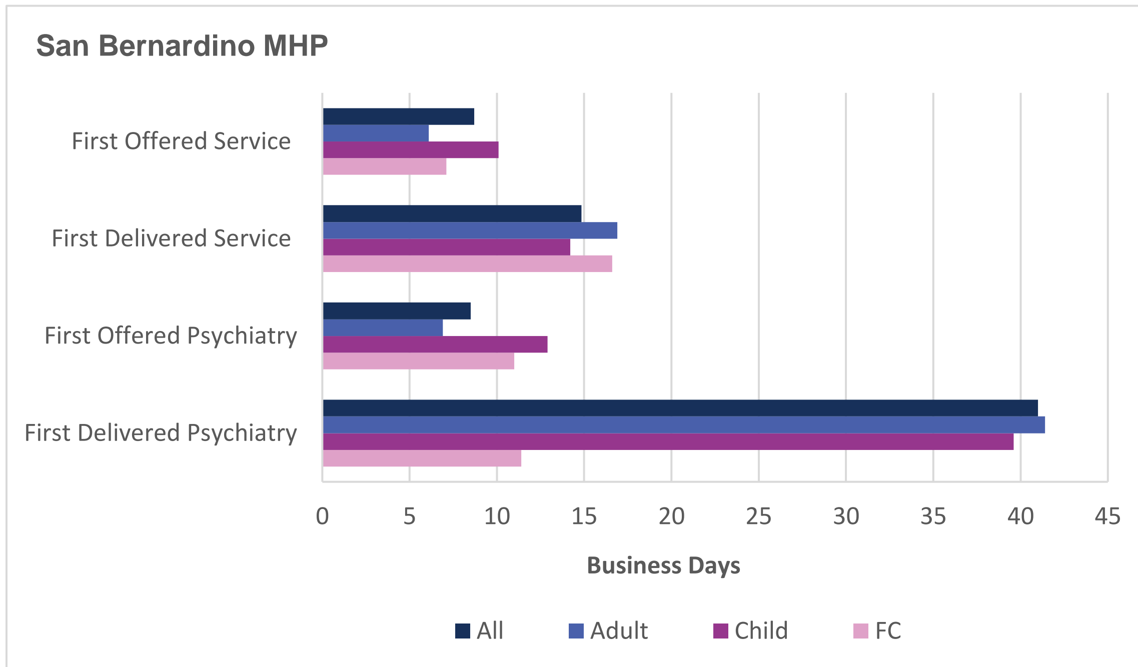


Figure 13: Wait Times for Urgent Services

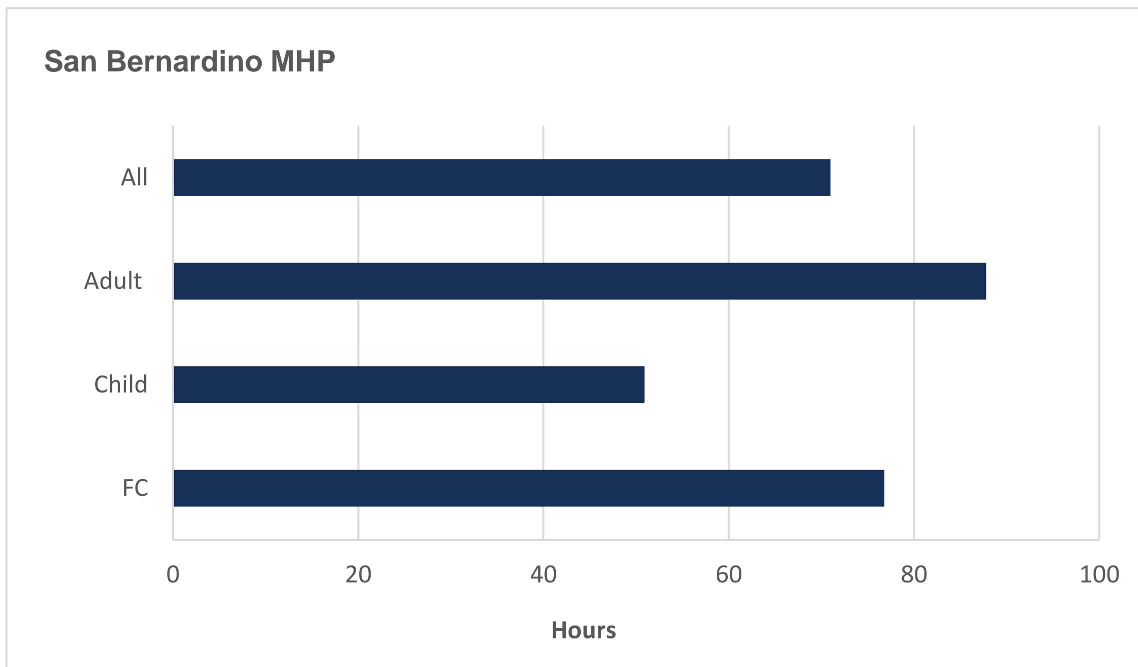
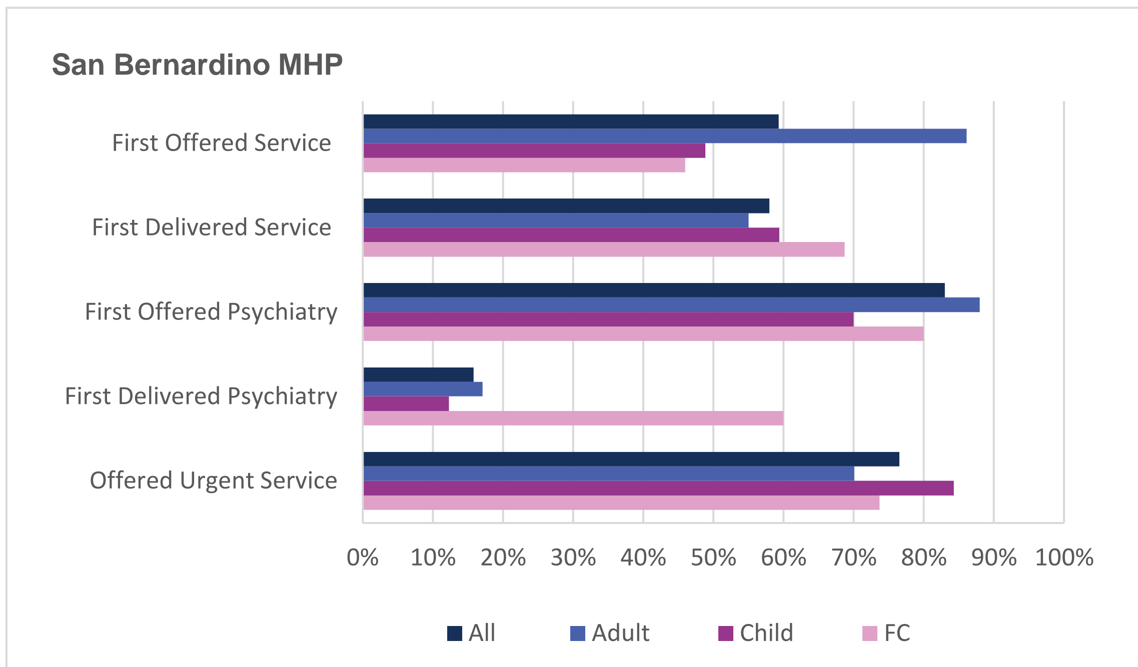


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments, unscheduled assessments.
- 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 "In FY2021-22 the definition (urgent) was not standardized across programs." There were reportedly 3951 urgent service requests with a reported actual wait time to services for the overall population at 71.0 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 "DBH policy is for beneficiaries to receive and initial assessment by clinical staff and refer for psychiatric services based on determination of need; however, this is not currently collected within the EHR in an easily accessible manner."
- 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 an overall no-show rate of 14.6 percent for psychiatry, and 6.0 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- With a 15-day standard, the average time to the first non-urgent psychiatry service received was 41 days. The 15-day standard was met at a rate of 15.8 percent. This indicates that MHP may be experiencing challenges in providing psychiatry services to beneficiaries in a timely manner, which is reinforced by the observations of stakeholders who are involved in the service delivery process. While there are reports this may have recently improved, concerns about capacity in this area should remain a focus for the MHP.
- With a 7-day standard for receiving a service after discharge from a psychiatric hospital facility, the average service was received on post release day 12. The 7-day standard was met at a rate of 21.2 percent. This indicates that MHP may be experiencing challenges in providing the first post hospital follow-up service to beneficiaries in a timely manner. The MHP is encouraged to re-evaluate how services are delivered to this important vulnerable population.

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 subsumed within the Quality Management Program, which includes the Access Unit Call Center, administrative staff who are tasked with completion of the Annual Quality Improvement Performance Plan (QIPP), Annual QIPP Evaluation, and MHP Implementation Plan. The Chief Quality Management Officer facilitates bimonthly QM meetings and oversees all QM aspects, including PIPs, the Authorizations Unit, Credentialling/Provider Relations Unit, the Inpatient Utilization Unit, the Managed Care Coordination Unit, the Outpatient Review Unit, and the Utilization Management (UM) Program. The Quality Management Action Committee (QMAC) and its subcommittees and workgroups perform many of the quality activities of the MHP.

The MHP monitors its quality processes through the Quality Management Action Committee (QMAC), the QIPP workplan, and the annual evaluation of the QIPP workplan. The QMAC, comprised of QM staff, practitioners, providers, administrative staff, contract providers, consumers and family members from both DMC/ODS and MHP stakeholder groups, is scheduled to meet every other month. Since the previous EQR, the MHP QMAC met four times. Of the 36 identified FY 2021-22 QAPI workplan goals, the MHP met 11, partially met 17, and identified 8 as not met.

The MHP utilizes the following level of care (LOC) tool: Child, Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35), and for adults the Adult Needs and Strengths Assessment (ANSA). Within Children's System of Care (CSOC) the MHP has not created a scoring bands crosswalk to level of care, but the MHP is developing an algorithm to crosswalk scores to high level services such as IHBS. There is also a client dashboard that includes CANS and PSC-35 scores, and provides drill-down information regarding services. The adult ANSA implementation has reportedly been slower and more difficult for aggregate data reports to be developed.

The MHP utilizes the following outcomes tools: CANS, PSC-35, ANSA, Patient Health Questionnaire (PHQ-9).

Within the CSOC, a wide variety of reports, both aggregate and individual, have been developed that support deeper analysis of outcomes and level of care determination.

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	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	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	Met

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

- The MHP's use of data is a strength, including numerous CANS and PSC-35 dashboards for children's system of care.
- The MHP utilizes the Adult Needs and Strengths Assessment (ANSA) as a level of care tool. But has not yet created and implemented guidance regarding scoring bands associated with each LOC. In the CSOC, the MHP has created an algorithm intended to provide direction as use of scores with LOC selection. The MHP is in the process of preparing the implementation of the DHCS screening

and transition tools. There continue to be challenges with MCP providers and their understanding of criteria for specialty mental health services, resulting in referral back to the MHP of individuals determined to meet MCP level of care. Aggregate tracking of bidirectional referrals, coupled with identification of trending problematic issues does not seem to be routinely occurring. This item is considered partially met for the above reasons.

- As part of medication monitoring, the MHP performs peer review of all prescribers who staff directly operated programs. Contract providers are reviewed when quality of care issues arise, and once every three years. Quality management provides review of those psychiatrists who are sole practitioners at a contract agency. The MHP has recently operated a PIP that focused on tracking and treating elevated serum blood sugar and lipid values for those beneficiaries that were not engaging in primary care.
- The MHP has found challenges in tracking, trending and reporting aggregate beneficiary outcomes for adult programs. This results in a partially met rating for this element.
- Clubhouse members commented on an apparent change of focus that includes broad use of facilities by large numbers of drop-in unhoused participants. This is experienced as disruptive to the tight-knit relationships that have evolved in these often physically small programs over time. This merits exploration by the MHP and gathering of input from clubhouse membership as to the best approach for navigating these changes. This component is identified as partially met due to the lack of a formal process which would consistently inform beneficiaries about clubhouse resources when entering services. It is suggested that the MHP consider an informing process which provides each newly served beneficiary with written and verbal information about clubhouse participation eligibility and the range of activities and services provided as part of the intake process.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

  This measure is partially met due to limitation of tracking that excludes HEDIS APC, APM, and contract provider activity. Some MHPs utilize a modified JV-220 review process to ensure all prescriber activity reviewed and tracked. This item is considered partially met due to being limited to directly operated programs and the absence of HEDIS APC and APM tracking (see below).

  - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): The MHP tracks HEDIS ADD, with the exception of contract provider activity.
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): The MHP is currently not able to track and trend HEDIS APC.
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): The MHP does not track and trend HEDIS APM, and

experiences challenges with acquisition of lab work due to lack of data sharing with the lab vendor.

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): The MHP tracks HEDIS APP for directly-operated programs.

QUALITY PERFORMANCE MEASURES

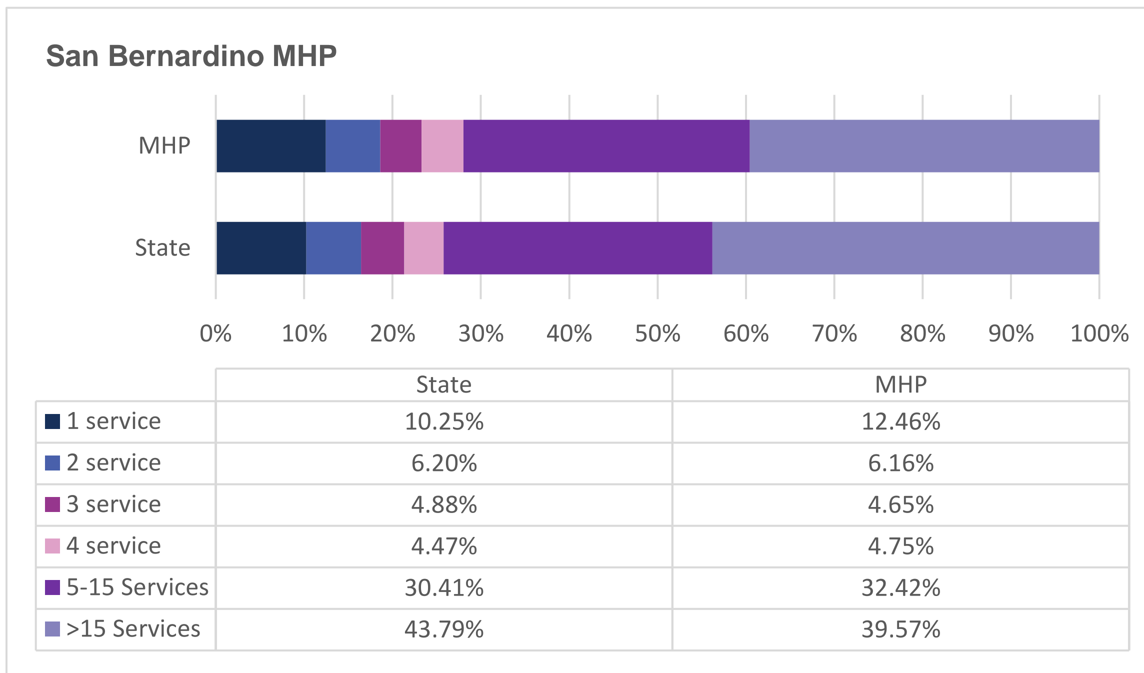
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



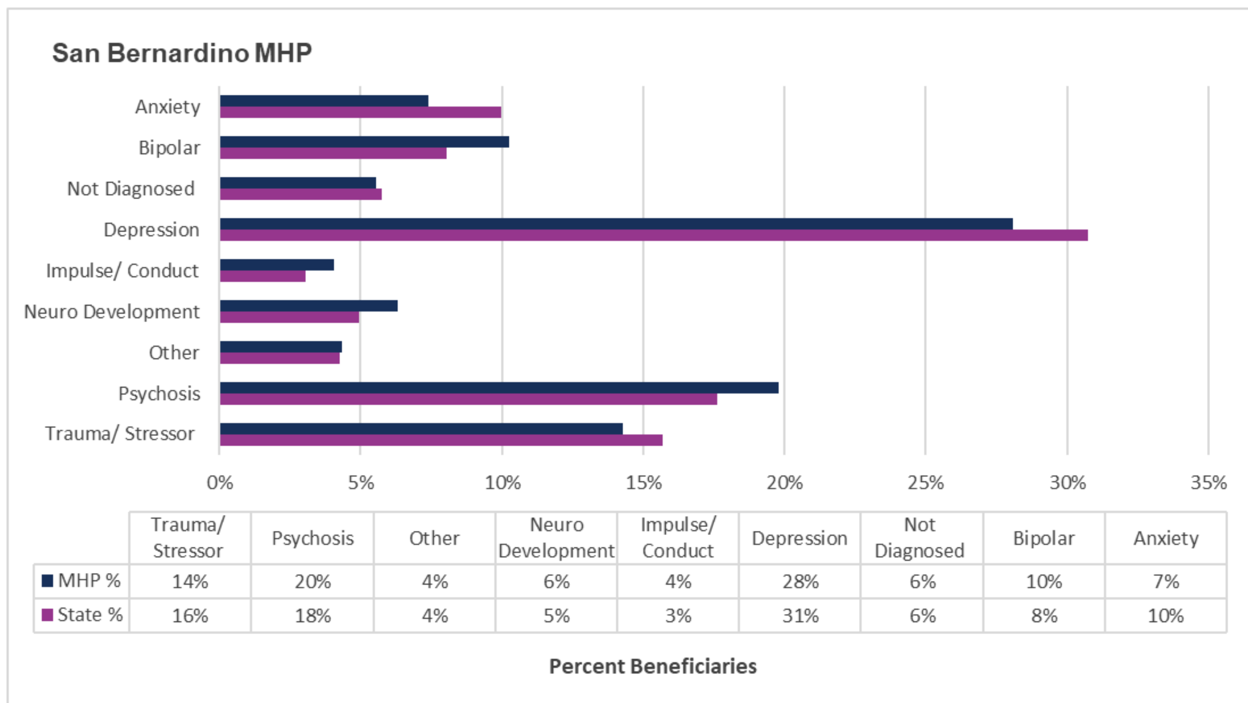
	State	MHP
1 service	10.25%	12.46%
2 service	6.20%	6.16%
3 service	4.88%	4.65%
4 service	4.47%	4.75%
5-15 Services	30.41%	32.42%
>15 Services	43.79%	39.57%

- A single service was provided to 12.46 percent of beneficiaries, 21.6 percent above the statewide rate of 10.25 percent.
- More than 15 services were provided to 39.57 percent of beneficiaries, 9.6 percent less than the statewide rate of 43.79 percent.

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.

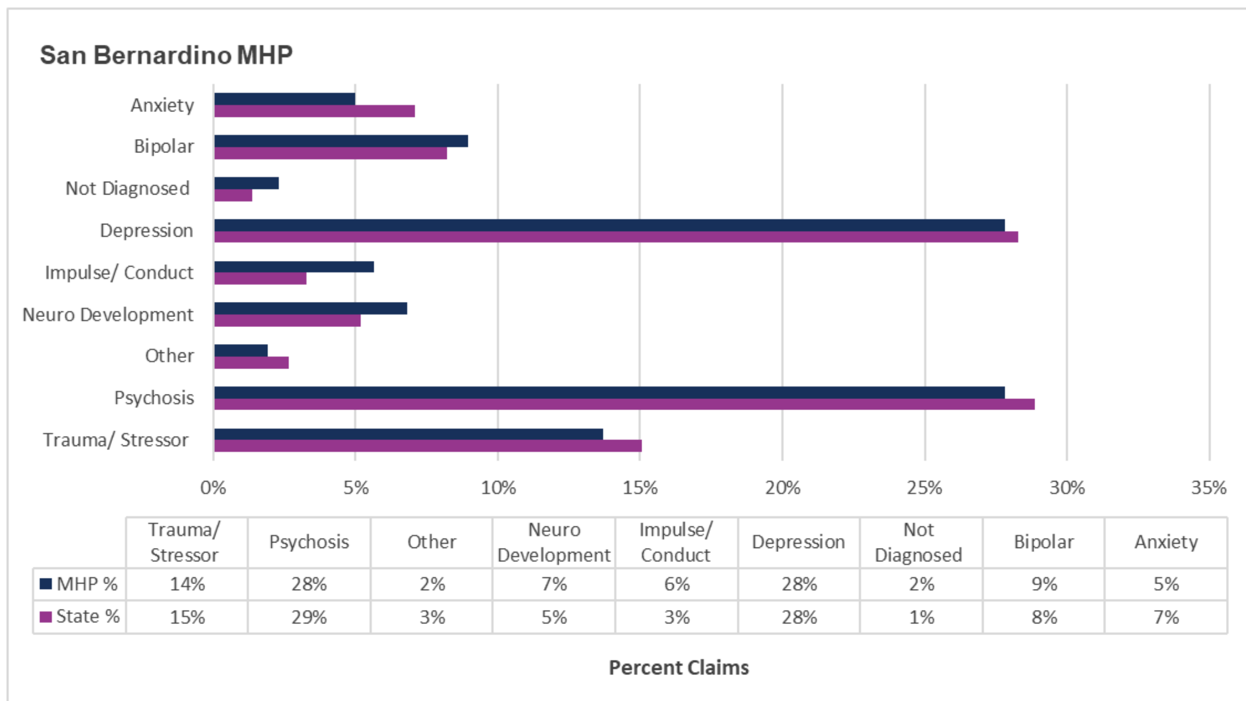
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	20%	4%	6%	4%	28%	6%	10%	7%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Sixty-two percent of beneficiaries had one of three diagnoses: Depression (28 percent), psychosis (20 percent), and trauma/stressor related (14 percent). The MHP's diagnostic pattern was generally comparable to statewide pattern.

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 %	14%	28%	2%	7%	6%	28%	2%	9%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Approved claims generally align with diagnostic patterns in the MHP.

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	4,218	14,653	5.64	8.86	$7,674	$12,052	$32,367,128
CY 2020	3,527	12,100	5.69	8.68	$7,057	$11,814	$24,890,930
CY 2019	4,685	18,585	4.49	7.80	$6,199	$10,535	$29,044,062

- The unique number of beneficiaries served in inpatient settings increased 19.6 percent (3,527 vs. 4,218) from CY 2020 to CY 2021, and total inpatient admissions increased 21.1 percent (12,100 vs. 14,653) during this period.

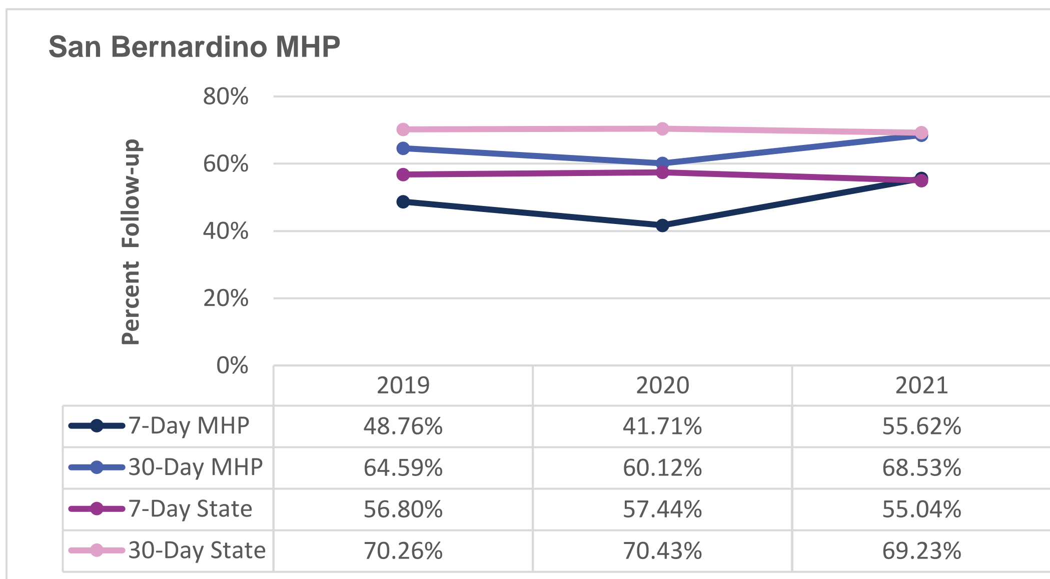
- LOS remained stable from CY 2020 to CY 2021 (5.69 days vs. 5.64 days) and was 36.3 percent less than the statewide average LOS in CY 2021 (5.64 days vs. 8.86 days).
- AACB increased 8.7 percent from CY 2020 to CY 2021 ($7,057 vs. $7,674) and was 36.3 percent less than the statewide average in CY 2021 ($7,674 vs. $12,052).

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.

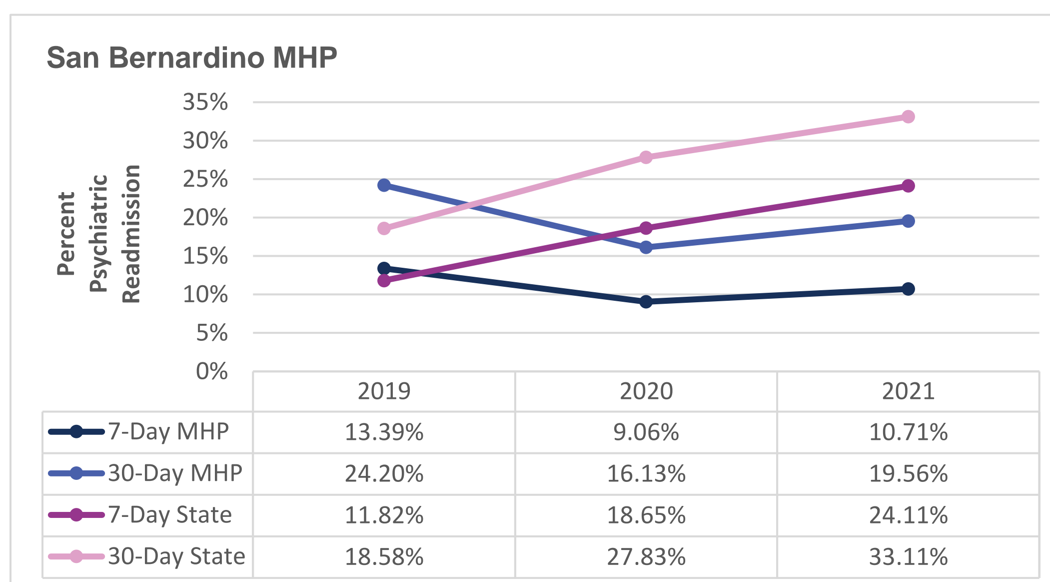
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	48.76%	41.71%	55.62%
30-Day MHP	64.59%	60.12%	68.53%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	13.39%	9.06%	10.71%
30-Day MHP	24.20%	16.13%	19.56%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The 7-day post psychiatric inpatient follow-up rate increased 33.3 percent from CY 2020 to CY 2021 (41.71 percent vs. 55.62 percent) and was comparable to the statewide rate in CY 2021 (55.62 percent vs. 55.04 percent).
- The 30-day post psychiatric inpatient follow-up rate increased 14 percent from CY 2020 to CY 2021 (60.12 percent vs. 68.53 percent) and was comparable to the statewide rate in CY 2021 (68.53 percent vs. 69.23 percent).
- The 7-day psychiatric readmission rate increased 18.2 percent from CY 2020 to CY 2021 (9.06 percent vs 10.71 percent) but was 55.6 percent lower than the CY 2021 statewide rate (10.71 percent vs. 24.11 percent).
- The 30-day psychiatric readmission rate increased 21.3 percent from CY 2020 to CY 2021 (16.13 percent vs 19.56 percent) but was 40.9 percent less than the CY 2021 statewide rate (19.56 percent vs. 33.11 percent).
- As noted in the timeliness section, the absence of weekend, holiday and afterhours acute hospital discharge and aftercare coordination is an area that could be improved through expansion of specialized services in this area.

High-Cost Beneficiaries

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

the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	991	3.02%	24.77%	$49,848,744	$50,301	$41,996
	CY 2020	600	1.93%	20.07%	$30,110,864	$50,185	$42,056
	CY 2019	818	2.30%	22.01%	$39,035,430	$47,721	$40,343

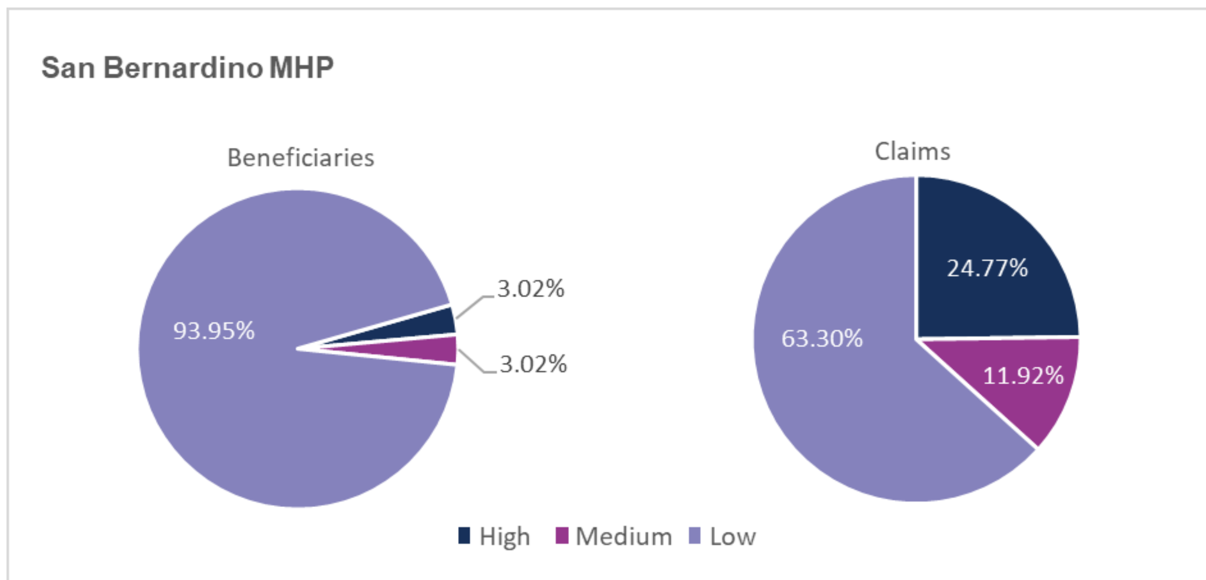
- The HCB count increased 65.2 percent from CY 2020 to CY 2021 (600 vs. 991). The percentage of HCBs increased 56.5 percent from CY 2020 to CY 2021 (1.93 percent vs. 3.02 percent).
- In CY 2021, the percentage of HCBs was 32.9 percent less than the statewide rate (3.02 percent vs. 4.50 percent).
- The CY 2021 average approved claims per HCB was 9.4 percent less than the statewide average ($50,301 vs. $55,523).

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)	991	3.02%	11.92%	$23,994,894	$24,213	$23,868
Low Cost (Less than $20K)	30,805	93.95%	63.30%	$127,385,892	$4,135	$2,639

- While low-cost beneficiaries comprised 93.95 percent of those served, 63.30 percent of approved claims dollars were spent on this subpopulation.

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



- While HCBs comprised 3.02 percent of those served, 24.77 percent of approved claims dollars were attributed to this subpopulation.

IMPACT OF QUALITY FINDINGS

- A single service was provided to 12.46 percent of beneficiaries, 21.6 percent greater than the 10.25 percent statewide rate. More than 15 services were provided to 39.57 percent of beneficiaries, 9.6 percent less than the 43.79 percent statewide rate.
- Sixty-two percent of beneficiaries had one of three diagnoses: depression (28 percent), psychosis (20 percent), and trauma/stressor related (14 percent). The MHP's diagnostic pattern was generally comparable to the statewide pattern.
- While the percentage of HCBs was 32.9 percent less than the statewide rate (3.02 percent vs. 4.50 percent), the MHP's HCB count increased 65.2 percent from CY 2020 to CY 2021 (600 vs. 991).
- The 7-day psychiatric readmission rate increased 18.2 percent from CY 2020 to CY 2021 (9.06 percent vs 10.71 percent) but was 55.6 percent lower than the CY 2021 statewide rate (10.71 percent vs. 24.11 percent).
- The 30-day psychiatric readmission rate increased 21.3 percent from CY 2020 to CY 2021 (16.13 percent vs 19.56 percent) but was 40.9 percent less than the CY 2021 statewide rate (19.56 percent vs. 33.11 percent).
- The MHP's current challenge in reviewing SB1291 HEDIS measures for those FC youth served by contract providers creates a gap in prescribing monitoring that could adversely affect this population. Until improved information sharing becomes available, the MHP might consider building on a modified JV-220

review process that results in the monitoring of all FC prescribing to ensure this element of the population receives regular review.

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: Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions (a. ED data exchange infrastructure and b. care coordination workflow, see section 1.6) will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5%, by June 30, 2024.

Target Population: The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. This includes members with an ED visit with a principal diagnosis of Mental Illness or Intentional Self-harm (referred to as MH conditions throughout the document), and applies to members age 6+ with Commercial, Medicaid and Medicare health insurance.

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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

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

Summary

The MHP will be building on existing relationships with emergency departments in order to improve follow-up for individuals who are treated in an emergency department for self-harm or mental health conditions. The development of information sharing between the emergency department and MHP navigators will further improve this follow-up. In addition, the MHP intends to develop an information sharing process which will augment this access.

The critical tracked measures in the 7/30 day follow-up data, and the interventions are chiefly the navigator activities within the emergency department and post-release follow-up to ensure the connection with clinical services occurs.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: The essential structure of this PIP that relies on communication between the MHP, emergency departments, and MCPs, and the actions of an onsite navigator are likely to produce significant results, but the recruitment and hiring of navigators is critical to success.

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

- Suggesting the MHP may wish to address the differences in scope described by the PIP Aim Statement and the target population. The AIM statement focuses only on MC beneficiaries, while the population statement includes commercial, Medicare, and Medi-Cal beneficiaries.
- Fast-tracking the identification, hiring and training of navigators is critical to achieving significant improvements within the time limits of this PIP. There will also likely be operational issues that arise and require resolution between the ED/MCP staff and with MHP program staff that makes early implementation important.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Optimizing the Waiting Room Experience

Date Started: 03/2022

Date Completed: 03/2023

Aim Statement: Over a 6-month period, in FY 21-22, will a clinic lobby health information video at a PIP pilot outpatient clinic, improve:

1. Client knowledge of Departmental and community resources.

2. Client grievances.

Target Population: Pilot/test clinic implementation impacting all receiving services from that site.

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

Summary

The MHP sought to address a problem related to lack of health care information at its clinics, including expectations of treatment, well-being techniques, identification of contact individuals when help is needed, and grievance information. Some of these topics were derived from the consumer perception survey results for the target clinic. Utilizing available literature on this topic, the MHP concluded that these identified factors could be mitigated by the development of an informational video available in the clinic lobby. Contributions to this topic were also provided by the target clinic program manager, Consumer Evaluation Council and Clubhouse beneficiaries. The MHP's intervention is a video that is run in the target clinic lobby. The performance measures include the number of days the video has run at the clinic, the number of beneficiaries exposed to the video, the pre/post resource knowledge survey results, and the number and percent of grievances received pre-and-post intervention.

The results of this one-year PIP were that the video did not have a statistically significant improvement effect upon the knowledge survey, but there were found to be improvements in agreement/satisfaction. Grievances have reduced by 86 percent, from seven to one. Statistical analysis does not support that an improvement occurred.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: while not supported by the statistical analysis, this short-term PIP was associated with decreases in grievances and the video exposure will be an ongoing process which may have a cumulative effect. This may result in further improvements, in both knowledge and in grievance reduction.

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

- Continuation of the video intervention at the pilot site should be continued, as well as grievance tracking to determine if there continues to be an impact on the number of grievances filed at that site.

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 Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for two years. Currently, the MHP has a new system in place that was installed within the past five years where the MHP must dedicate staff and resources to implement all components of the EHR.

Approximately 5.92 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 County IT.

The MHP has 1,492 named users with log-on authority to the EHR, including approximately 1,007 county staff and 485 contractor staff. Support for the users is provided by 52.1 full-time equivalent (FTE) IS technology positions, 37 System Security and Operations positions (SaOS) which provide desktop, helpdesk, and infrastructure support, and 15.1 Behavioral Health Management Information Systems (BHMIS) positions which provide Avatar support. Currently there are 18 vacancies: 8 SaOS positions and 10 BHMIS positions. The number of vacant positions has been impacted by the addition of nine SaOS and five BHMIS positions in the past year.

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	24%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	49%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	27%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
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 does not have a PHR. This functionality is expected to be implemented within the next two years.

Interoperability Support

While the MHP is not currently a member or participant in a HIE, there are plans to implement Netsmart's CareConnect module which will allow the MHP to share information across HIEs. Healthcare professional staff use secure information exchange directly with service partners through secure email and electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Contract providers and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- Avatar is currently locally hosted with plans for migration to a web-based platform supported by Netsmart Technologies.
- Contact providers use their own EHRs for the documentation of clinical beneficiary information.
- Data analytic support is provided by the Research and Evaluation group. Current staffing consists of 19 FTEs with 8 current vacancies. All positions are in recruitment and two offers were recently made.
- The PHQ-9 is used by the Enhanced Care Management Program (ECM) to measure improvements related to enhanced case management and this tool is available through Avatar.
- Objective Arts provides detailed CANS and PSC-35 reporting.
- Security training is included during the employee onboarding process. The Department of Behavioral Health provides annual security training, additional yearly security training is provided by County IT. In the event of a specific identified risk, email notifications are provided to enhance staff awareness of the threat. Two faux phishing emails were utilized in the past year to assist in the identification of staff who required refresher cyber security training.
- The MHP's CY 2021 denied claims rate of 2.11 percent is higher than the CY 2021 statewide average of 1.43%. The MHP's implementation of Avatar may have contributed to the increased claim denial rate. Approximately 80 percent of claim denials were due to three denial reasons.
- There is an Operations Continuity Plan for critical business functions that is maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency and it is reviewed annually.
- The MHP maintains a SAS data warehouse that replicates the Avatar system to support data analytics.

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.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	65,497	$15,526,641	$72,673	0.47%	$14,188,694
Feb	67,591	$16,061,643	$45,418	0.28%	$14,656,550
Mar	75,325	$17,891,443	$61,789	0.35%	$16,703,509
April	69,051	$18,043,626	$58,271	0.32%	$16,575,344
May	64,498	$17,360,354	$74,901	0.43%	$15,921,939
June	63,136	$17,068,854	$43,857	0.26%	$15,805,958
July	59,028	$15,744,593	$312,112	1.98%	$14,903,228
Aug	61,022	$15,688,234	$307,072	1.96%	$14,803,700
Sept	63,368	$15,647,660	$382,400	2.44%	$14,466,113
Oct	60,247	$15,521,227	$338,387	2.18%	$14,667,835
Nov	58,366	$14,915,600	$639,644	4.29%	$13,940,958
Dec	57,077	$15,145,368	$1,777,410	11.74%	$12,999,985
Total	**764,206**	**$194,615,243**	**$4,113,934**	**2.11%**	**$179,633,813**

- This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Service line is a duplicate and a repeat service procedure code modifier not present	4,659	$1,672,216	40.65%
Other healthcare coverage must be billed before submission of claim	2,329	$660,673	16.06%
Place of service incomplete or invalid	417	$601,920	14.63%
Medicare Part B must be billed before submission of claim	1,938	$536,662	13.04%
Beneficiary not eligible or non-covered charges	1,466	$464,674	11.30%
Late claim	315	$124,648	3.03%
Service location NPI issue	99	$26,675	0.65%
Other	17	$21,112	0.51%
Deactivated NPI	37	$5,352	0.13%
Total Denied Claims	**11,277**	**$4,113,932**	**100.00%**
Overall Denied Claims Rate	**2.11%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- Approximately 80 percent of claim denials were due to three denial reasons:
  - Service line is a duplicate and a repeat service procedure code modifier not present.
  - Other health coverage must be billed before submission of this claim.
  - Place of service incomplete or invalid.
- Claims with denial codes Medicare Part B or other health coverage must be billed prior to the submission of this claim and Other health coverage must be billed before submission of this claim are generally rebillable within State guidelines upon successful remediation of the reason for denial.
- The claim denial rate for CY 2021 of 2.11 percent exceeds the statewide average of 1.43 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- While the Avatar system is currently locally hosted, the planned migration to a web-based platform, supported by Netsmart Technologies, will reduce the MHP's need for in-house operational support.
- Without contractor provider use of the Avatar EHR, a significant amount of beneficiary health information is maintained in disparate electronic health records, which limits 24/7 access to a beneficiary's complete health information.

- Contract provider use of disparate EHR systems creates processes and timelines outside of the MHP's control for disaster recovery and operations continuity planning. Expectations for contract provider disaster recovery timelines could be standardized, and contract provider annual review of internal operations continuity plans could be required, to assist in assuring timely availability of beneficiary data in the event of a disaster or other data compromising event.
- The current staffing challenges experienced by the MHP extend to IT and Avatar support, with 18 combined positions currently vacant, and 8 vacant analytics positions. Salary surveys could be conducted to ensure competitive wages and a review of job descriptions could be done to ensure the description of duties and qualifications is targeting appropriate candidates.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP has incorporated the CPS results in the FY 2022-23 QIPP, including goals to use CPS data with quality improvement efforts. The CPS will be reviewed during quality meetings and to bring this information to the CEC consumer council for review. The MHP is also considering posting the CPS results to the MHP's website.

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 two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each. The caregiver focus group received very low participation, which resulted in the results being added to the summary of findings, but omitted from a full, unique write-up of the session.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included seven participants, four of whom initiated services within the prior 12 months. All consumers participating receive clinical services from the MHP.

Initial access to care was described by half of these participants as very quick, with a response ranging from a few days to a week. For the others, psychiatry took three weeks, with psychotherapy taking seven months. Another individual reported still waiting for psychosocial therapy ten months following intake. Capacity for providing talk therapy is severely impacted by staffing. One individual who has not yet been connected with psychotherapy reported that improvement in their condition has occurred from medications prescribed.

The frequency of psychiatric service was cited as monthly by all. While requests for change of psychiatric practitioner were supported by the MHP, psychiatry turnover left at least one individual waiting for a new psychiatrist and no longer receiving the medications that were previously prescribed.

Psychosocial therapy is received by most varying from weekly to every two weeks. As mentioned, one individual has waited since the first of 2023 to be assigned a therapist. Another individual has been waiting for a therapist assignment for ten months. One participant who receives services for unsheltered individuals was informed that he was not eligible for psychotherapy, only peer support. Another individual who has managed to obtain a therapist was informed that there was a 10-session cap on psychotherapy services, and felt this was not sufficient.

Assistance with appointments comes in the form of reminder calls or texts, with five of these individuals receiving electronic reminders, and two are provided an appointment slip. Missed appointments are followed up either the next week, or if psychiatry is missed, usually the following month, depending on circumstances and program capacity.

Psychiatry was exclusively received through telehealth. Psychosocial clinical services are for the majority in-person, with a smaller subset by Zoom or phone. With some receiving a mix of in-person and telehealth services. Participants reported being provided a choice of how services are received.

Support of cultural beliefs and preferences was acknowledged by all. At intake all of these participants recall being queried on their preferred language and offered interpreting services. The clubhouses are known to celebrate other cultures.

Transportation assistance is provided through bus passes, MCP provided transportation (must be scheduled five days in advance), and direct assistance by the MHP programs. There is a newer service provided by the MCP which is called “Call the Car.” It was noted that there are often insufficient numbers of drivers for this service to be considered reliable. Cancellation of bus passes provided by Medi-Cal recently occurred.

Inclusion of family or supportive friends is welcomed by MHP program staff, with some beneficiaries bringing a friend or other support person to sessions. In relation to overall health, these participants reported clubhouses encourage physical activity, such as walking and exercise groups, and practicing breathing exercises. The encouragement to attend to physical health through activity was reportedly reinforced by psychiatry and therapists.

Some reported information sharing by psychiatrist and primary care providers. Some mentioned visibility of lab results by both psychiatrist and primary care.

In regards to changes of provider, several mentioned difficulties with psychiatrist fit, and requests for a change of practitioner were granted. These changes took a number of months to achieve due to staffing limitations.

Numerous urgent and crisis resources were cited by participants, including a crisis center in Fontana, the emergency department at Loma Linda, the crisis response team, and the use of 211. Some mentioned newly acquired skills that clinical staff have assisted with for managing stress and crisis situations.

Participants mentioned furnishing feedback on services through clubhouse surveys. Results of these surveys are shared with clubhouse board members, but not with the general surveyed population. Communication about services occurs via clubhouse flyers and from therapists. None were aware of the MHP's website.

Clubhouse participation requires one to have some history of a mental health issue and to be able to safely manage those issues. Transportation was mentioned as available through the MCP, but there are no bus passes available for these individuals.

Opportunities to volunteer or obtain paid work include: participation in the TAY advisory board, employment as a peer or family advocate. Volunteering at the clubhouse can result in paid work opportunities.

All mention that services have created a sense of hope for the future, referencing the clubhouse structure as an element. With clinical services, all feel that their input is important and well-received.

Recommendations from focus group participants included:

- The TAY program would benefit from more structure and routine.
- Provision of bus passes.
- Several experienced psychiatrists were unwilling to treat the autism component of their conditions, which was felt to be an important aspect of treatment.
- Increased staffing so that appointments can occur more frequently.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of family members of children and youth who initiated services in the preceding 12 months. The focus group was held virtually and included only two participants. Two preserve the confidentiality of participants, this session is not uniquely documented. However, the salient issues derived from that meeting are incorporated in the summary of beneficiary feedback findings.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

In general, focus group participants experienced difficulties related to the adequacy and stability of the MHP's staffing, resulting in changes of clinician, monthly appointment cancellations, and extended intervals between appointments. Therapist turnover for children is disruptive to the therapeutic relationship and may result in the emergence of regressive behavior after months of positive changes. Although varying from clinic to

clinic, those with a less critical presentation may wait many months for psychosocial treatment services.

The vast majority experience services as having a positive impact on their mental health condition and their lives, and they feel involved in their own care.

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. A strong relationship with the two primary MCPs was evidenced from their participation in review sessions, and involvement in ongoing coordination activities. (Access, Quality)
2. The MHP emphasizes stakeholder communication and has a communication plan that includes District Advisory Committees that serve as a conduit for supervisorial district regional input. The MHP's multi-media team that supports communication efforts. The CEC that the MHP involves for guidance on all beneficiary related topics. Meetings occur with contract providers monthly, ensuring they are kept informed. (Quality)
3. The MHP has developed aggregate reports within Objective Arts for the CANS and PSC-35 which support analysis of overall results and assist with improving care. (Quality)
4. The MHP's clubhouses/wellness centers are a MHP strength, with these resources located in each major population centers across the county, including three TAY centers. (Access, Quality)
5. The CEC creates a strong beneficiary input process that is utilized to inform the MHPs decision-making process about services. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to experience losses of staff and difficulties with recruitment and retention, particularly with licensed clinical staff and prescribers. The needs in this area were reinforced by the input of multiple stakeholder groups that participated in this review and indicated extended delays in both clinical and psychiatric services, depending upon clinic location. This issue has significance in the serving of Hispanic/Latino beneficiaries and Spanish language preferred individuals in that there was a 15 percent decrease in Spanish speaking service staff between September of 2022 through 2023. (Access, Timeliness)
2. The MHP has made an effort to improve completeness and accuracy of timeliness data as evident in this review; however, the first offered non-urgent psychiatry total event numbers (399 requests) for FY 2021-22 are very low considering the scale of the MHP. (Timeliness, Quality)

3. While the relationships between the MHP and MCPs are positive, feedback indicates a concerning level of repeat referrals between SMHS and MCP mental health services. (Access, Quality)
4. The MHP currently has 15 of 49 PFA lived experience positions vacant. The MHP has yet to clarify the career ladder opportunities for certified and non-certified peers, and whether certification is required for new peer hires. (Quality)
5. While the MHP has implemented mechanisms to review high frequency acute care utilizers, there remains a lack of weekend and after-hours care coordination and discharge with acute psychiatric inpatient units. (Access, Timeliness, Quality)

RECOMMENDATIONS

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

1. Formalize broad implementation of flexible schedules and other work benefits that are seen as beneficial by staff, including where possible some degree of telework. Considering the loss of Spanish speaking service providers, recruitment of relevant clinical staff who are bilingual should be an additional priority. With prescribers, this could include consideration of additional prescribers that could provide telehealth-only services. (Access, Quality)

   (This recommendation is a modified carry-over from FY 2021-22.)
2. Develop a validation process that is applied to timeliness data collection to assist in identification of possible under-reporting. This could involve comparison of first offered numbers with total newly registered beneficiaries and first psychiatry service recorded. (Access, Timeliness)

   (This recommendation is a modified carry-over from FY 2021-22.)
3. Implement aggregate tracking and trending of bidirectional MHP/MCP referrals, including analysis of trend issues in the referrals where repeat bidirectional referrals occur in a short period of time. (Quality)
4. Clarify the lived experience position career ladder and how certified and non-certified peers are affected and fast-track filling of vacant PFA positions. (Access, Quality)
5. Develop a team that provides liaison, care coordination, and discharge planning support to hospitalized beneficiaries that includes weekends and afterhours support. (Access, Timeliness, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a California public health emergency (PHE) was in place until February 28, 2023 and a national PHE 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 Bernardino MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Community-Based Services Agencies Group Interview

CalEQRO Review Sessions – San Bernardino MHP
Information Systems Billing and Fiscal Interview
Telehealth
Wellness Center Site Visit (Virtual)
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer
Bill Walker, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Pamela Roach, 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.

MHP County Sites

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
Achuff	Susan	Program Manager II	Behavioral Health
Alsina	Jennifer	Deputy Director	Behavioral Health
Bagwell	Bryan	Business Systems Analyst I	Behavioral Health
Belford-Saldana	Dr. Alyce	Deputy Director	Behavioral Health
Block	Dr. David	Associate Medical Director	Behavioral Health
Cannon	Derrick	Clubhouse Operations Supervisor	Behavioral Health
Canseco	Miranda	Public Relations and Outreach Coordinator	Behavioral Health
Carpenter	Amber	Program Manager II	Behavioral Health
Carson	Kim	Program Manager II	Behavioral Health
Chavira	Maria	Clinic Supervisor, Qualified Individual Unit	Behavioral Health
Cunningham	Allison	Senior Program Manager	Behavioral Health
Dela	Mark	Biostatistician	Behavioral Health
Deroian	Liana	Program Manager II	Behavioral Health
Entz	Christina	Interim Senior Program Manager	Behavioral Health
Espinosa	Marina	Deputy Director	Behavioral Health
Ferrer	Arlene	County Programs Liaison	IEHP
Frausto	Dr. Teresa	Chief Psychiatric Officer	Behavioral Health
Gonzaga	Laurence	Program Manager	Molina
Grace	Patricia	Business Systems Analyst III	Behavioral Health
Granillo	Olga Elena	Clinic Supervisor	Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Gutierrez	Maribel	Senior Program Manager	Behavioral Health
Guzman	April	Administrative Manager	Behavioral Health
Haigh	Keith	Behavioral Health Informatics Manager	Behavioral Health
Hale	Julie	Deputy Director	Behavioral Health
Harris	Alicia	Clinic Supervisor, Victor	Behavioral Health
Hermosillo	Brian	Business Systems Analyst II	Behavioral Health
Hernandez	Jeanette	Clinic Supervisor, Phoenix	Behavioral Health
Hougen	Dr. Timothy	Deputy Director	Behavioral Health
Jackson	Steven	Program Manager II	Behavioral Health
Jackson	Nina	Business Systems Analyst III	Behavioral Health
Kanakaole-Sweitzer	Rachel	Peer and Family Advocate	Behavioral Health
Karp	Claire	Program Manager II	Behavioral Health
Keres	Dr. Rene	Program Manager II	Behavioral Health
Knight	Michael	Assistant Director	Behavioral Health
Knutson	Barbara	Business Applications Manager / BHMIS	Behavioral Health
Liu	Michelle	Supervising Accountant II	Behavioral Health
Longo	Nancy	Program Coordinator, West SART	West End Family Counseling
Louer	Heather	Program Manager I	Behavioral Health
Mancilla	Jose	Human Resources Analyst	Human Resources

Last Name	First Name	Position	County or Contracted Agency
Marshall	Alesha	Clinic Supervisor	Behavioral Health
Montecinos	Jessica	Staff Analyst II	Behavioral Health
Morales-Gamez	Rudy	Staff Analyst I	Behavioral Health
Mungcal	Kristen	Program Manager II	Behavioral Health
Nevarez	Antenique	Clinic Supervisor	Behavioral Health
Ochoa	Erica	Chief Compliance Officer / Privacy Officer	Behavioral Health
Otis	Zakiya	Program Manager I	Behavioral Health
Parker	Patricia	CEC Member	Desert Stars Clubhouse
Parra	Martha	Program Manager II	Behavioral Health
Partida	Marlene	Supervising Accountant II	Behavioral Health
Patel	Dr. Ravi	Child Psychiatrist	Behavioral Health
Patterson	Ashley	Media Specialist II	Behavioral Health
Poulakos	Dr. Anthoula	Research and Planning Supervisor	Behavioral Health
Rodriguez	Martha	Business Systems Analyst III	Behavioral Health
Roth-Felter	Cynthia	Program Manager II	Behavioral Health
Schreur	Dr. Christopher	Associate Medical Director	Behavioral Health
Scott-Young	Dr. Rebecca	MHSA Administrative Manager	Behavioral Health
Shackelford	Rick	Business Systems Analyst III	Behavioral Health
Silva	Ilse	Staff Analyst I Trainee	Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Smith	Jill	Program Manager I	Behavioral Health
Suphavarodom	Tan	Deputy Director	Behavioral Health
Sweitzer	Michael	Program Manager II	Behavioral Health
Taylor	Dr. Joshua	Senior Program Manager	Behavioral Health
Thayer	Jonathan	Staff Aide	Behavioral Health
Tompkins	Briceida	Ethics & Compliance Coordinator	Behavioral Health
Toruno	George	Staff Analyst II	Behavioral Health
Trujillo	Nathan	Clubhouse Operations Supervisor	Behavioral Health
Ugwuala	Gloria	Staff Analyst II	Behavioral Health
Van	Kimberlee	Administrative Manager	Behavioral Health
Vandale	James	Supervising Automated Systems Analyst II	Behavioral Health
Vasquez-Silva	Natividad	Program Director/Supervisor	West End Family Counseling
Wolkenhauer	Dr. Dianne	Program Manager II	Behavioral Health
Wong	Matthew	Staff Analyst I	Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Structurally, this PIP appears to be a logical approach for the improvement in FUM 7/30 results and thus receives moderate confidence; however, interventions and data tracking are very early in process and will be used to further evaluate confidence rating in the future. The MHP is in the process of hiring navigators and resolving data sharing agreements and functionality with the emergency departments and MCPs.

General PIP Information
MHP/DMC-ODS Name: San Bernardino County Department of Behavioral Health
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness (FUM)
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions (a. ED data exchange infrastructure and b. care coordination workflow, see section 1.6) will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5%, by June 30, 2024.
Date Started: 09/2022
Date Completed: 06/2024
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: n/a

General PIP Information
Target population description, such as specific diagnosis (please specify): This PIP includes members with an ED visit with a principal diagnosis of Mental Illness or Intentional Self-harm (referred to as MH conditions throughout the document), and applies to members age 6+ with Commercial, Medicaid and Medicare health insurance.

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): ED navigation and care coordination.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Hiring navigators to support emergency department contact and follow-up.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Development of a data exchange process for ED contacts which involved self-harm or a mental health condition. The exchange relates to MCP information sharing and ED communication of relevant contact events.

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
1. The percentage of ED visits for MH where the client received a follow-up MH treatment service from the MHP within 7 or 30 days (FUM). Target: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5%, by June 30, 2024.	CY2921	3,109 (53%) of ED visits, for MH conditions (5,841) resulting in a follow-up mental health service within 7 days (FUM7), and 3,713 (64%) resulting in a follow-up service within 30 days (FUM30).	n/a	n/a	n/a	n/a

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

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.				

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP was unable to establish improvements in healthcare knowledge from the survey instrument following application of the video intervention. However, there was a clear reduction from seven to one grievance following the video intervention. Thus, moderate confidence in the impact of this educational tool was assessed, with the MHP encouraged to follow-up in the future to determine if a greater impact has occurred over time.

General PIP Information
MHP/DMC-ODS Name: San Bernardino County Behavioral Health
PIP Title: Optimizing the Waiting Room Experience
PIP Aim Statement: Over a 6-month period, in FY 21-22, will a clinic lobby health information video at a PIP pilot outpatient clinic, improve: 1. Client knowledge of Departmental and community resources 2. Client grievances
Date Started: 03/2022

General PIP Information
Date Completed: 03/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Participants at the target clinic.
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): Communicating healthcare information to beneficiaries through a 1.5-hour video.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
1. An improvement in difference between pre & post knowledge survey scores Target: Statistically significant improvement between baseline and post intervention resource knowledge survey scores	August 2022	N=101 qu3_visit_satisfaction M = 4.27, SD = 0.87 qu4_understanding_visitM = 4.44, SD = 0.65 qu5_awareness_mh M = 4.53, SD = 0.56 qu6_awareness_sud M= 4.38, SD = 0.70 qu7_learned_technique M= 4.38, SD = 0.71 qu8_community_serviceM = 3.89, SD = 1.03 qu9_complaint_contactM = 3.90, SD = 1.10 qu10_privacy M = 4.46, SD = 0.61 qu11_twentyfourhr_lineM = 4.10, SD = 1.12 Mean response to all nine	December 2022	N=129 qu3_visit_satisfaction M = 4.17, SD = 1.01 qu4_understanding_visitM = 4.30, SD = 0.77 qu5_awareness_mh M = 4.47, SD = 0.72 qu6_awareness_sud M = 4.36, SD = 0.81 qu7_learned_techniquesM = 4.28, SD = 0.85 qu8_community_servicesM = 3.95, SD = 1.00 qu9_complaint_contact M = 3.98, SD = 0.96 qu10_privacy M = 4.28, SD = 0.83 qu11_twentyfourhr_line M = 4.19, SD = 0.95 Mean response to all nine	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Levene's test for each of the nine items did not detect variances of responses pre and post intervention to be significantly different (smallest test statistic and p-value among the nine items: F = 2.29, p = .13. None of the nine one-sided t-tests to determine mean differences between populations were statistically significant (test statistics for test with the smallest p-value: t(224) = 0.62, p= .27) The one-sided *t*-test assuming the equal variance assumption for the follow-up analysis was not statistically significant (*t*(228) = -0.08, *p* = .5307).

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
		questions M = 4.16, SD = 0.72		questions M = 4.17, SD = 0.68		Levene's test for equal variance: F = 0.05, p = .83.
2. Reduction in the number of grievances Target: 5% reduction from baseline.	July 2021-March 2022	N=7	July 2022-Janurary 2023	N=1	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a Statistical significance was not calculated for this measure.

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): PIP 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.

PIP Validation Information
EQRO recommendations for improvement of PIP: As this PIP has ended, recommendations for improvement are not relevant. The MHP plans to continue using the video to communicate about the healthcare provided to beneficiaries. As cited by the MHP, this may also continue to show improvements with beneficiary comprehension and expectations of services.

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 THE DIRECTOR

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