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 MATEO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 22-23, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — February 22-23, 2023

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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	0	4	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	2	3	1
Quality of Care	10	2	8	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**13**	**12**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Increasing youth engagement in remote services	Clinical	04/2021	6th and final remeasurement	No Confidence
Increase client's ability to utilize telehealth services	Non-Clinical	04/2021	6th and final remeasurement	No Confidence

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	5
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
3	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members Adults ☐Other	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The San Mateo Behavioral Health and Recovery Services (BHRS) Director's Update presents a monthly summary of BHRS issues relevant to all stakeholders, including program descriptions, staff acknowledgments, performance data and CalAIM progress.
- Primary care integration exists in five public health clinics serving adults and children and youth. Substance use disorder and mental health referrals are received, totaling approximately 2,500 annually.
- The MHP is in the process of evaluating the need for additional authorized positions to the service delivery system considering the possible increased demands that are associated with CalAIM access criteria changes.
- The MHP has continued to collaborate on the development of housing resources for the seriously mentally ill and homeless, resulting in additions to shelter resources for adults and older adults.
- The MHP has established monthly meetings with its managed care partners, with meetings that target needs of children and youth, others for the adult population, as well as implementation and coordination planning meetings.

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

- Timeliness data reported for this FY 2022-23 review did not include first offered non-urgent psychiatry data.
- The MHP does not currently utilize an adult outcome instrument that is applied across the entire adult population.
- Contractor data is not consistently included in all timeliness and SB 1291 reporting.
- While the MHP's quality improvement (QI) staff are skilled and knowledgeable, the number of improvement targets that have been suspended due to implementation of CalAIM and other changes suggests staffing may not be adequate to keep pace with demands.
- Limitations in IS and analytic staffing may be constraining the implementation and use of technologic advances and development of reporting and dashboard advances.

Recommendations for improvement based upon this review include:

- Implement the mechanism for tracking and reporting first offered non-urgent psychiatry appointments and urgent service request, including regular review of resultant data by MHP leadership.
- Research and select a universally applied adult outcome instrument, with implementation following resolution of CalAIM implementation issues.
- Implement successful tracking and reporting, plus regular review of timeliness data for the entire contractor and county-operated system.
- Evaluate the staffing need of the QI unit, ensuring capacity is sufficient to sustain key quality improvement metric tracking and corrective actions.
- Evaluate the adequacy of IS and analytic staff, such that the MHP is able to utilized the tools available, and develop important reporting functionality.

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 Mateo County MHP by BHC, conducted as a virtual review February 21-23, 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/after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP experienced some loss of staff, and challenges in meeting service demands. 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.

- BHRS hybrid service shift, with greater opportunities for in-person care when preferred by beneficiaries.
- The Community Wellness Crisis Response Teams, a two-year pilot of BHRS involving four city police departments for co-response to behavioral health calls, was launched one year ago.
- The Crisis/Outreach and Engagement programs are being restructured, which includes a single telephone number and point of contact, which then identifies the proper response unit. This will improve results of crisis calls, due to improved linkage protocols, which also include direct linkage and referral.
- Improvements to housing include senior housing in Redwood City; and 75 additional Mainstream vouchers, bringing the total to 251, that targets those 18-61 years.
- Within the children's system of care, the School-Based Central Assessment Team clinicians were assigned to regional school-based teams, which improved not only responsiveness but also continuity of care, in that the clinician could continue with the beneficiary into treatment rather than transferring to another clinician.

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: Research, develop a plan, and begin to implement strategies to fully integrate analytics into systems and processes, providing greater insight into strategies for improving access, timeliness, and quality.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- San Mateo has been working to implement tools that support analytics, including: Development of custom Netsmart add-ons to coordinate referrals to external providers, expanding utilization of PowerBI dashboards for demographic and crisis utilization information and timely access analysis for outpatient services, expansion of Netsmart timeliness reports for crisis services utilization, developing crisis dashboards, participation in Carequality Health Information Exchange (HIE), and working to implement Collective Medical's tool to provide notifications of beneficiary admissions to regional hospitals.
- While the MHP has made progress in identifying and working to implement IS and technological strategies for the collection of data necessary for analytics, the lack of having dedicated research and evaluation staff to execute analytic functions remains a challenge in leveraging information for improving access, timeliness, and quality in the system.
- This recommendation will be modified and combined to create an IS/analytic staffing evaluation recommendation for this review period.

Recommendation 2: Research, develop a plan, and begin to implement strategies to address the possibility of greater investment in IS staffing to strengthen the MHP's

ability to use data for performance improvement, provide support to staff around security, use of the EHR, and move the MHP towards eventual implementation of a PHR system.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- While San Mateo County Health (the entity overseeing IS staff), has made investments to enhance data collection via IS modifications and tools, IS staffing has not been increased since the last EQR and there are no plans to do so.
- The barriers to achievement of this recommendation include the staffing of IS personnel is not directly within the MHP's sphere of control, and is determined by the health department. It would seem that this area may lack full understanding of the coming changes with CalAIM including payment reform that is placing higher demands on IS staff.
- This recommendation will be carried over in modified format for this current review, and include another related element of increased analytic staff needs.

Recommendation 3: Implement a standard and track and report first offered non-urgent psychiatry appointments and identify and track urgent request for services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Assessment of Timely Access (ATA) document submitted for this review contained no data for "First Offered Non-Urgent Psychiatry Appointment." The MHP's narrative stated that report development for this new data element is currently taking place. Data was present for "First Non-Urgent Psychiatry Service Delivered," which included both county- and contractor-operated services.
- The MHP reports that urgent services data includes both county- and contractor-operated urgent services, but current reporting was limited to those contacts that come through the Access Call Center. The MHP is aware of the limitations of this approach and has sought improvement by adding a field to the CSI Assessment form. In addition, detailed review of the status designations raised questions about the accuracy of both urgent and non-urgent designations, which merits a training effort.
- Due to concerns about comprehensiveness and accuracy, this recommendation will be continued for the coming year.

Recommendation 4: Implement a system and track and report all Healthcare Effectiveness Data and Information Set (HEDIS) measures for FC as required by SB 1291 for the entire system of care (county-operated and contractor-operated).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- JV-220 and JV-220a applications are reviewed in the Behavioral Health and Recovery Services (BHRS) psychiatry team during monthly meetings. Activities

include review of metabolic monitoring and provision of first line psychosocial care.

- The MHP provided quarterly review of prescribing trends, tracking the SB 1291 measures.
- The MHP has not developed a comprehensive review and feedback system that includes the contract provider prescribers.
- Due to CalAIM implementation and other priorities such as corrective action plans, the MHP will temporarily discontinue efforts in this area, and circle back when demands subside.
- As the MHP has stated that it cannot focus on this topic now in the midst of CalAIM changes, this recommendation will be suspended.

Recommendation 5: With CalAIM in mind, research options, and choose and implement a universally applied adult outcome tool.

(This recommendation is a carry-over from FY 2019-20 and FY 2020-21)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP is awaiting further guidance from DHCS regarding a universally applied adult outcome tool that may be used across counties.
- This recommendation will be continued in modified form. Hopefully, during the coming period the requested state guidance and local bandwidth will develop which enables progress in the selection of an adult outcome instrument.

Recommendation 6: Begin tracking and reporting timeliness to services for the entire service delivery system as versus county-operated services only.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reports that timely access is currently tracked for both county- and contractor-operated services. The MHP is developing a real-time dashboard to support the use of this information.
- The ATA submission for this current review lacks any information for First Offered Non-Urgent Psychiatry Appointments, which would include both county-operated and contractor-operated. First delivered data is reported and includes both contractor and county services. The MHP is looking to improve the accuracy of this information during the coming period.
- Urgent services requests are restricted to those visits that result from an Access Call Center request that is so-designated. The MHP believes more training in this area is needed in order to improve accurate capture of relevant events.
- This recommendation will be continued in a modified form for the coming year, focused on improvements in tracking and reporting cited in the MHP's response.

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 41 percent of services were delivered by county-operated/staffed clinics and sites, and 59 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 54 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Call Center available to beneficiaries 24-hours, 7-days per week that is operated by county staff during usual business hours, and Optum after customary business hours and weekends; beneficiaries may request services through the Access Call Center as well as through the following system entry points: the school system, FC system, and direct presentation to MHP clinics. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The assessment process occurs at the program of referral, with services provided that meet the needs of the individual possible during the assessment process.

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 1274 adult beneficiaries, 1252 youth beneficiaries, and 280 older adult beneficiaries across 17 county-operated sites and 18 contractor-operated sites. Among those served, an 434 number of 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 Mateo County, the time and distance requirements are 15 miles and 30 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No
The MHP ensures OON access for beneficiaries in the following manner:	☒ The MHP has existing contracts with OON providers ☐ Other: Click or tap here to enter text.

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- 1A - The MHP's focus on cultural competence principles is reflected in its contract with the Pride Center; a music program for engaging the Chinese community; and the Latinx Collaborative, with an annual health fair which is held in different areas of the county each year.
- 1D - The MHP monitors Access Line data and periodically reports out on the performance of this function. The data helps to identify any capacity issues with Access staffing, which the MHP can use to shift resources to higher demand periods.

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, San Mateo demonstrated better access to care than that seen statewide, with a total PR of 4.42 percent for CY 2021.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	156,316	6,912	4.42%	$74,628,195	$10,797
CY 2020	142,857	6,898	4.83%	$73,355,437	$10,634
CY 2019	140,318	7,501	5.35%	$73,461,659	$9,794

- The number of eligibles increased more than the number of beneficiaries served as compared with the previous year. Total approved claims and AACB also increased from CY 2020 levels, whereas total PR has been trending downwards over the past three years.

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	13,649	137	1.00%	1.69%	1.96%
Ages 6-17	33,154	1,150	3.47%	5.40%	5.93%
Ages 18-20	8,219	401	4.88%	4.06%	4.41%
Ages 21-64	82,066	4,508	5.49%	4.24%	4.56%
Ages 65+	19,230	716	3.72%	1.69%	1.95%
Total	**156,316**	**6,912**	**4.42%**	**3.99%**	**4.34%**

- This is the first year San Mateo has been categorized as a large county and compared to all large counties for “similar size counties” comparisons. In prior years San Mateo has been grouped with medium counties.

- The PRs in both youth age categories were lower than in other large counties and statewide. For all three adults and older adult age groups, the PRs exceeded the statewide rates as well as those of similarly sized counties.
- The highest PR was for the 21-64 age groups.
- Total PR was higher in San Mateo than statewide and in similarly sized counties.

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
Cantonese	43	0.62%
Spanish	1,433	20.73%
Total Threshold Languages	**1,476**	**21.35%**
Threshold language source: Open Data per BHIN 20-070		

- The threshold languages were Spanish and Cantonese, with nearly 21 percent of beneficiaries being identified as Spanish speaking.

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	53,310	2,005	3.76%	$18,786,850	$9,370
Large	2,150,000	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. This trend held true in the MHP, with both PR and AACB for the ACA population being lower than for all beneficiaries as a whole.
- The PR for the ACA population in San Mateo was higher than in similarly sized counties but lower than statewide. AACB was higher than in similarly sized counties and statewide.

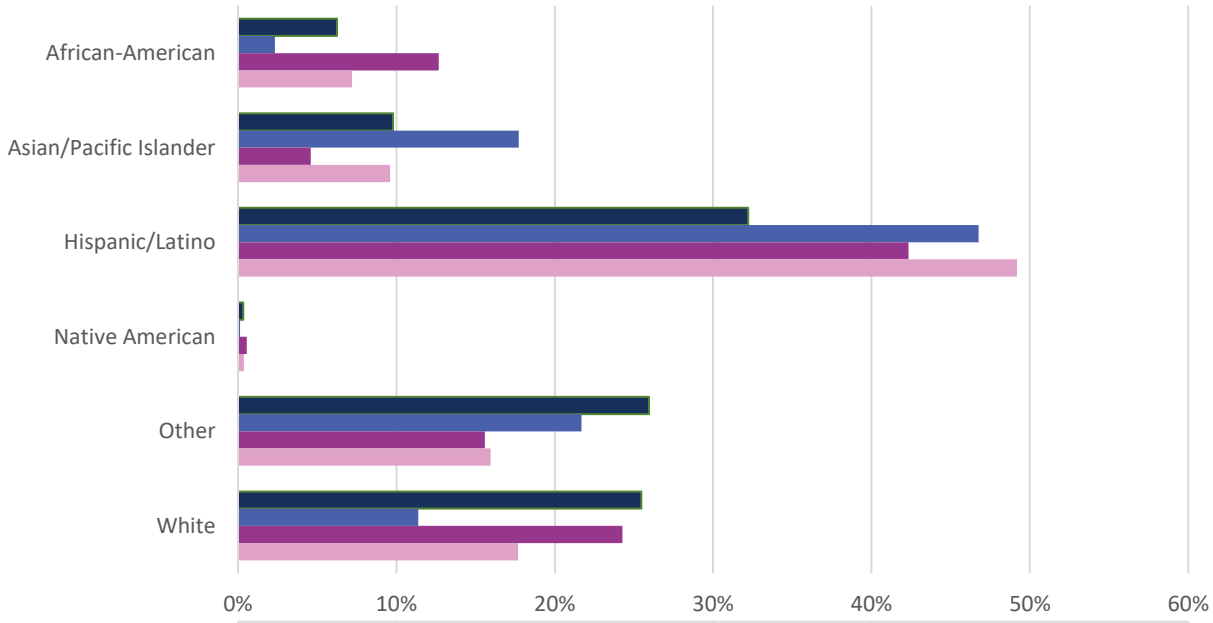
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	3,655	432	11.82%	7.64%
Asian/Pacific Islander	27,695	677	2.44%	2.08%
Hispanic/Latino	73,082	2,227	3.05%	3.74%
Native American	189	23	12.17%	6.33%
Other	33,894	1,793	5.29%	4.25%
White	17,803	1,760	9.89%	5.96%
Total	**156,318**	**6,912**	**4.42%**	**4.34%**

- San Mateo's PRs were higher than the statewide PRs for all racial/ethnic groups with the exception of Hispanic/Latinos.
- Of all the MHP's race/ethnicity penetration rate categories, the API rate remains lowest, but still is greater than statewide.

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

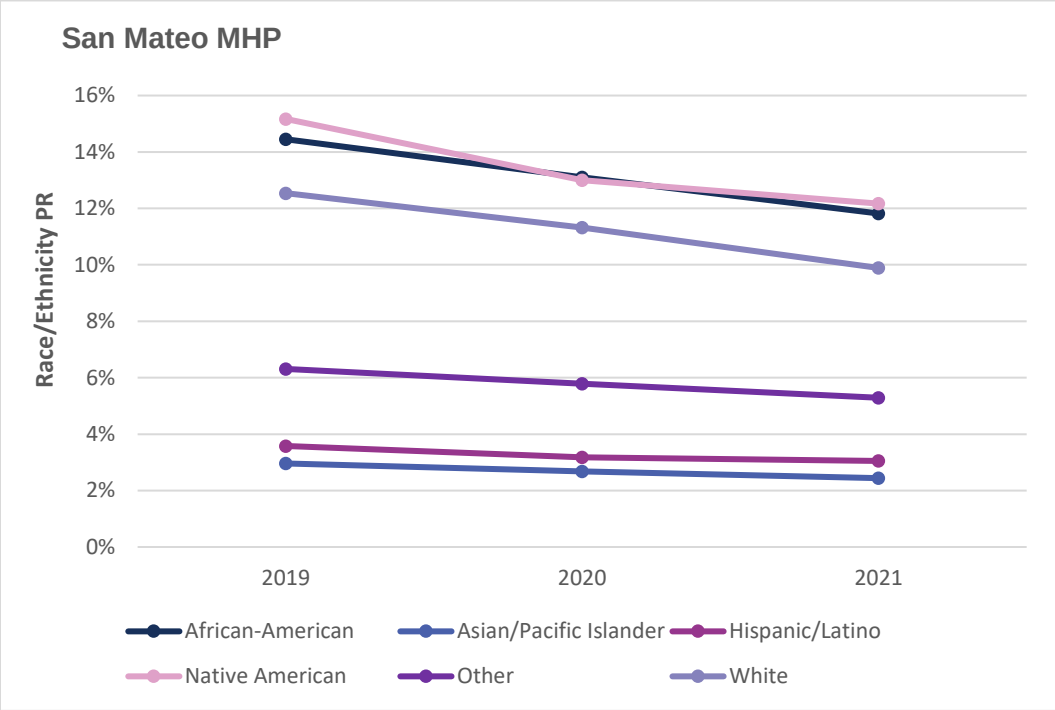


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	25%	26%	0%	32%	10%	6%
MHP % Eligible	11%	22%	0%	47%	18%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The most proportionally overrepresented group in San Mateo were Whites, and the most proportionally underrepresented groups were Hispanic/Latinos and Asian/Pacific Islanders.

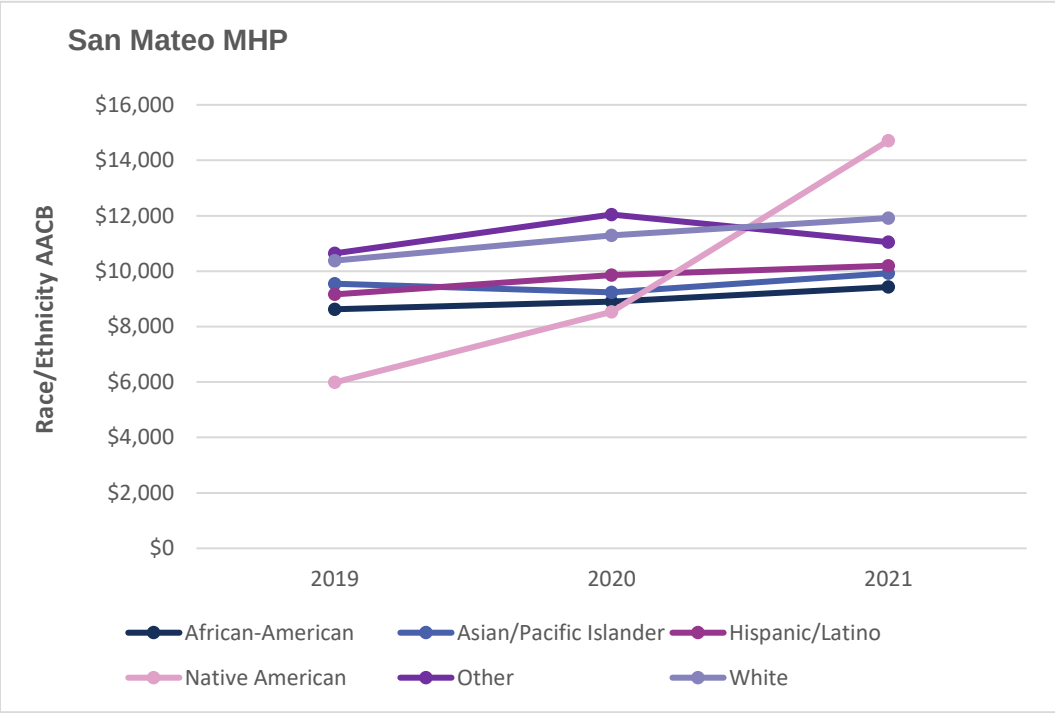
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



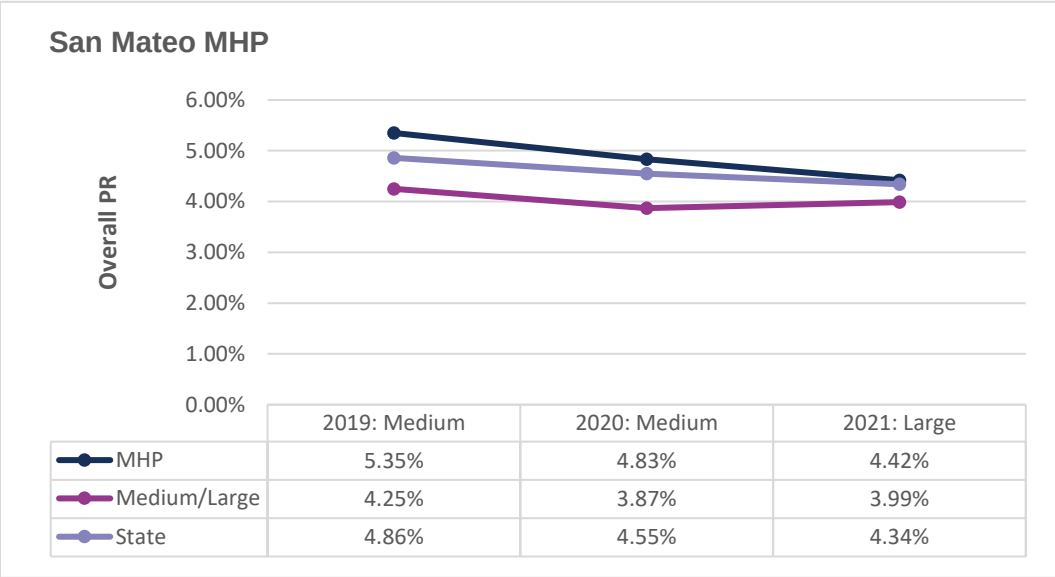
- PRs for most racial/ethnic groups have been trending downwards over the past three years. PRs for Native Americans, African-Americans, and, to a lesser extent, Whites, have consistently been the highest, whereas PRs for Asian/Pacific Islanders and Hispanic/Latinos have consistently been lowest.

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



- AACBs across racial/ethnic groups have been fairly steady over the past three years, with no extreme disparities across groups with one exception: The AACB for the Native American population was quite low in CY 2019 but has risen over the past three years and in CY 2021 was higher than for any other group. This could be due to a relatively small number of outliers, however, because the number of Native Americans served in the MHP was quite small (n=189 for CY 2021).

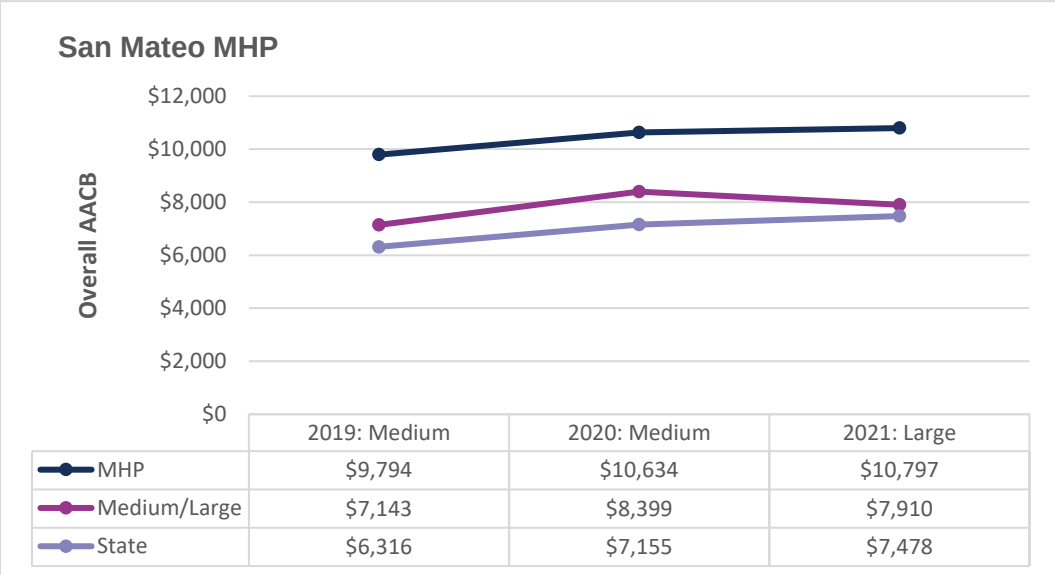
Figure 4: Overall PR CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	5.35%	4.83%	4.42%
Medium/Large	4.25%	3.87%	3.99%
State	4.86%	4.55%	4.34%

- Over the past three years PR has been trending downwards both in the MHP and statewide. San Mateo had slightly higher PRs than statewide in CYs 2019 and 2020, whereas in CY 2021 it was still higher, but just slightly.

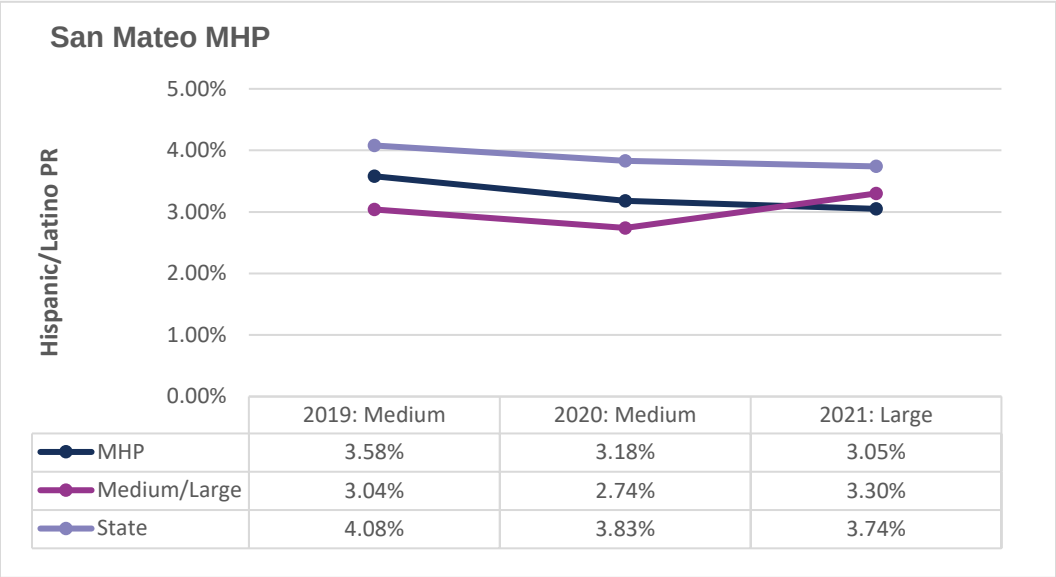
Figure 5: Overall AACB CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	$9,794	$10,634	$10,797
Medium/Large	$7,143	$8,399	$7,910
State	$6,316	$7,155	$7,478

- AACB has trended up slightly over the past three years. AACB has been consistently higher in San Mateo than in other medium/large counties (depending on the year) and statewide.

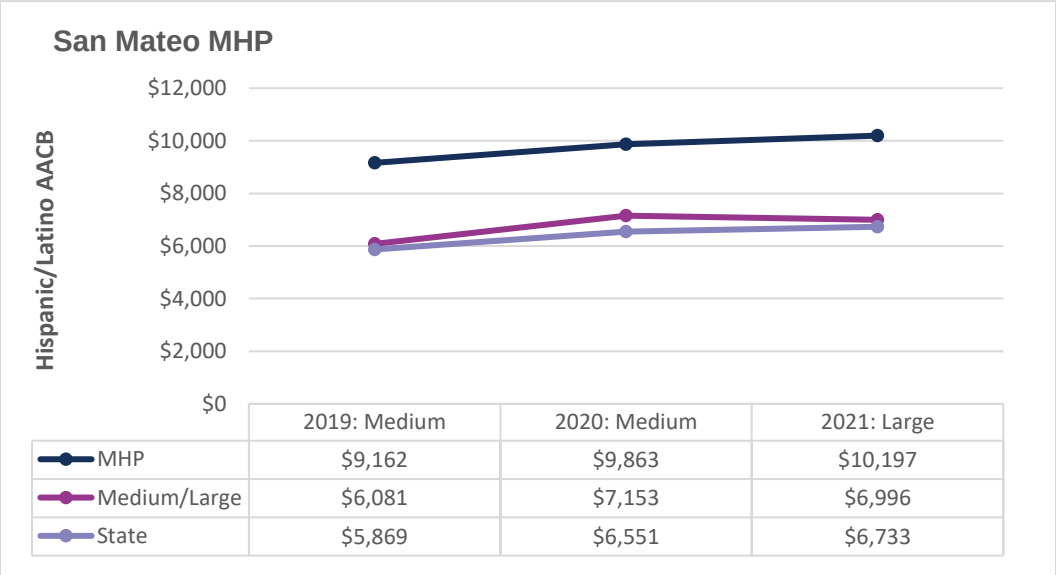
Figure 6: Hispanic/Latino PR CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	3.58%	3.18%	3.05%
Medium/Large	3.04%	2.74%	3.30%
State	4.08%	3.83%	3.74%

- The PR for Hispanic/Latino eligibles was in between that of similarly sized counties and statewide in CYs 2019 and 2020, but is now lower than both comparisons, after consistently trending downwards slightly.

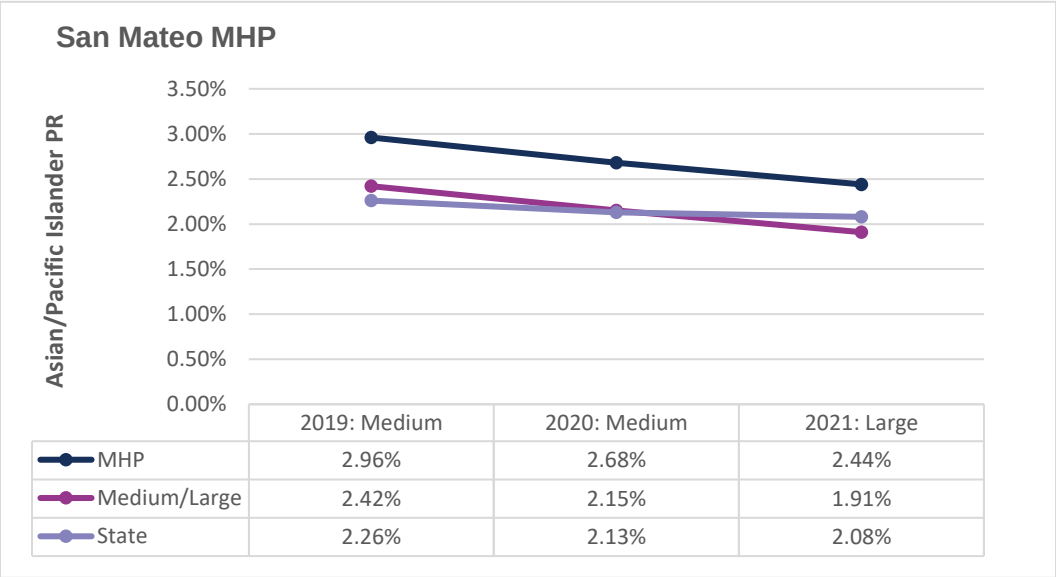
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	$9,162	$9,863	$10,197
Medium/Large	$6,081	$7,153	$6,996
State	$5,869	$6,551	$6,733

- AACB for Hispanic/Latino beneficiaries has been increasing slightly over time and has been consistently higher than in comparably sized counties and statewide over the past three years.

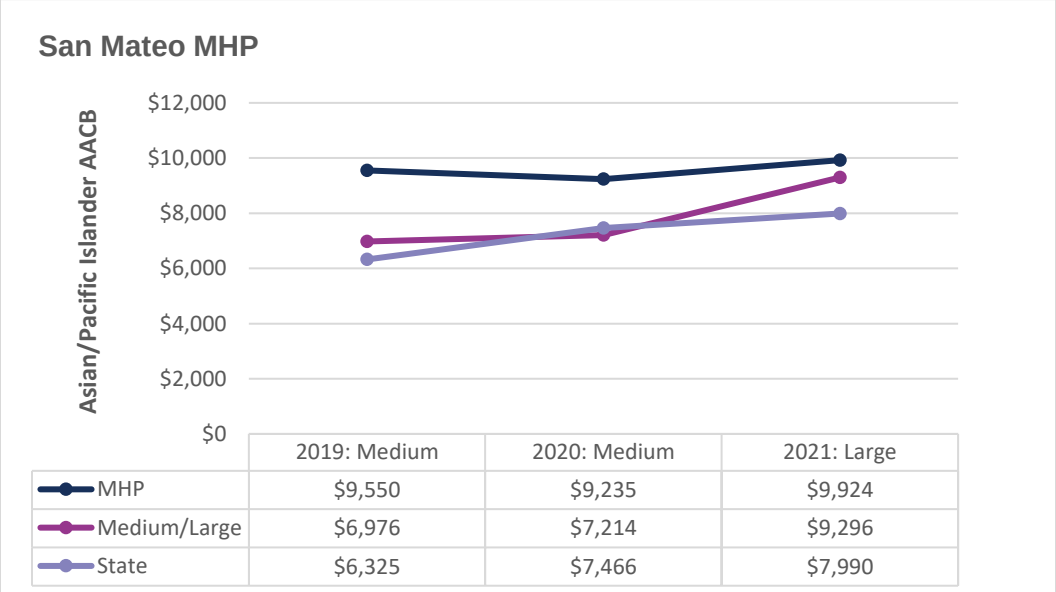
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	2.96%	2.68%	2.44%
Medium/Large	2.42%	2.15%	1.91%
State	2.26%	2.13%	2.08%

- The PR for Asian/Pacific Islander eligibles has been consistently higher than in other similarly sized counties and statewide over the past three years, and trended downward similar to both comparisons, over that period.

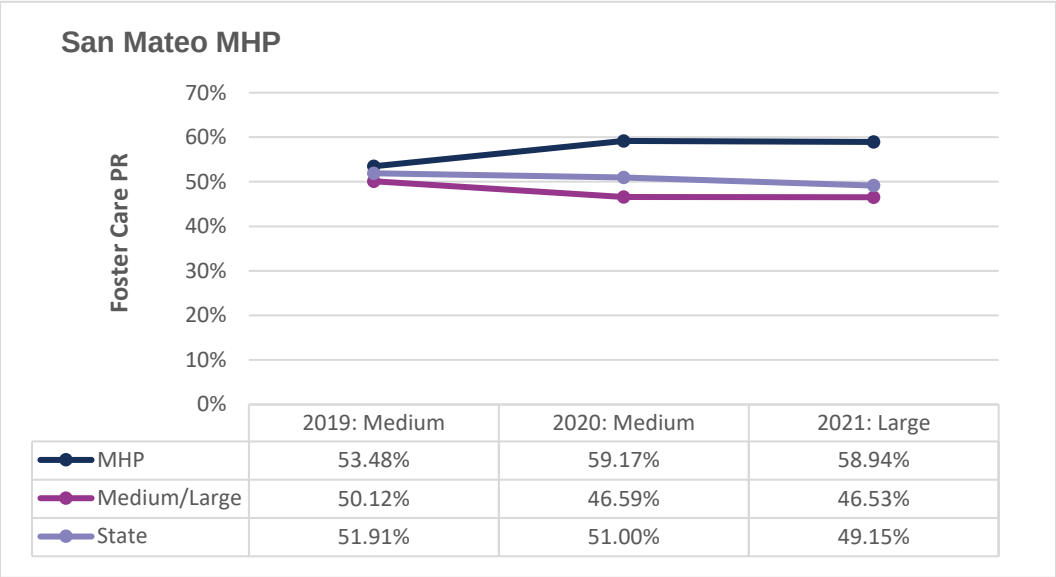
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	$9,550	$9,235	$9,924
Medium/Large	$6,976	$7,214	$9,296
State	$6,325	$7,466	$7,990

- AACB for Asian/Pacific Islander beneficiaries has been fairly stable since CY 2019 (within a range of less than $1,000) and was higher than comparably sized counties and statewide for all three years reflected in Figure 9.

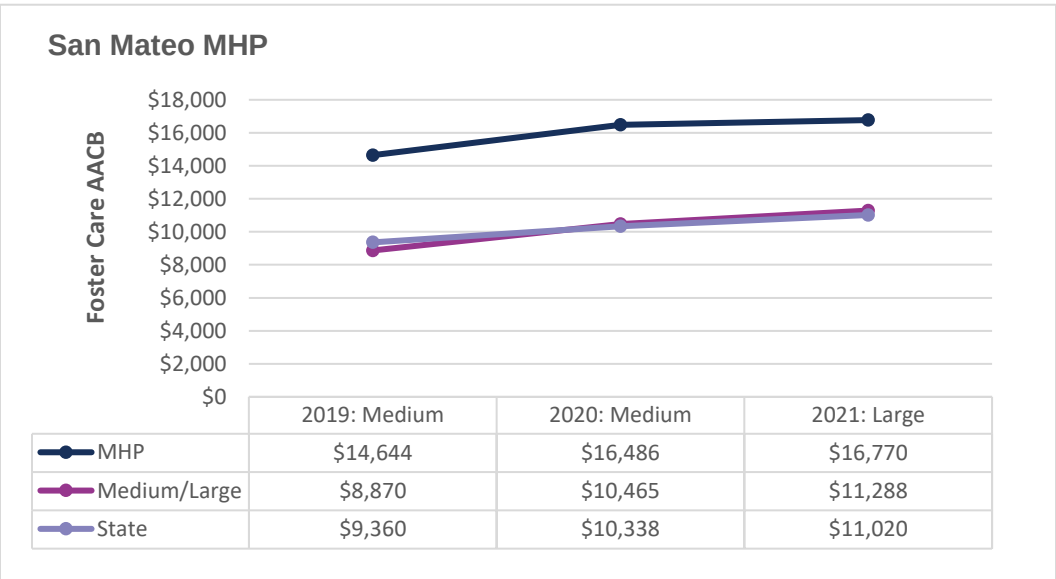
Figure 10: Foster Care PR CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	53.48%	59.17%	58.94%
Medium/Large	50.12%	46.59%	46.53%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed in Figure 10. Foster care PR increased in the MHP from CY 2019 to CY 2020, and then decreased ever so slightly in CY 2021. San Mateo's FC PR has been consistently higher than statewide and in similarly sized counties.

Figure 11: Foster Care AACB CY 2019-21



	2019: Medium	2020: Medium	2021: Large
MHP	$14,644	$16,486	$16,770
Medium/Large	$8,870	$10,465	$11,288
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased slightly each year. The MHP's FC AACB was relatively stable between CY 2020 and CY 2021, and has been consistently quite higher than the AACB seen statewide and in other similarly sized counties.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 5,626				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	492	8.7%	20	11	11.6%	16	8
Inpatient Admin	41	0.7%	32	23	0.5%	23	7
Psychiatric Health Facility	0	0.0%	0	0	1.3%	15	7
Residential	55	1.0%	137	120	0.4%	107	79
Crisis Residential	184	3.3%	31	18	2.2%	21	14
Per Minute Services							
Crisis Stabilization	712	12.7%	1,914	1,200	13.0%	1,546	1,200
Crisis Intervention	403	7.2%	116	78	12.8%	248	150
Medication Support	3,889	69.1%	352	260	60.1%	311	204
Mental Health Services	4,302	76.5%	798	265	65.1%	868	353
Targeted Case Management	3,127	55.6%	322	103	36.5%	434	137

- Inpatient was the most-used per day service, followed by Crisis Residential (CR). While CR was utilized at a slightly higher rate than that seen statewide, Inpatient was utilized at a lower rate. The average units (days) billed were higher for both of these services than those seen statewide.
- Average units for residential were substantially higher than statewide service unit averages. Inpatient administrative days were higher than statewide as well.
- Mental Health Services and Medication Support were, by far, the most-used per minute services in the MHP. This is congruent with statewide utilization patterns, though rates of utilization in San Mateo were higher than statewide.
- Targeted Case Management (TCM) was also utilized at a notably higher rate than statewide.

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

Service Category	MHP N = 146				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	11	7.5%	36	20	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	3,420	2,430	3.1%	1,398	1,200
Crisis Intervention	<11	-	103	71	7.5%	404	198
Medication Support	43	29.5%	275	198	28.3%	394	271
TBS	<11	-	2,902	1,058	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	37	25.3%	660	265	40.0%	1,351	472
Intensive Care Coordination	16	11.0%	853	446	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	135	92.5%	1,558	676	96.3%	1,848	1,103
Targeted Case Management	86	58.9%	458	159	35.0%	342	120

- The only per day service with FC utilization was Inpatient, which was utilized at a higher rate, and for quite a few more days on average, than statewide.
- Similar to statewide, the far and away most-used service for FC youth was Mental Health Services, though the utilization rate and median billed service units were slightly lower than statewide. The second most-used service by FC youth in the MHP was TCM, which had far greater utilization than that seen statewide. Intensive Home-Based Services and Intensive Care Coordination were utilized at much lower rates and had much fewer average minutes billed than statewide, perhaps indicating challenges to implementation of Pathways to Well-Being in the MHP.

IMPACT OF ACCESS FINDINGS

- CY 2019 through CY2021 data has reflected a steady increase in eligible beneficiaries while at the same time a steady decrease in penetration rate of those served, which may an indication of capacity challenges for the MHP.
- The MHP's age-based penetration rates indicate lower access than similar sized MHPs for those 0-5 years and 6-17 years, but higher than comparison counties for those 18-20, 21-64 and 65+ in age. This could reflect barriers to access for the younger eligibles population.
- Based on MHP feedback during the review, it does not appear that the impact of the broader CalAIM access criteria has yet to be reflected in MHP data.
- The API penetration rate of 2.44 percent is the lowest of all race/ethnicity categories for this MHP, which some stakeholders suggested could potentially improve through contracting with one of the dedicated API providers serving neighboring Bay Area MHPs.

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	Not Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Met

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

- 2B - The MHP states that a report is under development for the first non-urgent psychiatry appointment offered. At the time of this review there was no data available to share with EQR. This data element is noted by the MHP to have a number of coding issues that impact the completeness and accuracy of this data,

and likely does not reflect the entire picture. The MHP did report on the first non-urgent psychiatry appointment delivered.

- 2C - Urgent appointments lacked data for children's and FC services. While the numbers in this area are often low, there are usually some events reported. This likely reflects an event capture and coding issue that the MHP has noted needs to involve a training effort. The MHP also states this data is limited to only those requests for service that come through the Access Call Center.
- 2E - The submitted psychiatric inpatient readmission rates submitted by the MHP for this review are a small fraction of that based on claims data analyzed by the EQR. Considering the EQR information is limited to Medi-Cal beneficiaries and the MHP's data is based on all hospitalizations regardless of payor source, there is a possibility that a data capture issue exists for the MHP that also would likely reduce post-hospital follow-up.
- The MHP's timeliness reports are generated quarterly; review in QIC and leadership meetings is noted to occur annually, which could represent missed improvement opportunities if performed more frequently. Employees mention a general awareness of the timeliness requirements discussed in team meetings, but had not received complete reports of timeliness metrics.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12month period of 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 for first offered, urgent, and post-hospital discharge follow-up and readmissions. First offered non-urgent psychiatry service is not currently captured in the report furnished for this review.

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	6.01 Business Days	10 Business Days*	83.60%
First Non-Urgent Service Rendered	8.28 Business Days	10 Business Days**	73.53%
First Non-Urgent Psychiatry Appointment Offered	***	15 Business Days*	***
First Non-Urgent Psychiatry Service Rendered	33.35 Business Days	15 Business Days**	38.53%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.45 Hours	48 Hours**	99.69%
Follow-Up Appointments after Psychiatric Hospitalization	***	7 Days**	41%
No-Show Rate – Psychiatry	0.94%	5%**	n/a
No-Show Rate – Clinicians	2.74%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

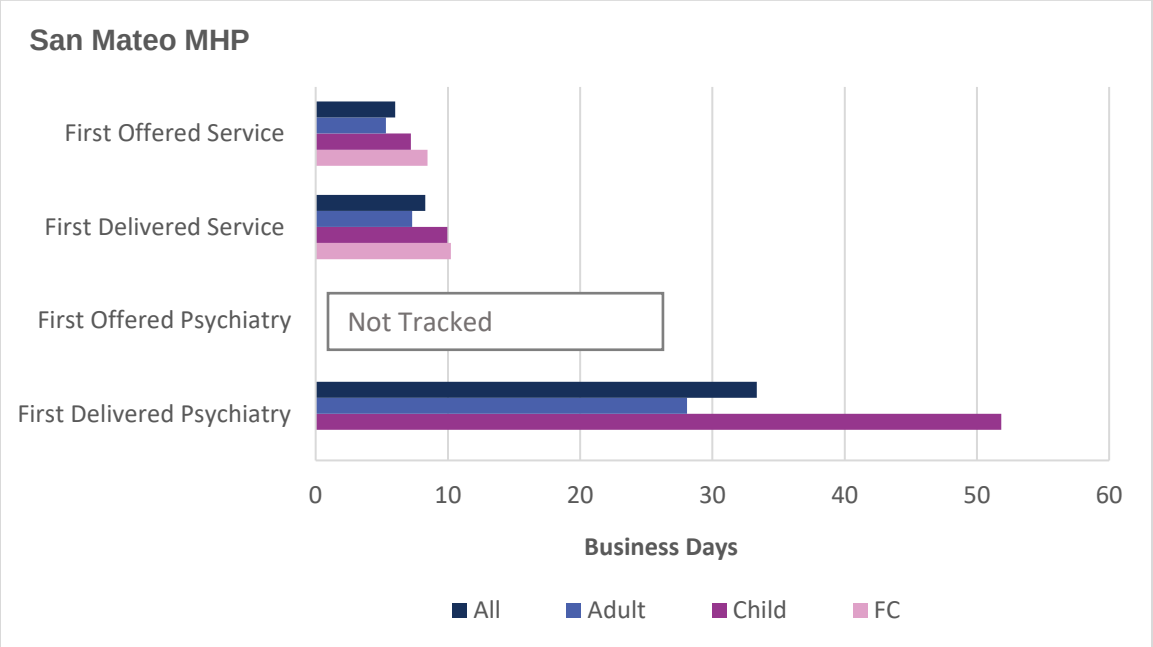


Figure 13: Wait Times for Urgent Services

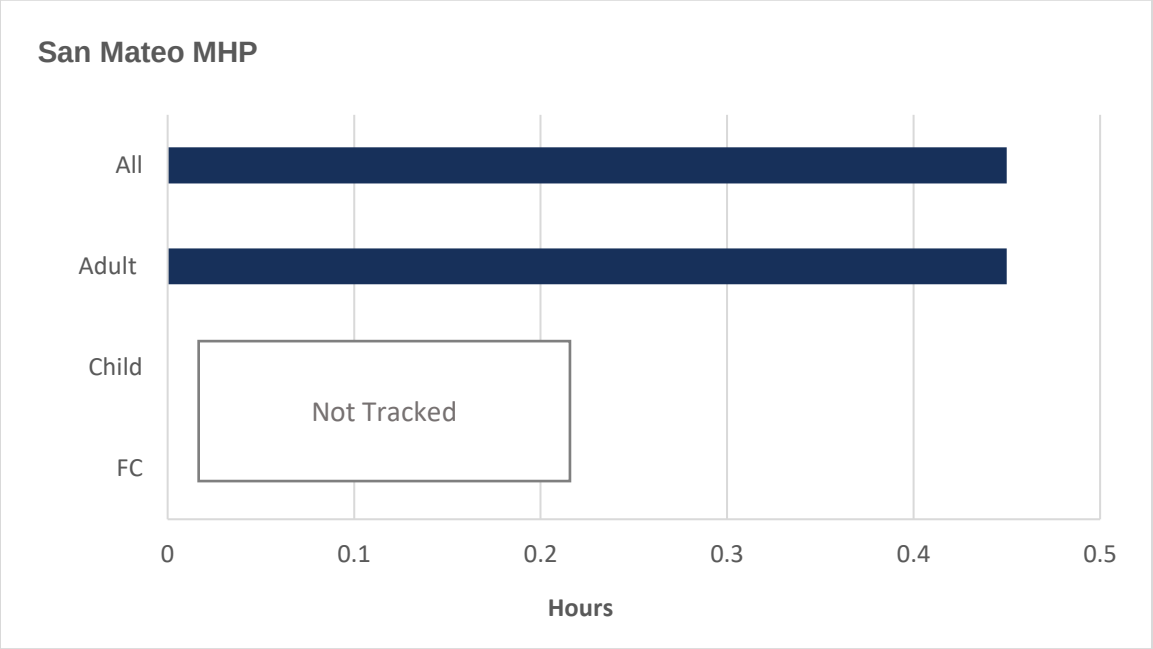
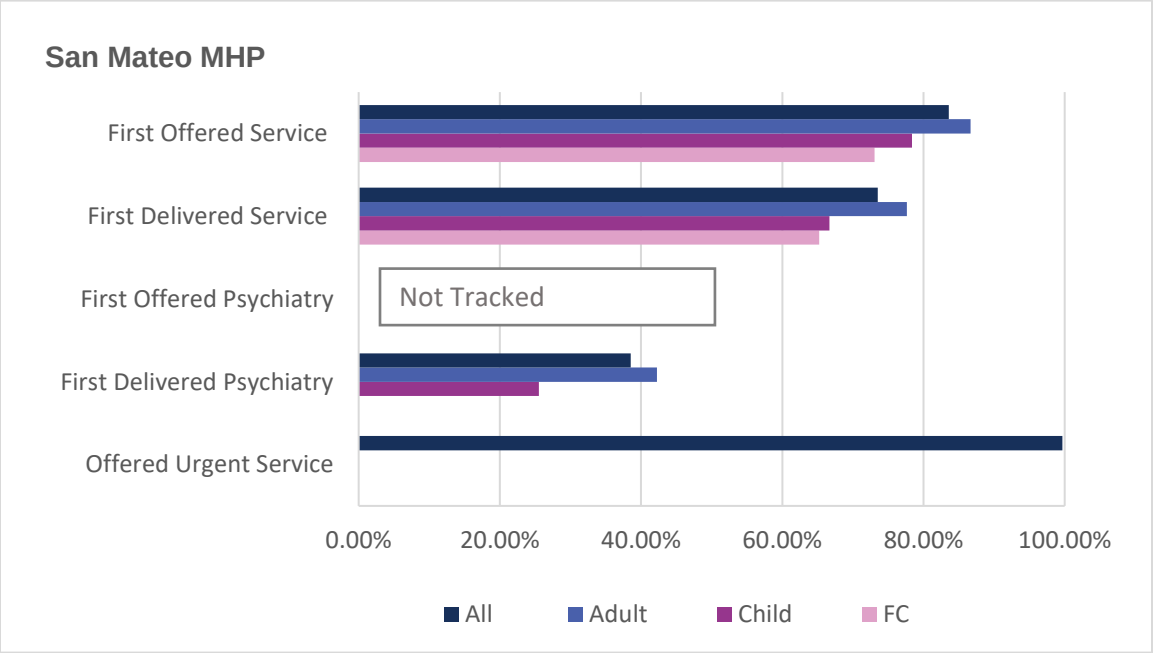


Figure 14: Percent of Services that Met Timeliness Standards



- 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 13, 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 “An urgent appointment means that it has been determined that taking the standard time to provide an appointment could seriously jeopardize the beneficiary’s life, physical or mental health or ability to attain, maintain, or regain maximum functioning. If another provider indicates an appointment is urgent, consider it urgent. If a client says their request is urgent, BHRS/CBO should assess their need and make a determination of whether or not an appointment is urgently needed. This assessment should be documented in the client’s chart.” There were reportedly 321 of urgent service requests with a reported actual wait time to services for the overall population at 0.45 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the beneficiary’s initial service request which occurred when initially requesting services.
- 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 represent a subset of county-operated service programs. The MHP reports a psychiatry no-show rate of 1.03 percent for adult services, and 0.06 percent for children’s services. No-shows for non-psychiatry clinical staff are 2.11 percent for adult services, and 3.79 percent for children’s services. These no-show statistics reflect extremely low percentages when compared to other MHPs.
- The MHP did not yet track or did not report data for first offered non-urgent psychiatry service. A report for this metric is under development, as the MHP works to resolve and capture the various ways that first psychiatry appointment requests may present.

IMPACT OF TIMELINESS FINDINGS

- In a number of areas, such as first offered non-urgent psychiatry service and urgent services, the MHP is working to improve comprehensiveness and accuracy of event capture and is developing a data dashboard. This should improve the MHP’s timeliness monitoring and support more real-time data-driven decisions of capacity needs.
- CalAIM impact does not currently appear to be reflected in the timeliness data for this review.

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 Quality Assessment and Performance Improvement (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 to an assistant director, who oversees Quality Improvement Management, which includes Quality Assurance (QA) and Quality Improvement (QI). A number of other units also are on the same level as Quality Improvement Management, such as the Access Call Center, and Communications.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, is comprised of BHRS managers, supervisors, Executive Team members, QM staff, clinical and administrative staff, clients/consumers and family members, representatives from BHRS teams, the Office of Consumer & Family Affairs, the Office of Diversity & Equity, medication assisted treatment services and others. Non-BHRS participants are included as well, such as San Mateo Medical Center Psychiatric Emergency Services, and contracted community-based providers of behavioral health services. The goal of the QIC is to have 35 members. The QIC is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the 23 identified FY 2021-22 MHP and combined MHP/SUD QAPI workplan goals, the MHP met ten goals, partially met six goals, and considered not met four goals. Three items were continued without formal evaluation of progress.

The MHP utilizes the following level of care (LOC) tools: The MHP did not identify any LOC tools for adults or children/youth.

The MHP utilizes the following outcomes tools: General Anxiety Disorder-7, Pediatric Symptom Checklist-35, Child and Adolescent Needs and Strengths, Patient Health Questionnarie-9. The results are summarized and aggregated for MHP operated programs.

The MHP runs aggregate CANS and PSC-35 reports monthly from county-operated programs.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Partially Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially 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:

- 3J - The MHP utilizes individuals with lived experience throughout the system in a variety of roles, with opportunities for advancement, including the lead for the Office of Consumer and Family Affairs, who reports to the Director.
- 3A - The MHP operates with dynamic, informed Quality Improvement Management unit; however, due to lack of capacity and challenges such as CalAIM implementation, improvement efforts which target areas such as medication monitoring improvements have been paused due to lack of capacity. The QAPI also reflects other areas in which important planned improvement areas that would benefit from continuation have been paused in order to respond to current and anticipated changes.

- 3D - While the MHP has a robust continuum of care; the adoption of specific level of care tools, which provide decision support, have yet to occur in both the adult and children's systems.
- 3E - Medication monitoring for the adult system of care is occurring regularly, with results summarized. However, this type of oversight has yet to expand to include contract providers. With the system changes in process involving CalAIM and other requirements, efforts to expand in this area have been paused.
- 3G - The MHP received a recommendation from the previous review to identify and implement an adult outcome instrument, but due to the significant system and CalAIM-driven changes, it lacks the staffing capacity to follow-through. There are also concerns that if an instrument were to be adopted, direction from the state may soon identify another instrument which would produce a costly and time-consuming conversion. Within the children's system of care, the MHP generates summary PSC-35 and CANS reports for county-operated services that track beneficiary success rates, and use comparative data to make clinical adjustments in treatment, and identify beneficiary strengths.
- 3H - The MHP has started including beneficiary satisfaction survey results in the QAPI Work Plan evaluation, which is currently posted to the MHP's website. The current evaluation provides a high-level review of data by age group, which could provide greater utility if the information was to be broken out by program. A mechanism for notifying stakeholders of this posting should be developed by the MHP.
- 3F - The MHP does track and trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): Aggregated quarterly.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): Aggregated quarterly.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): Aggregated quarterly.
    - The MHP did not report on the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

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

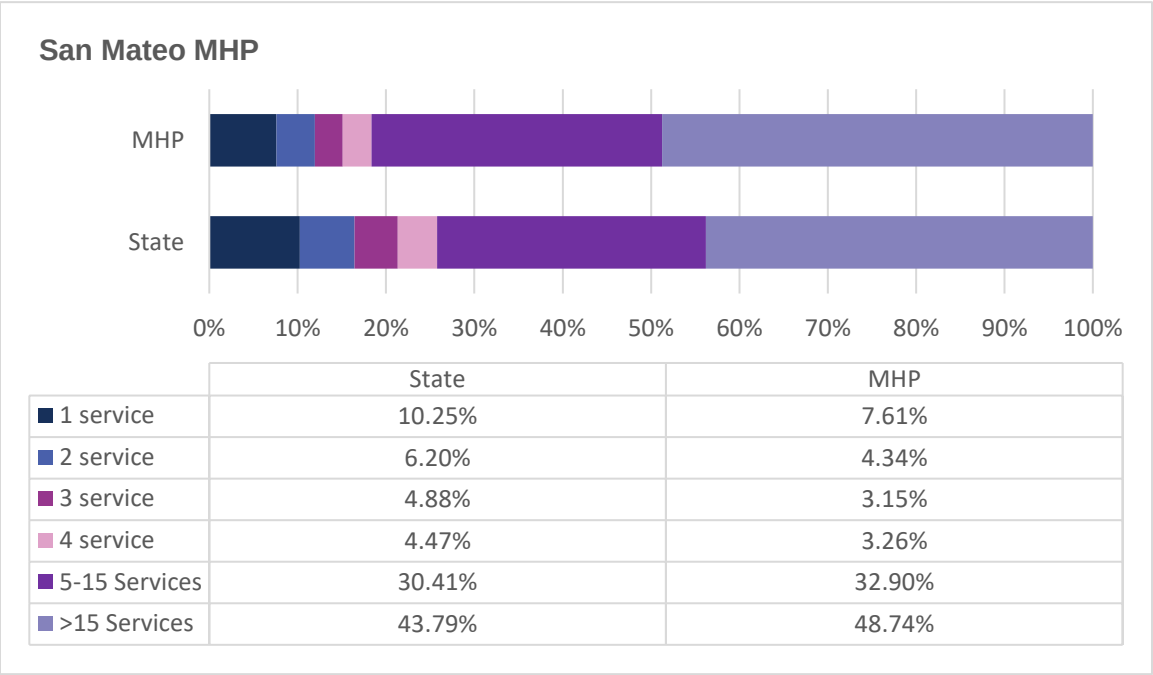
- Retention in Services
- Diagnosis of Beneficiaries Served

- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	7.61%
2 service	6.20%	4.34%
3 service	4.88%	3.15%
4 service	4.47%	3.26%
5-15 Services	30.41%	32.90%
>15 Services	43.79%	48.74%

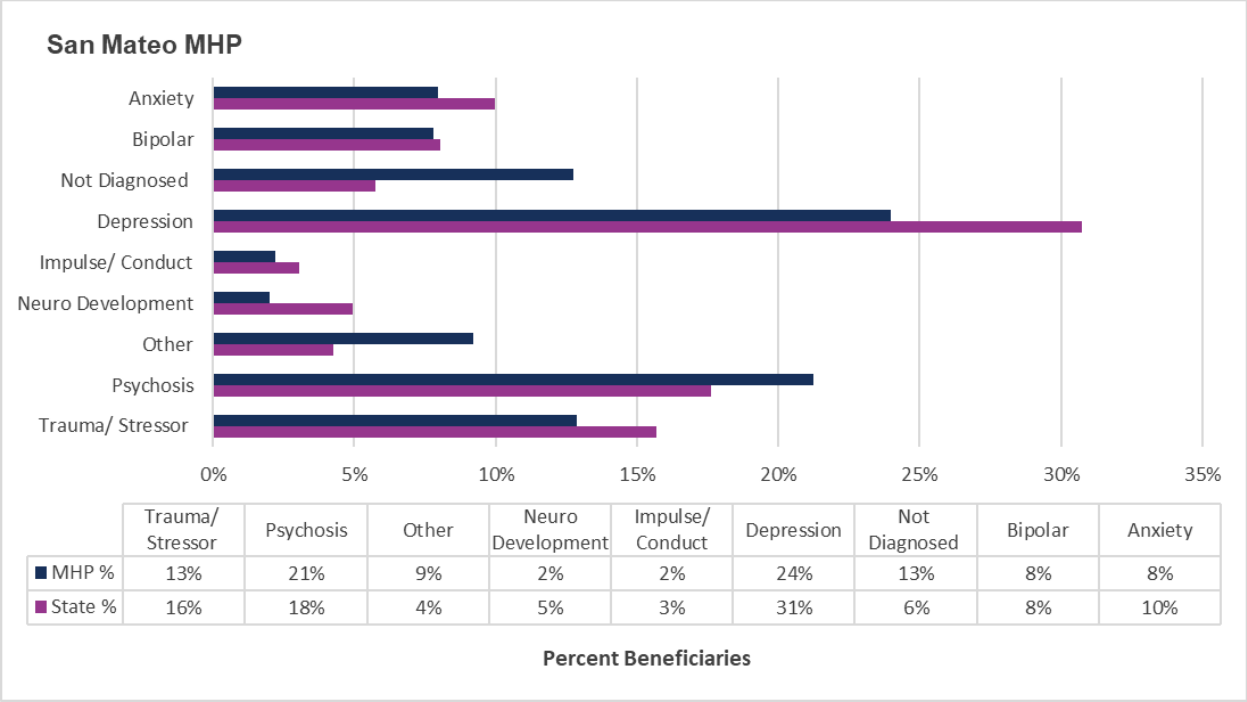
- The MHP has very strong retention in services, with over 81 percent of beneficiaries receiving five or more services as compared with 74 percent statewide.

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 figures below 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.

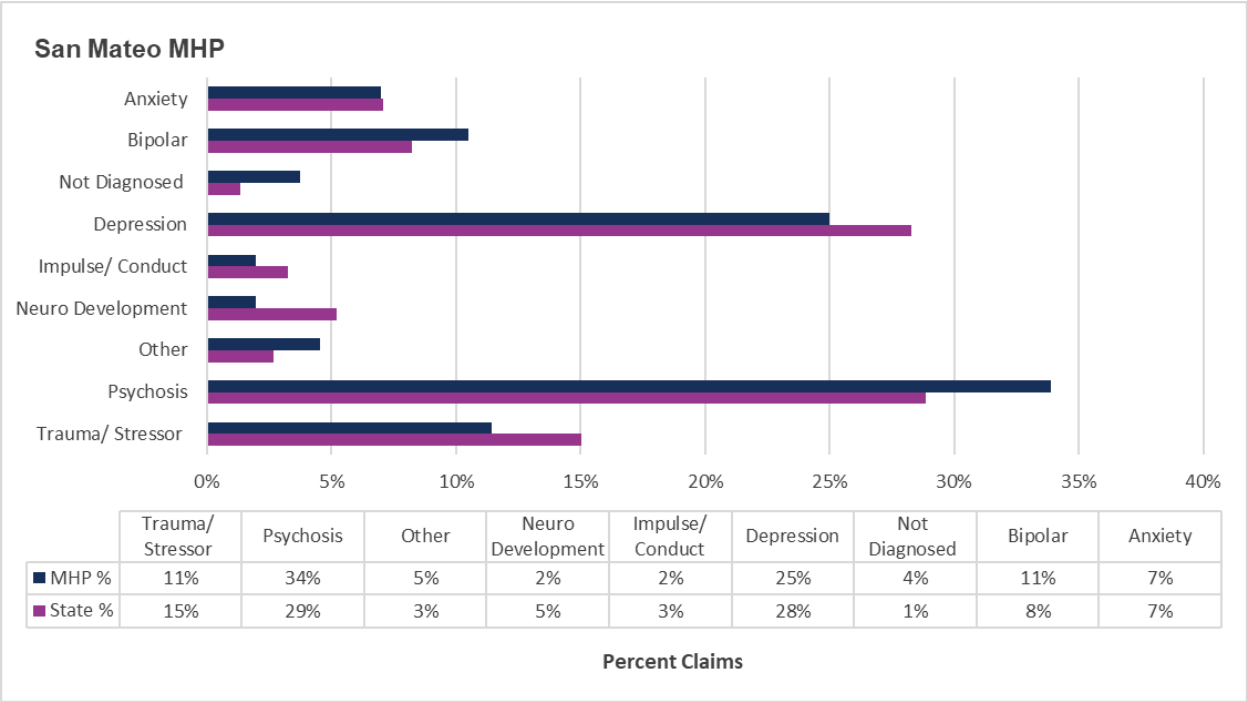
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	21%	9%	2%	2%	24%	13%	8%	8%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Depression and Psychosis were the most common diagnostic categories in the MHP. San Mateo had higher rates of “Other” and “Not Diagnosed” beneficiaries than statewide.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	34%	5%	2%	2%	25%	4%	11%	7%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- In general, claims were proportionate to diagnostic rates in the MHP, with the greatest exception being Psychosis, which accounted for 21 percent of diagnoses and 34 percent of claims. This may be due to the acuity of the diagnosis and need for a higher LOC.

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	555	1,320	11.57	8.86	$20,275	$12,052	$11,252,523
CY 2020	622	1,114	10.68	8.68	$22,112	$11,814	$13,753,641
CY 2019	758	1,278	9.10	7.80	$19,534	$10,535	$14,807,034

- The number of unique beneficiaries utilizing Psychiatric Inpatient services has been steadily declining over the past three years. For CY 2021, about 8 percent of all beneficiaries in the MHP received these services.

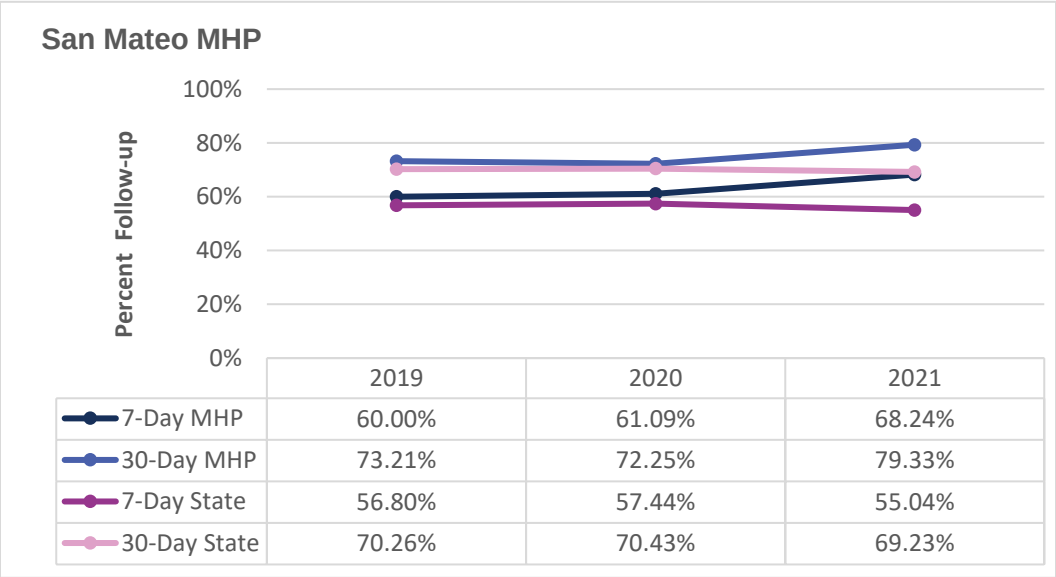
- While total admissions went down from CY 2019 to CY 2020, they rose in CY 2021 above the CY 2019 level. The average number of admissions per beneficiary was 2.4 for CY 2021 compared to 1.8 in CY 2020 and 1.7 in CY 2019.
- The average LOS has been increasing over the past three years and is consistently higher than the statewide average LOS.
- The MHP's AACB for inpatient services increased in CY 2020 but decreased in CY 2021, and has consistently been markedly higher than the statewide AACB over the past three years. Total approved claims for inpatient services have been decreasing over the past three years. For CY 2021 these claims represented 16.8 percent of all claimed dollars in the MHP.
- The MHP's data indicated a total of 184 total hospital admissions for FY 2021-22 and included all MHP clients, regardless of payor source. While it is expected for the MHP's data to not match the data in Table 13 (due to the different reporting period and different samples included), the sheer amount of difference between these two data sources may reflect issues with the MHP's ability to track admissions. The MHP has been taking steps to improve its abilities in this area, with the implementation of Collective Medical, which will provide notifications of beneficiary hospital admissions to the MHP.

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.

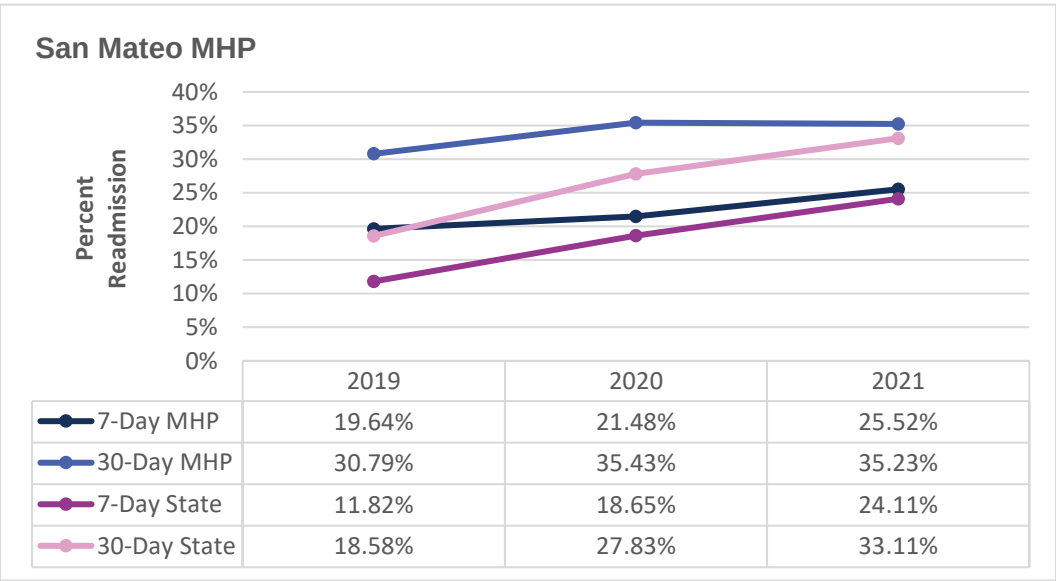
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	60.00%	61.09%	68.24%
30-Day MHP	73.21%	72.25%	79.33%
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	19.64%	21.48%	25.52%
30-Day MHP	30.79%	35.43%	35.23%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Both 7- and 30-day post psychiatric follow-up rates are much higher in the MHP than statewide, with substantive increases in both rates from CY 2019 to CY 2021.
- The MHP reported lower rates of follow-up than was reflected in the CY 2021 claims data shown in Figure 18 (MHP reports 41 percent at 7 days and 58 percent at 30 days). The MHP data reflects FY 2021-22 and includes all MHP clients regardless of payor source.

- The MHP's 7-day readmission rate has increased over the past three years. 30-day readmissions increased from CY 2019 to CY 2020, but decreased slightly in CY 2021. Both 7- and 30-day readmission rates in the MHP are comparable to statewide rates.
- The MHP reported much lower readmission rates than was reflected in the claims data shown in Figure 19 (6 percent for 7-day and 12 percent for 30-day). The MHP data reflects FY 2021-22 and includes all MHP clients regardless of payor source.

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	511	7.39%	38.48%	$28,717,329	$56,198	$44,690
	CY 2020	506	7.34%	39.79%	$29,190,208	$57,688	$44,938
	CY 2019	502	6.69%	39.25%	$28,835,838	$57,442	$45,622

- The total count and percentage of beneficiaries served falling into the HCB category has increased by very small amounts each of the past two years, and

for CY 2021 represent a higher percentage of beneficiaries than statewide. HCBs represented 38.48 percent of claims in the MHP, a proportion that has been fairly stable over time, as compared to 33.45 percent statewide.

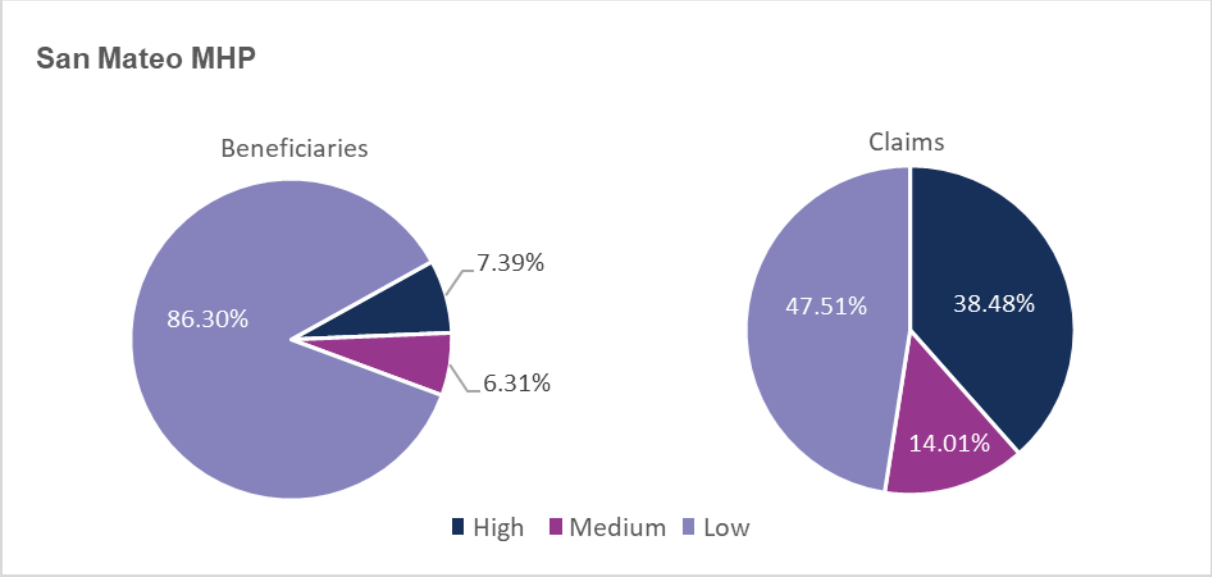
- Both average and median approved claims per HCB in the MHP were comparable to the statewide average and median.

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)	436	6.31%	14.01%	$10,452,241	$23,973	$23,466
Low Cost (Less than $20K)	5,965	86.30%	47.51%	$35,458,625	$5,944	$4,431

- About 86 percent of beneficiaries fell into the low-cost category, and the median approved claims per beneficiary in that group was $4,431.
- Less than 7 percent of beneficiaries fell into the medium cost category, with a median approved claim per beneficiary of $23,466.

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



- The beneficiaries served that were in the low cost category (86 percent) represented about 48 percent of claims, and medium cost beneficiaries represented about 6 percent of all beneficiaries and about 14 percent of claims. HCBs represented about 7 percent of beneficiaries served and about 38 percent of all claims.

IMPACT OF QUALITY FINDINGS

- Similar to other MHPs, BHRS is experiencing a significant challenge in responding to changes, including the positive ones that accompany CalAIM. Implementation of numerous BHINs has the MHP pausing previous initiatives that include selection of an adult outcome instrument and improving the scope of medication monitoring activities with contract providers.
- The MHP's higher retention rates than statewide suggest a successful access and engagement process; however, with >15 services approaching 5 percentage points higher than the statewide average the MHP might consider adoption of a LOC or adult outcome measure tool to assist in evaluating treatment progress of its beneficiaries.
- The MHP's post-hospital discharge follow-up rates for 7- and 30-days are approximately 10 percentage points higher than statewide averages. But the MHP's readmission rates are close to the statewide average. The MHP might consider exploring the type and frequency of post-hospital follow-up to identify best practices for improved results.

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: Increasing youth engagement in remote services

Date Started: 04/2021

Date Completed: 02/2023

Aim Statement: Will the use of a clinical toolkit that provides interactive activities to use during remote services result in a 10 percent increase in the average total service minutes provided to youth clients ages 0-12?

Target Population: 0-12 age youth, served by directly-operated programs

Status of PIP: The MHP's clinical PIP is in the sixth remeasurement period with PIP completion in February of 2023.

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

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

Summary

During the COVID 19 pandemic, the MHP embarked on an effort to improve the use of telehealth by the served youth beneficiaries ages 0-12, through the provision of a toolkit that utilized online games as a mechanism of engaging individuals.

The performances measures used to monitor progress included total average minutes of service per beneficiary per quarter, beneficiary survey data which indicated engagement with services using online games, and survey data of staff which also indicated engagement in remote services through the use of online games.

While there were some variations across time; overall, the majority of metrics have shown a decrease. Also reflected was less participation in telehealth likely associated with a decreased need for that approach due to relaxing of COVID restrictions. It is doubtful that this PIP will have any significant impact on services at this time.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence, because: the majority of metrics reflected a decrease in results, including participation in survey activity. This is likely associated with the change in circumstances related to the waning pandemic needs.

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

- There are no recommendations for improvement, in that the PIP was scheduled to end at the time of this review.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Increase client's ability to utilize telehealth services.

Date Started: 04/2021

Date Completed: 02/2023

Aim Statement: Will providing technical support to clients to help them understand how to use remote service technology increase the proportion of remote services provided by telehealth from 21 to 30 percent?

Target Population: All age groups, but excluding those served by contract agencies. The exclusion was due to lack of consistent data about contractor services.

Status of PIP: The MHP's non-clinical PIP is in the 6th remeasurement period, and PIP termination.

Summary

The challenges of providing mental health services in a pandemic environment were addressed through the shift to video and telephonic telehealth services. While most staff and beneficiaries are conversant with telephonic interactions, it seems accepted that video telehealth provide a mechanism of interaction that is closest to in-person care. But the familiarity with telephonic interactions resulted in a natural shift to this service delivery mechanism. In order to help overcome the barriers to video interactions, the MHP developed a "cheat-sheet" that was to be provided to beneficiaries. It also later reviewed the platforms for telehealth and brought the more favored option, Zoom, into play as an option. The cheat-sheet intervention was not consistently offered to beneficiaries. And the results, while improving in the first remeasurement, have consistently dropped off. The need for telehealth has also decreased, with the movement back to in-person care. The decreased need for telehealth may have resulted in further lack of motivation to provide cheat-sheets and video telehealth. As of the time of this review, the PIP was slated to end.

TA and Recommendations

As submitted, this non-clinical PIP was found to have no confidence, because: the PIP demonstrated steady decreased positive results and increased negative results over time. If pandemic-related limitations to in-person care were to have continued, it is likely a more positive result would have occurred. But at the time of this review the shift to in-person care was on the increase, and the need for telehealth was diminished. As this PIP ended at the time of this review, no recommendations for improvement will be made. The prominent use of telephonic services underscores how simpler, less technologically complex processes become the go-to option when in-person care is limited.

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

- Due to this PIP being slated for discontinuation as of the current review, no TA is currently relevant.

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 13 years. Currently, the MHP is in the process of implementing an upgrade to Avatar NX. The county is also considering replacing some or all Avatar functionalities with Epic within the next three years, and planning for that potentiality is in the very preliminary stages.

Approximately 4 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving the MHP and San Mateo Health, as IS positions are allocated by San Mateo Health. The FY 2022-23 budget allocation represents a slight increase from the prior year, when 3 percent of the budget was dedicated to support the IS.

The MHP has 582 named users with log-on authority to the EHR, including approximately 527 county staff and 55 contractor staff. Support for the users is provided by four full-time equivalent (FTE) IS technology positions. Currently there is one FTE vacancy. The number of FTEs and vacancies are unchanged since the last EQR.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	25%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☒ Monthly	25%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	50%
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 PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have a PHR available to beneficiaries but does plan to implement a PHR within the next year.

Interoperability Support

The MHP is a member or participant in a HIE, Carequality. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Mental Health CBOs/contract providers, alcohol and drug CBOs/contract providers, hospitals, and primary care providers.

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	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- 4A - While BHRS provided estimates of IS and analytic staffing levels for EQR purposes, the reality is that all IS and analytic staff are employed by San Mateo Health's IT department rather than BHRS or the MHP specifically. Staff report BHRS used to have a dedicated research and evaluation unit, but they no longer have a clear delineation between IS and analytic staff, nor MHP and DMC-ODS IS staff. The EQRO recognizes that due to the staffing structure being primarily under the control of San Mateo Health, it is challenging for BHRS to gain additional resources for these staff positions. However, it appears the staffing situation has left the MHP without the resources it needs to conduct important analyses pertaining to access, timeliness, and quality. As CalAIM requirements continue, this may place an even bigger strain on staff that are responsible for performing IS and analytic functions in a timely manner.
- 4A - BHRS leveraged funding from the Mental Health Services Act and the Coronavirus Aid, Relief, and Economic Security Act to support CBOs in acquiring technology necessary for providing telehealth services and other mobile/field-based services. Additionally, BHRS provided devices and data plans to vulnerable beneficiaries, as well as family partners and other peer staff, in order to support service delivery during the COVID-19 PHE.
- 4C - Fiscal/billing staff participate in cross-training activities to ensure that all staff performing these duties have at least one back-up, and the department has demonstrated the effectiveness of their overall training strategies by achieving a claims denial rate of 0.39 percent (as compared with the statewide denial rate of 1.43 percent).
- 4E - IS has implemented strong security safeguards, including maintaining and regularly testing an Operations Continuity Plan, supporting two-factor authentication for password changes and strong password requirements, as well as providing and tracking participation in regular cyber-security trainings.
- 4F - While not all CBOs choose to do direct entry into the EHR, BHRS does allow access for those who want to. BHRS is also a member in an HIE to further support interoperability.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

The MHP reports that claims are submitted weekly. This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame under review.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	17,326	$5,774,851	$2,765	0.05%	$5,355,095
Feb	16,720	$5,659,307	$4,493	0.08%	$5,349,026
Mar	19,730	$6,665,047	$5,299	0.08%	$6,361,603
April	17,981	$6,116,847	$8,027	0.13%	$5,816,204
May	16,974	$5,938,487	$11,102	0.19%	$5,456,879
June	16,916	$5,928,495	$2,366	0.04%	$5,642,377
July	15,950	$5,757,427	$20,078	0.35%	$5,493,319
Aug	17,053	$6,141,243	$5,612	0.09%	$5,909,005
Sept	16,303	$5,914,082	$18,761	0.32%	$5,653,826
Oct	15,919	$5,845,718	$38,092	0.65%	$5,433,354
Nov	15,455	$5,619,407	$116,955	2.08%	$5,250,803
Dec	15,293	$5,591,523	$40,304	0.72%	$5,268,268
Total	**201,620**	**$70,952,434**	**$273,854**	**0.39%**	**$66,989,759**

- The MHP has a consistent claims volume across CY 2021. The MHP reports an increase in denied claims in November 2021 due to changes to aid codes pertaining to immigration status that resulted in a large number of denials. San Mateo continues to work to resolve these claims.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	71	$121,265	44.28%
Other healthcare coverage must be billed before submission of claim	87	$54,761	20.00%
Service line is a duplicate and a repeat service procedure code modifier not present	103	$51,457	18.79%
Late claim	16	$21,998	8.03%
Beneficiary not eligible or non-covered charges	50	$21,812	7.96%
Other	10	$1,594	0.58%
Service location NPI issue	10	$652	0.24%
Deactivated NPI	4	$313	0.11%
Total Denied Claims	**351**	**$273,852**	**100.00%**
Overall Denied Claims Rate	**0.39%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The largest proportion (44.28 percent) of denied claims dollars were denied because Medicare Part B needed to be billed first. The other primary denial codes were “Other healthcare coverage must be billed before submission of claim” (representing 20.00 percent of denied dollars in the MHP), and “Service line is a duplicate and a repeat service procedure code modifier not present” (cited for 18.79 percent of all denied claims dollars).
- The MHP’s overall denied claims rate is much lower than the statewide denial rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP, and BHRS as a whole, have been working to implement technological tools to improve analytic capabilities, despite not receiving any additional staff dedicated to either IS or analytic functions from San Mateo County Health. While their efforts are commendable, and staff are doing everything they can with what they have, there remains a need for additional staff in order to make the most of their IS resources.
- Work on improving tracking of referrals to outside providers, expanded dashboards, improvements to timeliness reports in Avatar, participation in an HIE, and impending implementation of Collective Medical’s hospitalization notification tool, among other projects, have BHRS well-poised to make improvements to their MHP that would likely have positive impacts on quality improvement efforts, but the staff making these improvements possible need

additional support, especially with greater demands associated with CalAIM requirements on the horizon.

- The IS, analytic, fiscal, and quality management staff should be praised for their dedication to improvement and efforts in collaborating across teams. Additionally, San Mateo is taking a measured approach to considering shifting to a different EHR that will allow ample time to prepare for the transition, should they choose to move ahead, while also continuing to make improvements to their current EHR by implementing Avatar NX.

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 provided an analysis of CPS data which was incorporated in the QI Work Plan evaluation, with plans to post on the website to provide information to stakeholders. The current data presentation does not yet include comparison data over time.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of parents/caregivers of children and youth beneficiaries who initiated services in the preceding 12 months. The focus group was held virtually and included five participants. All participants have a family member who receives clinical services from the MHP. A small segment of the participants initiated services within the past year.

For those with initial access experience in the past year, timeliness to service was considered very fast – nearly immediate. Those whose access experience was prior to the last year, initial access timeliness varied from one week to two to three months. A key element seemed to involve understanding and experience with the MHP system. Once that has been attained, it becomes easier, such as if another child requires mental health care.

Appointment reminders are received by most for psychiatry appointments, but non-psychiatry appointment reminders varied. Regarding cultural and linguistic issues, availability of bilingual clinicians and psychiatrist were mentioned. Participants were also

aware of transportation support services, with a very small segment requiring that type of assistance. All felt the cultural needs of their children were well addressed.

Caregivers mentioned that most practitioners also focus on physical health and physical activity as an important adjunct to therapy and medications. A significant number of these family members mentioned successful changes in clinician when the issue of fit arose.

Most currently receive in-person services, but mention that telehealth, including telephone, is available. The frequency of services varies widely, tracking with the progress in treatment. Some have weekly therapy sessions, with monthly psychiatry. The intervals begin to extend as the child progresses and becomes more stable. Missed appointments are easily rescheduled.

A variety of options are available for urgent care needs, including texting the therapist, going to the emergency room, or calling the joint police/MHP response team. However, it should be noted that some continue to have apprehensions about calling law enforcement, uncertain as to how their child might be handled.

Family support has been utilized by the majority of these caregivers. This includes support groups, parent mentors, and parenting classes. Satisfaction survey feedback has been provided by almost everyone in the group. In addition, they receive information from therapists, and access training such as mental health first aid.

Universally, they would like more support and instruction. Also, the caregivers feel they themselves need supportive therapy to manage the stress of having a child with mental health problems. Others suggest that family partners and the Parent's Café is very helpful, and becomes part of the family.

A small component of this parent/caregiver group has participated in MHP committees and meetings. Others would like such involvement.

The wellness center for youth was cited as too far away to be practical for some, but the concept of such a program was thought to be helpful.

Recommendations from focus group participants included:

- More education about mental illness so that early identification and treatment can occur.
- More information for parents, more staff available, and more support groups.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included 8 participants; a Spanish language interpreter was used for this focus group. All participating consumers receive clinical services from the MHP. None had initiated services within the last year.

The initial experience for those accessing care before there were standard expectations for initial services thought their wait time was very brief, with the exception of one individual for whom it took two months.

Appointment reminders are received by several members, consisting of email or phone calls. Interpretation services are received by some members. Transportation assistance was received by several members. Some were unhappy that Lyft or Uber was required, not a taxi, which was felt to be safer and more reliable. Taxis would respond after the appointment, whereas there were circumstances when Lyft or Uber would drop off but not pick up, stranding the individual temporarily.

Involvement of family in treatment was not a relevant topic for most participants. Some stated it could occur if desired by the beneficiary.

Physical health incorporation with mental health treatment is common, such as talk about losing weight and engaging in physical activity. Some mentioned receiving health information brochures about self-care. In several instances, the psychiatrist was seeking lab results to review related to tracking health metrics.

Poor therapist fit was a topic that produced a few divergent responses. One member has sought changes with several providers, including network practitioners. This resulted in being referred back to MHP operated services because service needs were too extensive, and is still awaiting assignment of a therapist. Others have switched several times, and found the experience easy. Some are apprehensive about changing because it can be difficult to quickly be assigned a replacement therapist.

The method of receiving services saw significant discussion. Some started with telehealth and subsequently either attend clinic services, with some receiving in-home services. Another member received telephonic telehealth, and that was due to the beneficiary's personal schedule. Others have received Zoom sessions for the assessment and telephone services thereafter. Some opined that telephonic sessions are very convenient. Another felt that staff tend to default to telehealth and that one must be assertive to receive in-person sessions.

In this session, there were adults that felt it is difficult to get services for oneself, but seeking treatment for their children was comparatively easier. Service frequency varied significantly, but tended to track progress in treatment. Some receive twice a week services, others once a week or month, with the largest interval every other month. However, some find once the interval begins increasing, it is difficult to get in quickly if life circumstances change.

Missed appointments have a range of responses. At times, the program calls after a missed appointment. Others mentioned a psychiatric appointment is just rescheduled.

Involvement with peer support has included attending National Alliance on Mental Illness (NAMI) events, and receiving navigation assistance. Attending the Lived

Experience Academy, in which issues about treatment can be brought up was considered helpful. Bridges to Wellness was another positive option mentioned.

Crisis and urgent needs presented a complex picture. Some mentioned trying to call the county services six times and could not get through. Some felt there was lack of information as how to deal with shelter crisis. Others had a much more successful experience with crisis support. This included having a crisis number and using it to obtain help. One member shared that Serenity House was a great resource where you can stay a week or more if you need it. The utility of 988 was yet to be experienced by these individuals. One individual cited the SMART team through the police, which was very helpful in providing an immediate response.

The majority have participated in a consumer satisfaction survey, with the sole observation upon the survey long length. Obtaining information about MHP resources was a complicated topic with varied experiences. Some cited family partners as a good information resource, NAMI and BHRS meetings were also mentioned.

Wellness centers had not been heard of by a minority of participants. The rest either knew about them or had attended them. A doctor or therapist completing a referral form was identified as the process to become a member.

The majority felt their cultural needs are fully taken into consideration.

Requests for changes in therapist can result in the individual being referred to a network provider. Following an assessment, this process can result in referral back to MHP services when the network provider then determines the individual has higher needs than mild to moderate. Following referral back to the MHP, often there are delays for the individual seeking treatment. One participant mentioned that when requesting case management, he was informed that he was seeing the “wrong type of psychiatrist.” Another individual had a different experience, and this was with dependent children that had become adults. The freedom of those over 18 years to make independent decisions creates concern for the parent who can no longer can coordinate services with the treatment team.

Recommendations from focus group participants included:

- Several of these adult participants while pleased with the psychiatry and other clinical services received, felt that case management assistance, such as with obtaining housing should be easily flexed in and be more responsive.
- Several participants were pleased with their services and the results and had no recommendations.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of caregivers of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included four participants; a Spanish language interpreter was used for this focus group. All

participant family members have a family member who receives clinical services from the MHP.

The family members were all recent advocates for treatment for their adult biological children. The participants highlighted the challenges that exist when children reach age 18, and are then on their own to make decisions about treatment and also sharing of healthcare information, unless there is a conservatorship in place.

The parents described the circumstances wherein their adult children wanted to return to the parental home for shelter, seeing it as a housing resource, but were marginally involved in in treatment and unwilling to sign a consent for the parents to receive any information from the program staff.

One participant highlighted the challenges of having a dually diagnosed adult child, who needs the structure of residential substance abuse treatment program but also has a severe mental illness. It was difficult finding a substance abuse treatment program that would accept the severe mental illness. Without the adult's willingness to sign a release of information, the parent is not willing to take back into the home. Also, there are concerned their loved one will be on the streets.

The common theme for this group of individuals is that upon reaching majority, each of their adult children no longer wanted them involved or informed about treatment needs, yet each of those individuals wanted to utilize the parental home as a resource for shelter. These caregivers wanted to see the MHP take a more active role in resolving these conflicts.

Recommendations from focus group participants included:

- The MHP to develop a family advocate role that can provide guidance in general regarding how to approach the desire of caregivers of adults to support their loved ones while respecting confidentiality boundaries.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The consumer-family member focus groups included an adult beneficiary group, a caregiver of children group and a caregiver of adult beneficiaries. As might be expected, the experiences varied between the feedback groups.

The caregivers of children and youth did not include any whose initial access occurred during the past year. The majority receive in-person services now, ranging from clinic-based to in-home services. Family support services in the form of support groups and parent mentors have been utilized by the majority. There is a desire on the part of these participants to receive more support and instruction regarding the best way of responding to their children. Additionally, they would like to receive direct therapy for themselves in order to manage the stress related to having a child with mental health problems. In summary, the caregivers would like to receive more and continuing

education about mental illness, and have more support groups available to them. This also includes more staff in the programs serving their children.

The adult beneficiary focus group all initiated services prior to the past year, and for those individuals access was generally considered quick. Several had concerns about the transportation assistance offered by the MHP and the MCP, which tended to be a ride-sharing service that many considered unreliable. Adult beneficiaries wished for case management support to easily be added to their menu of services when circumstances such as a housing crisis occurred. They found that one had to be in a specific client category in order to have case management available. It should be noted that the majority were pleased with their services and had nothing to recommend.

The caregivers of adult beneficiaries focus group all described complex challenges of their family members. The caregivers experienced the barrier of confidentiality and their adult family member not wanting to have any information shared with them by treatment staff. At the same time, the family member in treatment was wanting to return to and reside at the family home, while also often displaying high-risk behaviors. Navigating this complex issue was the caregivers' main concern, in that they wanted to provide shelter but not without some knowledge of what treatment was being provided and assurance their loved one was following through. The need for an adult family advocate/mentor was discussed, as well as shared with the MHP. NAMI family-to-family and other meetings were cited to these participants as additional resources.

CONCLUSIONS

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

STRENGTHS

1. The MHP's communication efforts, as reflected in the monthly Director's Update, provides a rich level of detail regarding programs, performance data, changes and challenges of the department. (Access, Quality, IS)
2. The MHP participates in primary care service integration in five public health clinics with staff colocation and collaboration between health and mental health practitioners, improving service access for adults and children.
3. The MHP is in the process of considering the need for additional positions in light of current demand, increases in eligibles, and CalAIM impacts. (Access, Timeliness, Quality)
4. The MHP is collaborating on housing developments that support the needs of beneficiaries across the age spectrum and their access to shelter. (Access, Quality.)
5. To facilitate CalAIM implementation, the MHP has had frequent, regular meetings scheduled with the Health Plan of San Mateo, to discuss coordination issues, with separate sessions targeting adults, children, and a work group meeting that review local implementation requirements. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Timeliness data reporting for the FY 2022-23 review period did not include first offered non-urgent psychiatry appointments.
2. The MHP lacks a universally applied adult outcome instrument, which could assist in determination of treatment needs and step-down suitability.
3. Contract agency supplied information is not uniformly and comprehensively included in timeliness or SB 1291 reporting.
4. While the MHP possesses knowledgeable quality improvement staff, the increased demands on this unit produced by CalAIM and other changes are resulting in the pausing of existing important improvement efforts due to lack of capacity. (Quality)

5. While BHRS has made investments in improving IS and technologies, the lack of sufficient IS personnel and dedicated analytic staff and may be a hindrance to making the most of these new tools. (Quality, IS)

RECOMMENDATIONS

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

1. Track, report and evaluate first offered non-urgent psychiatry appointments and identify, track, and routinely review urgent request for services. (Timeliness, Quality, IS)

   (This recommendation is a carry-over from FY 2019-20, FY 2020-21 and FY 2021-22.)

2. Prepare for a state-selected universal adult level of care tool by mapping out the requisite workflow so that implementation will be rapid and effective. (Quality, IS)

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

3. Demonstrate successful tracking, reporting and regular review of timeliness for the entire service delivery system, including county-operated services. (Timeliness, Quality)

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

4. Review the scope of responsibilities of the QI/QA unit, and consider increased staffing if the demands exceed current capacity. (Quality)

5. Evaluate the adequacy of IS and analytic staff capacity to support the critical improvement efforts and full utilize the tools available, and initiate the process to augment positions if they are determined insufficient.

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

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. 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 Mateo 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
PIP Validation and Analysis
Performance Measure Validation and Analysis
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 – Clinical Management and Supervision
Information Systems Billing and Fiscal Interview
Telehealth

CalEQRO Review Sessions – San Mateo MHP
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer
Lynda Hutchens, Quality Reviewer
Leah Hanzlicek, Information Systems Reviewer
David Czarnecki, Consumer-Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Altomari	Annina	QM Clinical Analyst	BHRS
Alvarez	Elizabeth	Supervising Mental Health Clinician	BHRS
Avery	Doreen	Financial Services Manager II	BHRS
Bermudez	Roberto	Case Manager/Assessment Specialist III	BHRS
Blitzstein	Lear	Marriage & Family Therapist II	BHRS
Boyden	Clara	Deputy Director, AOD Services	BHRS
Bruton	Noelle	Clinical Services Manager II	BHRS
Buggs	Colleen	Clinical Services Manager I	BHRS
Cabrera	José	Community Support Worker	BHRS
Cabuslay	Edith	Program Services Manager I	BHRS
Chan	Tracey	Program Specialist	BHRS
Chapralis	Steve	Executive Director	Telecare
Chavez	Karen	Peer Support Worker II	BHRS
Chu	Shirley	Clinical Services Manager I	BHRS
Ciprez	Luis	Supervising Mental Health Clinician	BHRS
Coate	Stephanie	Supervising Mental Health	BHRS
Cooper	Ondray	San Mateo County Probation	Probation

Last Name	First Name	Position	County or Contracted Agency
Davis	Margarie	Community Mental Health Nurse	BHRS
De Ocampo	Hedwig	Supervising Mental Health Clinician	BHRS
Del Rosario	Michael	Director of Correctional Health Services	Correctional
Dell	Peter	Deputy Medical Director	BHRS
Essex	Jeff	Executive Director “El Centro de Libertad”	El Centro
Estremera	Doris	Program Services Manager II	BHRS
Fong	Doug	Clinical Services Manager II	BHRS
Fullerton	Mary	Clinical Services Manager II, AOD Services	BHRS
Gamayo	Kris	Program Specialist	BHRS
Gard	Janet	Deputy Director, Finance & Administration	BHRS
Giannini	Elizabeth	Supervising Mental Health Clinician	BHRS
Godinez	Iris	Marriage & Family Therapist II	BHRS
Gonzalez	Claudia	Marriage & Family Therapist II	BHRS
Gruendl	Scott	Assistant Director	BHRS
Grunert	Richard	Peer Support Worker I	BHRS
Guandique	Marta	Marriage & Family Therapist II	BHRS
Gutierez	Joe	Executive Director	One Life CS
Huerta	Ivette	Program Specialist	BHRS

Last Name	First Name	Position	County or Contracted Agency
Hughs	Suzie	Executive Director	One Life CS
Kang	Kimberly	Supervising Mental Health Clinician	BHRS
Kauffman	Lynda	Director of Government and Public Affairs	Psynergy
Kemple	Chad	Contractor	BHRS
Krahn	Karen	Deputy Director, Older Adult & Adult Services	BHRS
Lanzarin	Daniel	Marriage & Family Therapist II	BHRS
Lau	Eddie	Health IT Manager	BHRS
Lin	Maureen	Marriage & Family Therapist II	BHRS
Lobos	Frances	Community Health Planner	BHRS
Lorente Foresti	Maria	Director, Office of Diversity & Equity	BHRS
Mancini	Lisa	Interim Director	BHRS
Mealey	Jeannine	Contractor for QM	BHRS
Medal	Mercedes	Medical Office Specialist	BHRS
Meeds	David	Executive Director	Caminar
Modha	Ritu	Financial Manager II	BHRS
Moreno	Regina	Clinical Services Manager II	BHRS
Nadel	Laura	Quality Director	Psynergy
Nguyen	Angel	Supervising Mental Health Clinician	BHRS
Noland	Sean	Supervisor	Correctional Health

Last Name	First Name	Position	County or Contracted Agency
Ochoa	Ziomara	Deputy Director, Child & Youth Services	BHRS
Olsen	Eric	Peer Support Intern	BHRS
Ortiz-Gallardo	Betty	Quality Assurance Manager	BHRS
Pena	Aurora	Supervising Mental Health Clinician	BHRS
Perez	Marta	Supervising Mental Health Clinician	BHRS
Platte	Melissa	Executive Director	Mental Health Association
Prehn	Cara	Executive Director	Edgewood
Racy	Talisha	Clinical Services Manager II	BHRS
Ramirez	Claudia	Marriage	BHRS
Ramirez	Yolanda	Senior Community Program Specialist	BHRS
Ramos	Alberto	SUD Supervisor	BHRS
Robaina	Louise	Supervising Mental Health Clinician	BHRS
Rocha	Carlos	Peer Support Worker II	BHRS
Russell	Amanda	Executive Director	Caminar
Rutherford	Jim	Supervising Mental Health Clinician	BHRS
Shapiro	Annya	Executive Director	Jefferson Union

Last Name	First Name	Position	County or Contracted Agency
Soliz	Iliana	Peer Support Worker II	BHRS
Souter	Tasha	Medical Director	BHRS
Stavn	Mary	Supervising Mental Health Clinician	BHRS
Tinoco-Elizondo	Claudia	QM Unit Chief	BHRS
Tsujii	Eri	QM Program Specialist	BHRS
Tucker	Tennille	Supervising Mental Health Clinician	BHRS
Uyan	Sheryl	Administrative Service Manager I	BHRS
Vasquez	Christina	Psychiatric Social Worker II	BHRS
Vasquez	Sonia	Peer Support Worker II	BHRS
Wilches	Jairo	OCFA Interim Director	BHRS
Zamora	Jessica	Program Specialist	BHRS

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	This PIP was developed to improve the engagement of youth in virtual services that were necessary during the pandemic. The intent was to use online games to support engagement in both video and telephonic services to increase the duration of virtual treatment sessions. Due to a variety of untracked factors, participation by staff in learning and using the virtual game toolkit was very limited; on the beneficiary side, their use of virtual games was also quite limited. A number of the tracked metrics lacked any baseline data, and for comparison purposes in this report the first remeasurement period was used as a baseline proxy. The service minutes and numbers of sessions did have baselines, and these showed a drop for most periods and for the 6th remeasurement period. Due to the low performance, which was impacted by low participation of both staff and beneficiaries, one must conclude no confidence. This improvement effort targeted an important aspect of services, but with the re-emergence of in-person care, the benefit and need of this PIP is currently quite limited.
General PIP Information	
MHP/DMC-ODS Name: San Mateo BHRS	
PIP Title: Increasing youth engagement in remote services	
PIP Aim Statement: Will the use of a clinical toolkit that provides interactive activities to use during remote services result in a 10 percent increase in the average total service minutes provided to youth clients ages 0-12?	
Date Started: 04/2021	
Date Completed: 02/2023	
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)	

General PIP Information
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: 0-12 years
Target population description, such as specific diagnosis (please specify): n/a
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): Use of a toolkit with 0-12 year of age children/youth that is intended to improve their engagement and use of remote services through online games
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providing training to children's clinical staff in the use of a toolkit intended to improve engagement with remote services by the use of online games.
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): Training for MHP children's staff that involves the use of online games to support improvements in engagement and then bringing duration of remote services more in line with in-person care sessions.

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) Total Average Minutes of Service per client per quarter	March-August 2020	418.43 min	#6. 10/2022	379.38 min	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
2) Survey Data from Clients indicating client engagement with remote services through the use of online games (Phone; Telehealth)	Currently 0% baseline as client's self-assessment of engagement in sessions has not been consistently measured prior to PIP implementation. 7/2021 First Remeasurement (Baseline Proxy)	n/a 1/3 reported that online games help them stay engaged in phone appointments; 1/2 reported that online games help them stay engaged in video sessions.	#6: 10/2022	(No clients responded to these questions)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 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
3) Survey Data from Staff indicating client engagement with remote services (Percent of staff who report client is more engaged when using virtual toolkit)	Currently 0% baseline as staff's assessment of client engagement in sessions has not been consistently measured prior to PIP implementation. Baseline Proxy below: Re-measurement 1: 7/2021	n/a 1st Remeasurement (baseline proxy) 30%	Re-measurement 6: 10/2022	0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
4) Average Duration of Remote Service Minutes (Telehealth Minutes, Phone Minutes)	August 2020	37.98; 54.63	6: 10/2022	33.74; 57.25	☒ Yes ☒ No Video services decreased; telephonic increased.	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): 6th remeasurement Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The circumstances of telehealth services have changed significantly since the origin of this PIP. It is also scheduled to end in the time of this review. The barriers of both beneficiary and staff participation in the PIP were doubtless challenges which occurred on top of the stresses associated with the pandemic in staffing, caseloads and MHP capacity. With the shift back to in-person care which is currently occurring, improvements to this PIP would likely not take hold. However, this PIP does provide a foundation for future work if circumstances again present a need to provide massive amounts of non-in-person care. Perhaps the general fatigue of staff with all of the changes required for COVID-19 also presented a barrier to adopting a new practice during this time. Therefore, there are no recommendations related to the improvement of this PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	COVID-19 required a shift from in-person services to remote services. The MHP surveyed staff regarding this change, and discovered that both staff and beneficiaries were facing a number of technical issues that were barriers to rapid adoption of telehealth. The data showed an 11 percent increase in the number of services and an average of ten minutes fewer of service time. Phone services were decreased in duration (37 minutes, average), whereas video services were longer (66 minutes, average). Except for the initial positive results early on, the data has shown a downturn. This is likely related to the change in pandemic response which makes in-person care broadly available. Likely those who continue to opt for telehealth, including video services, possess the hardware, bandwidth and technical skills to be successful with this modality. Those who do not are likely returning to in-person care. The original driving force behind this PIP was the decreased ability to provide in-person care, which has changed in recent months. Thus, the likelihood of success of this activity is very low, and the results reflect no confidence.
General PIP Information	
MHP/DMC-ODS Name: San Mateo BHRS	
PIP Title: Increase client's ability to utilize telehealth services.	
PIP Aim Statement: Will providing technical support to clients to help them understand how to use remote service technology increase the proportion of remote services provided by telehealth from 21% to 30%?	
Date Started: 04/2021	
Date Completed: 02/2023	
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)	

General PIP Information
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): Limited to MHP served beneficiaries, with contract provider services excluded.
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): Provision of a telehealth “cheat-sheet” to assist in overcoming technical challenges.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Education of clinical and admin staff to provide telehealth “cheat-sheets” to beneficiaries.
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): Training of staff in the utility of telehealth “cheat-sheets” for beneficiaries not receiving in-person services.

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
Percent of service minutes provided via telehealth.	March-August 2020	21%	Re-measurement 6: 10/2022	24%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Percent of clients who report that it is easy or very easy to access telehealth services.	No baseline – first remeasurement used as proxy 7/2021	No baseline – first remeasurement used as proxy 79%	6th remeasurement 10/2022	Zero response for using telehealth	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Percent of clients who report feeling satisfied or very satisfied with telehealth services.	No baseline – first remeasurement used as proxy 7/2021	No baseline – first remeasurement used as proxy 64%	6th remeasurement 10/2022	Zero response for using telehealth	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): 6th remeasurement and PIP completion Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: This PIP was scheduled to end as of the month of this review; therefore, no recommendation would be relevant.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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