OFFICE OF AUDITS & ADVISORY SERVICES

COUNTY MENTAL HEALTH CLINICS AUDIT

FINAL REPORT

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Report No. A24-008 June • 2025

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JUAN R. PEREZ
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June 9, 2025

TO: Nadia Privara, Acting Director
Behavioral Health Services

FROM: Juan R. Perez
Chief of Audits

FINAL REPORT: COUNTY MENTAL HEALTH CLINICS AUDIT

Enclosed is our report on the County Mental Health Clinics Audit. We have reviewed your response to our recommendations and have attached it to the audit report.

The actions taken and/or planned, in general, are responsive to the recommendations in the report. As required under Board of Supervisors Policy B-44, we respectfully request that you provide quarterly status reports on the implementation progress of the recommendations. You or your designee will receive email notifications when these quarterly updates are due, and these notifications will continue until all actions have been implemented.

If you have any questions, please contact me at (858) 495-5661.

JUAN R. PEREZ
Chief of Audits

AUD:WA:nb

Enclosure

c: Patty Kay Danon, Chief Operations Officer, Health and Human Services Agency
Tracy Drager, Auditor and Controller
Amy Thompson, Chief Financial Officer, Health and Human Service Agency
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About the Office of Audits & Advisory Services

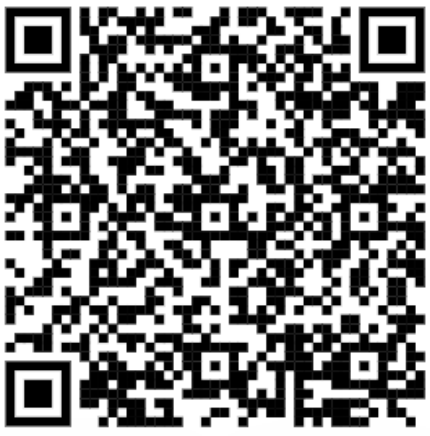
The mission of the Auditor and Controller's Office of Audits & Advisory Services (OAAS) is to provide independent, objective assurance and consulting services designed to add value and improve the County of San Diego's operations. OAAS helps the County accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Audit Authority

OAAS derives its authority to conduct audits of County departments and programs primarily from the County Charter, County Administrative Code, Board of Supervisors Policy Manual, and California Government Code.

Statement of Auditing Standards

This audit was conducted in conformance with the International Standards for the Professional Practice of Internal Auditing prescribed by the Institute of Internal Auditors as required by California Government Code, Section 1236.



AUDIT OBJECTIVE & SCOPE

The objective of this audit was to evaluate the capacity and utilization of the County operated behavioral health outpatient service clinics, including direct service productivity and linkage of clients to necessary social service resources.

The audit examined clinic operations for fiscal years 2022-23 and 2023-24, focusing on operational efficiency, resource allocation, and compliance with regulatory requirements. The review did not include evaluations of clinical treatment outcomes or financial management.

AUDIT RESULTS

In our opinion, there is reasonable assurance that clinics are functioning efficiently and are effectively connecting clients to the necessary resources. However, the following findings present opportunities to enhance compliance, service accessibility, documentation practices, and provider accountability.

Finding I:

Enhancing MRR Reporting and Quality Improvement Oversight

The Medical Record Review (MRR) process evaluates compliance using an overall percentage that aggregates multiple assessment categories. While this approach provides a general compliance rating, it has limitations that allow clinics to appear compliant despite deficiencies in critical service areas. Clinics achieving an overall compliance rate of 90% or higher are considered compliant, even when specific documentation areas show substantial non-compliance.

Under the current methodology, Quality Improvement Plans (QIPs) are required when overall compliance falls below 90%. However, Quality Assurance (QA) may also require QIPs at their discretion when significant deficiencies or recurring trends are identified during the review. As a result, deficiencies in individual assessment areas may not trigger formal corrective action. Instead, these issues are categorized as Quality Improvement Recommendations (QIRs), which serve as suggestions rather than mandatory corrective actions. Since QIRs do not require structured responses or follow-up, recurring deficiencies often remain unresolved.

The MRR tool, developed to align with State requirements, is applied at least annually by QA Specialists and is designed to evaluate clinical documentation across several categories within a specific review window. BHS policy allows for QIPs to be issued at the discretion of QA when concerns identified during the MRR rise to a level requiring structured intervention. If the identified issues do not represent regulatory or clinical risk, they may instead be categorized as QIRs, which do not require formal responses or tracking. Although QIRs are not monitored through follow-up actions, they are reviewed during subsequent MRRs to help identify patterns and guide areas of focus.

The MRR scoring methodology reflects the total number of “yes” and “no” responses across all reviewed elements. Lower subsection scores may result from missing administrative details (e.g.,

unchecked boxes or form errors). For instance, decreased compliance rates for progress notes in FY 2023-24 were largely attributed to changes in documentation timelines.

State regulations emphasize the need for structured compliance tracking and continuous quality improvement. Title 9 of the California Code of Regulations (§1810.440) requires that significant compliance issues impacting service quality or utilization be identified, addressed, and effectively tracked to ensure proper remediation. However, without a formal tracking mechanism for QIRs, clinics lack accountability for resolving identified deficiencies. This may result in persistent non-compliance and potential regulatory risks.

Key Findings by Clinic:
A review of MRR data across multiple clinics revealed ongoing documentation challenges in specific areas, even when overall compliance scores exceeded 90%. These challenges primarily involved demographic forms, progress notes, safety planning, and outcome measures, and were noted across both fiscal years.

North Central Behavioral Health Center (NCBHC)

- In FY 2022-23, NCBHC achieved a 92% overall compliance rate, though individual chart compliance was lower at 53%. Common issues included incomplete demographic forms (36%), non-compliant progress notes (33%), non-compliant safety planning (29%), and delays in outcome measure documentation which persisted from the prior review cycle.

- By FY 2023-24, overall compliance declined to 84%, and individual chart compliance fell to 13%. Significant challenges persisted in several areas, including progress notes (93% non-compliant), demographic forms (73% non-compliant), safety planning (33% non-compliant), and outcome measures, with 80% not completed within required timelines.

Southeastern Behavioral Health Center (SEBHC)

- SEBHC maintained high overall compliance in both years (91% in FY 2022-23 and 92% in FY 2023-24); however, individual chart compliance declined from 60% to 44%. In FY 2022-23, seven charts showed delays in outcome measure documentation, as noted by program attestation. PRA safety plan compliance declined significantly, from 38% to 67% non-compliance, while Behavioral Health Assessments (BHAs) showed a 56% non-compliance rate in the most recent review.

East County Behavioral Health Center (ECBHC)

- ECBHC's overall compliance remained consistent at 90% for both years; however, individual chart compliance declined slightly from 54% to 46%. Key areas of concern in FY 2023-24 included progress notes (92% non-compliant), PRA safety plans (46% non-compliant), and outcome measures, which continued to show documentation challenges with a 54% non-compliance rate.

While the clinics met overall compliance under current QA methodologies, opportunities remain to improve MRR reporting and tracking.

RECOMMENDATION:

To enhance the effectiveness of the MRR compliance assurance process and ensure that deficiencies are addressed, the following recommendations are proposed:

1. Reassess Compliance Metrics: Consider revising the compliance rate calculation methodology to ensure that significant sub-category issues are weighted appropriately and do not allow clinics to achieve "compliance" while critical deficiencies persist.

2. Redefine the criteria for QIP issuance: Redefine the criteria for QIP issuance to include recurring deficiencies in QIRs.

3. Establish a QIR Tracking System: Develop a centralized system to monitor QIR implementation, ensuring timely resolution and validation.

Finding II:

Improving Documentation Oversight and Records Accessibility

A review of client records from Utilization Reviews conducted during FY 2022–23 and FY 2023–24 identified opportunities to improve consistency in documentation practices and ensure timely completion of required clinical elements. While BHS's use of hybrid records during its transition to a fully electronic health record (EHR) system is permitted under BHS Policy #6052, California Health and Safety Code, and HIPAA, documentation gaps were observed in key areas, specifically problem lists, outcome measures, and client encounter documentation.

Although hybrid systems are allowable, the coexistence of paper and electronic records during the transition period may have contributed to variability in documentation practices and challenges in record accessibility. These dual systems can make it more difficult to ensure consistent adherence to documentation standards across clinics, particularly when information is split between formats or stored in decentralized locations.

Addressing these gaps can support timely access to accurate client information, enhance care coordination, and improve alignment with regulatory and internal expectations.

Regulatory and policy guidelines emphasize the importance of comprehensive and accessible documentation to support service delivery and compliance.

- The Outcome Measures Manual underscores the need for timely and consistent data entry into the mHOMS and CCBH systems to accurately track client progress and treatment outcomes.

- The Organizational Provider Operations Handbook (OPOH) further establishes documentation accuracy expectations, requiring that each client have a problem list reflecting symptoms, conditions, diagnoses, and risk factors. This list must be regularly updated to support clinical decision-making.

While these guidelines provide a structured framework, there are opportunities to enhance consistency in documentation and record management practices. Strengthening oversight and improving adherence to standardized documentation procedures will help ensure that providers have access to complete and accurate information to support timely and effective client care.

Key Findings by Category:

Problem Lists – Maintaining an accurate and up-to-date problem list is essential for treatment planning and continuity of care. The review found instances where problem lists were incomplete or outdated:

- At the East Clinic, 10% of cases had incomplete problem lists.
- At the North Central Clinic, 4% of cases had outdated problem lists that were not updated to reflect changes in client needs.

Outcome Measures – Timely and complete entry of outcome measures supports effective treatment monitoring and evaluation. The review identified instances where the required outcome measures were missing or incomplete:

- During discharge process testing, 30% of cases had missing or incomplete outcome measures, including key tools such as the Illness Management and Recovery (IMR) questionnaire, Milestones of Recovery Scale (MORS), and Recovery Markers Questionnaire (RMQ).
- These findings align with trends observed in the FY 2022-23 and FY 2023-24 Medical Record Reviews (MRR), which identified challenges in the timely completion and accuracy of outcome measures across multiple clinics. Adherence rates for completing required outcome measures ranged from 8% to 80%, with delays or omissions noted during both annual reviews and key treatment milestones.

Client Encounter Documentation – Accurate documentation of client encounters is essential for service tracking and continuity. The review identified an instance where documentation of a client encounter was incomplete:

- At the Southeast Clinic, 4% of sampled cases lacked adequate documentation of a client encounter, representing 1 out of 25 charts reviewed.

While hybrid record use is permissible, the above findings reflect opportunities to reinforce documentation consistency within the existing framework. Strengthening oversight and reinforcing adherence to documentation protocols may further ensure that records, whether electronic or paper, are complete, accessible, and support high-quality client care.

RECOMMENDATION:

Improve Documentation Oversight: Implement a centralized system to ensure all client records are accurately maintained, accessible, and allow for effective tracking and monitoring of the completion and updating of problem lists and outcome measures, promoting consistency across clinics.

Finding III:

Ensuring Effective Outreach for No-Show New Clients

Protocols and requirements are in place for following up with potential clients who miss scheduled appointments. According to the Organizational Provider Operations Handbook (OPOH) and the BHS Missed Appointment Guideline, clinical staff must contact clients within one business day, or the same day if identified as high-risk, and programs are responsible for developing procedures to track missed appointments.

During the audit testing period, the Access to Services Journal (ASJ) was the system in use to document and track access and timeliness of care. However, ASJ did not include standardized fields or functionality to record follow-up efforts for individuals who missed appointments. A review of a sample of no-show clients from clinic ASJ logs did not include documentation verifying that follow-up had occurred, making it difficult to confirm adherence to established outreach protocols. This limitation may have led to missed opportunities for timely client engagement, especially for high-risk individuals, and created challenges in verifying compliance with tracking requirements.

Since the conclusion of audit testing, BHS has discontinued use of ASJ and transitioned to SmartCare as the primary system for recording client interactions, including outreach and follow-up activities. The Access Team has also implemented updated follow-up procedures, now supported by a formal tracking system.

Although these improvements were implemented after the review period, ensuring that follow-up efforts remain fully documented and consistently monitored across programs continues to be critical, particularly during systems transitions.

RECOMMENDATION:

Ensure Consistent Documentation of Follow-Up Efforts in SmartCare: Reinforce standardized documentation practices to ensure that all outreach efforts for unconnected clients are properly recorded and accessible across programs.

Finding IV:

Defining Productivity Standards for Locum Tenens Psychiatrists

The contract with Interim Physicians, LLC, which provides Locum Tenens (LT) psychiatrists, does not contain explicit productivity benchmarks, such as the County's current standard of 64,800 service minutes per year (60% productivity) outlined in the OPOH. While productivity expectations are communicated during onboarding and monitored at individual clinics, formal productivity standards are not incorporated into the contract.

BHS monitors LT productivity at the clinic level, with expectations regularly discussed in staff meetings and tracked monthly alongside County-employed prescribers. In FY 2023-24, LT psychiatrists assigned to BHCs had an average productivity rate of 61.31%, exceeding the 60% productivity target. However, the absence of contractual productivity requirements presents risks to performance monitoring and accountability, particularly when negotiating service levels with contracted providers.

Regulatory and policy guidelines further underscore the importance of establishing measurable productivity standards in contracts. Board Policy A-81 requires quantifiable objectives to facilitate performance evaluation and ensure contractor compliance with service delivery expectations. Additionally, the policy emphasizes the need to maintain documentation of all monitoring activities and findings to protect County interests. The absence of defined productivity metrics for LT psychiatrists limits the County's ability to enforce service expectations and track performance effectively.

Formalizing productivity expectations, including the integration of performance benchmarks within contracts, would strengthen service expectations, compliance, and operational oversight.

RECOMMENDATION:

Amend Contract to Include Defined Productivity Benchmarks: BHS should amend the contract to explicitly incorporate measurable productivity standards. These should include established benchmarks such as 64,800 service minutes per year (60% productivity) and additional performance metrics, including compliance with outcome measures and documentation accuracy.

BACKGROUND

San Diego County's Behavioral Health Services (BHS) plays a vital role in delivering mental health and substance use disorder treatment to residents across the region. Operating within the Live Well San Diego framework, BHS provides services through a network of County-operated and contracted providers, ensuring access to care for individuals with moderate to severe mental health conditions.

Among these providers, three County-operated outpatient behavioral health clinics serve as direct providers of mental health services in San Diego County. These clinics offer comprehensive treatment for individuals with serious mental illness and co-occurring substance use disorders, prioritizing accessibility and continuity of care.

Service Delivery and Client Access

County-operated clinics follow a "No Wrong Door" policy, ensuring that individuals seeking behavioral health services can access care through multiple entry points:

- Access and Crisis Line (ACL) – A 24/7 hotline providing mental health support and service referrals.
- Direct Clinic Contact – Clients may call or visit clinics to schedule appointments and receive information.
- Walk-in Services – Immediate access to urgent behavioral health support without a prior appointment.

Upon seeking services, clients undergo screening to determine their eligibility for Specialty Mental Health Services. During this process, clinicians evaluate clinical history, risk factors (such as

suicidality or substance use), and immediate needs to ensure an appropriate and timely connection to care.

To support treatment planning and progress tracking, clinics utilize standardized outcome measures, which are recorded in the Mental Health Outcomes Management System (mHOMS) and Cerner Community Behavioral Health (CCBH). These measures provide ongoing insights into treatment effectiveness and guide service adjustments. Key assessment tools include:

- Illness Management and Recovery Questionnaire (IMR) – Evaluates clients' ability to manage their condition and progress in recovery.

- Milestones of Recovery Scale (MORS) – Identifies a client's recovery stage to inform treatment planning.

- Recovery Markers Questionnaire (RMQ) – Captures personal recovery milestones.

Assessments are conducted at intake, every six months, and upon discharge to ensure that treatment remains effective and aligned with client needs.

Regulatory and Compliance Framework

County clinics must comply with state and federal regulations as well as internal County policies designed to ensure service quality, documentation accuracy, and financial accountability. Key regulatory requirements include:

- Title 9, California Code of Regulations (CCR) – Medi-Cal Specialty Mental Health Services (SMHS) (§1810.100 – §1810.795): Establishes Medi-Cal service eligibility, provider responsibilities, and documentation standards for county-operated mental health programs.

- California Department of Health Care Services (DHCS) – Mental Health Plan (MHP) Contracts: Defines County obligations for Medi-Cal-funded services, including reporting, billing, and clinical care standards.

- Organizational Provider Operations Handbook (OPOH) – Provides standardized procedures for service delivery, productivity tracking, crisis intervention, and quality assurance to ensure regulatory compliance.

These frameworks ensure that mental health services are delivered effectively, tracked consistently, and monitored for compliance.

Clinic Capacity Management

To meet service demands while maintaining operational efficiency, BHS employs various strategies to optimize clinic capacity and resource allocation:

- Needs Assessments – Conducted using admission, discharge, and census reports to evaluate service demand, staffing levels, and resource availability.

- Census Monitoring – Monthly tracking of service utilization trends to identify gaps in care.

- Facility Planning – In cases of space constraints, BHS collaborates with the Department of General Services (Facilities) to explore renovations or alternative service locations.

- State-Level Program Adjustments – Initiatives such as the CARE Act and diversion programs impact clinic census by shifting clients between different levels of care. These fluctuations are continuously monitored to adjust service capacity accordingly.

- Contracted Psychiatric Staffing – To address psychiatrist shortages and ensure continuity of care, clinics utilize Locum Tenens (LT) psychiatrists through contracted providers. LT psychiatrists help fill staffing gaps and support service demand while permanent positions are recruited or maintained.

Productivity and Service Efficiency

County clinics follow strict productivity benchmarks to ensure the efficient delivery of mental health services. Staff are required to maintain a minimum annual productivity level of 64,800 minutes (60%), which encompasses direct client services, documentation, and administrative tasks.
To further enhance service efficiency, BHS implements a Utilization Management (UM) process, conducting quarterly client record reviews to evaluate medical necessity and treatment appropriateness. Special focus is placed on:

- Clients receiving long-term services (2+ years).
- Clients with stagnant recovery markers (e.g., unchanged MORS ratings).
- Clients with frequent emergency room visits or hospitalizations.

These reviews help clinics ensure that services remain appropriate and responsive to client needs, while also maintaining compliance with regulatory requirements.

Quality Assurance and Compliance Oversight

The BHS Quality Assurance (QA) Program ensures that County-operated clinics comply with Medi-Cal, Mental Health Plan (MHP), and state requirements. Key components include:

- Annual Compliance Monitoring – Routine reviews assess adherence to clinical, operational, and service delivery standards.

- Corrective Action Plans (CAPs) – Clinics with identified deficiencies must develop CAPs outlining corrective measures, with follow-up monitoring to ensure implementation.

- Medical Record Review (MRR) – Evaluates whether clinical documentation supports Medi-Cal billing, treatment appropriateness, and service effectiveness. Providers are required to implement corrective actions for any non-compliance.

To maintain service quality, clinics conduct internal reviews, site visits, and case evaluations, ensuring alignment with Medi-Cal, state, and federal regulations.

METHODOLOGY

OAAS performed the audit using the following methods:

- **Regulatory and Best Practices Review** – Examined relevant state and federal regulations, including Title 9 of the California Code of Regulations, Medi-Cal Specialty Mental Health Services requirements, and County policies. Additionally, reviewed best practices for mental health service delivery, performance monitoring, and client engagement.

- **Policy and Procedure Evaluation** – Reviewed BHS policies and procedures governing clinic operations, including service accessibility, appointment scheduling, follow-up protocols, documentation standards, and referral processes.

- **Clinic Process Assessment** – Evaluated clinic workflows related to client intake, service delivery, appointment scheduling, and no-shows to assess efficiency and adherence to established protocols. Examined processes for identifying, referring, and linking clients to essential social service resources, including housing assistance, employment services, and community support programs.

- I**nterviews with Key Personnel** – Conducted discussions with BHS leadership, clinic managers, clinicians, and administrative staff to gain insights into operational challenges, resource needs, and compliance with policies. Discussions also covered clinic capacity management strategies, including staffing levels, space utilization, and census monitoring.

- **Utilization Analysis** – Examined appointment scheduling trends, and no-show patterns to identify service delivery inefficiencies, gaps in care, and opportunities for improvement. Analyzed clinic capacity data to determine how effectively clinics manage service demand and resource allocation.

- **Productivity and Performance Review** – Analyzed clinic productivity reports, linkage data, and referral policies to evaluate service efficiency and the effectiveness of client engagement strategies. Reviewed utilization data to identify patterns that may impact access to care, service equity, and overall clinic performance.

DEPARTMENT'S RESPONSE
(BEHAVIORAL HEALTH SERVICES)

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KIMBERLY GIARDINA, DSW, MSW
DEPUTY CHIEF ADMINISTRATIVE OFFICER

NADIA PRIVARA BRAHMS, MPA
ACTING DIRECTOR, BEHAVIORAL HEALTH SERVICES

June 5, 2025

TO: Juan R. Perez, Chief of Audits
Auditor and Controller

FROM: Nadia Privara Brahms, MPA, Acting Director
Behavioral Health Services

DEPARTMENT RESPONSE TO AUDIT RECOMMENDATIONS: COUNTY MENTAL HEALTH CLINICS AUDIT

Finding I: Enhancing MRR Reporting and Quality Improvement Oversight

OAAS Recommendation: To enhance the effectiveness of the MRR compliance assurance process and ensure that deficiencies are addressed, the following recommendations are proposed:

1 Reassess Compliance Metrics: Consider revising the compliance rate calculation methodology to ensure that significant sub-category issues are weighted appropriately and do not allow clinics to achieve "compliance" while critical deficiencies persist.

2 Redefine the criteria for QIP issuance" Redefine the criteria for QIP issuance to include recurring deficiencies in QIRs.

3 Establish a QIR Tracking System: Develop a centralized system to monitor QIR implementation, ensuring timely resolution and validation.

Action Plan: BHS agrees with this finding and has already taken various steps to improve medical record review process and monitoring beginning FY 24-25 to align with DHCS Medi-Cal Transformation Initiatives and documentation reform requirements. Monitoring processes were aligned with DHCS shifted emphasis to a focus on fraud, waste and abuse as reasons for recoupment and emphasis on quality-of-care areas. Beginning July 1 2024, the FY 24-25 medical record review process was rebranded as Quality Assurance Program Audit (QAPR) and a review tool developed by California Mental Health Services Authority (CalMHSA) was revised to meet both DHCS and BHS program monitoring requirements with added survey questions which focused on identifying risk and safety issues, integration of substance use disorder and/or physical health treatment as clinically indicated and care coordination and continuity of care efforts across providers and delivery systems. CalMHSA is a Joint Powers of Authority (IPA) formed in 2009 by counties throughout the state to work on collaborative, multi-county projects that improve behavioral health care for all Californians. CalMHSA is an independent administrative and fiscal public entity representing California counties working in collaboration with DHCS to implement California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health initiatives in development of policies, procedures and technical assistance activities.

QA/QI efforts transitioned from a compliance-centered focus to actively enhancing clinical quality and making meaningful improvements. These areas of focus have been expanded with the development of the QAPR tool for FY25-26 to restructure sub-categories and revise subcategory questions to better identify significant issues which are weighted appropriately to reduce opportunities for programs to achieve "compliance" when critical deficiencies have been identified.

Recommendation 1: Reassess Compliance Metrics: Consider revising the compliance rate calculation methodology to ensure that significant sub-category issues are weighted appropriately and do not allow clinics to achieve "compliance" while critical deficiencies persist.

Action steps to address recommendation 1 to be implemented by July 1, 2025:

- QAPR tool restructured to ensure scoring to reflect weighting of individual assessment categories and greater emphasis on clinical high-risk areas to ensure an escalation process and standardized Quality Improvement Plan follow up for areas of concern.
- Quality Improvement Recommendations identified during QAPR process will be updated to include tracking and scheduled follow-up to ensure QIRs are addressed and resolved. QIRs that are unresolved or continue to evidence deficiency during follow-up will result in additional scheduled focus review(s) of the specific QIR(s) as determined by QA.
- QAPR tool restructure to include additional monitoring items that specifically address clinical high-risk areas to improve oversight and quality of care.
- FY 25-26 QAPR review process will include review of previous year's QAPR to identify trends, QIRs or QIP corrective actions required by program to ensure they are area of focus in current year review; QA Staff will review available EHR and program level data reports to identify additional clinical high-risk areas and compliance concerns.

Recommendation 2: Redefine the criteria for QIP issuance: Redefine the criteria for QIP issuance to include recurring or high-risk deficiencies identified in QIRs.

Action steps to address recommendation 2 be implemented by July 1, 2025:

- QAPR tool restructured to ensure scoring to reflect weighting of individual assessment categories and greater emphasis on clinical high-risk areas to ensure an escalation process and standardized Quality Improvement Plan follow up for areas of concern.
- QAPR tool results summary page includes language that clarifies QA discretion to require programs to address QIRs via a QIP for recurring or high-risk deficiencies identified during the QAPR process regardless of whether threshold scores that would require a QIP are met. *This action step has already been implemented in previous year(s) medical record reviews and will be ongoing.*

Recommendation 3. Establish a QIR Tracking System: Develop a centralized system to monitor QIR implementation, ensuring timely resolution and validation.

Action steps to address recommendation 3 to be implemented by July 1, 2025:

- Quality Improvement Recommendations (QIRs) made during the QAPR process will be shared during QA portion of clinic staff meetings by the QA Specialist to reiterate quality improvement themes.

- QA staff will centralize a list of QIRs from QAPR and work with Program Manager(s) and staff to incorporate review of items during subsequent internal chart monitoring processes. Results will be shared to reflect resolution or ongoing status for tracking until recommendations are validated.

Planned Completion Date: Action steps to be ongoing once implemented

Contact Information for Implementation: For ongoing oversight, Jill Michalski, QA Behavioral Health Program Coordinator

Finding II: Improving Documentation Oversight and Records Accessibility

OAAS Recommendation: Improve Documentation Oversight: Implement a centralized system to ensure all client records are accurately maintained, accessible, and allow for effective tracking and monitoring of the completion and updating of problem lists and outcome measures, promoting consistency across clinics.

Action Plan: BHS agrees with this finding and noted that all records are accessible across clinics. The current outcome measures process is complex, with specific "windows" during which information can be entered in the system. This process is not conducive to efficient or straightforward monitoring. Currently, there is no mechanism within the electronic health record for tracking the outcome measures process. The current outcome measures are required by the County; however, the State is exploring methods for collecting program outcome measures. Once a new process is established by the State, outcomes will be integrated into the electronic health record, which is ideal for improving tracking and monitoring capabilities for program compliance. In the interim, please see the following action steps that have been and/or will be taken to address the recommendation.

- As of January 29, 2025, the Behavioral Health Clinics (BHCs) have implemented a centralized tracking guideline to monitor outcome measure due dates and adherence to compliance standards.
- Beginning July 1, 2025:
  - QA Specialist and BHC program managers to run reports to monitor Outcome Measure and Problem list.

Planned Completion Date: Action steps to be ongoing once implemented

Contact Information for Implementation: For ongoing oversight, Megan Lawson, Behavioral Health Program Coordinator

Finding III: Ensuring Effective Outreach for No-Show New Clients

OAAS Recommendation: Ensure Consistent Documentation of Follow-Up Efforts in SmartCare: Reinforce standardized documentation practices to ensure that all outreach efforts for unconnected clients are properly recorded and accessible across programs.

Action Plan: BHS agrees with the finding and has already taken various steps to address this issue.

- Beginning in October 2024 the following occurred:

- The BHCs replaced Screening Teams with Access Teams to further align with the County's missions to provide accessible and equitable behavioral health services and reduce barriers to care. Access Teams were developed to increase access to services and increase opportunities for BHCs to immediately provide services for individuals seeking to connect with mental health services and/or who are transitioning between levels of care.
- Access Teams: Include Psychiatric Nurse, Licensed Mental Health Clinician (LMHC), Mental Health Case Management Clinician (MHCMC), and Mental Health Specialist (MHS) to allow multidisciplinary follow up as needed to reduce barriers in individuals connecting with behavioral health services.
- As of January 2025, the BHCs implemented a formal tracking system designed to re-engage individuals who have been referred to, outreached by BHC staff, and/or missed initial appointment.

Planned Completion Date: The above action steps related to this recommendation have already been implemented and will be ongoing.

Contact Information for Implementation: N/A

Finding IV: Defining Productivity Standards for Locum Tenens Psychiatrists

OAAS Recommendation: Amend contract to include Defined Productivity Benchmarks: BHS should amend the contract to explicitly incorporate measurable productivity standards. These should include established benchmarks such as 64,800 service minutes per year (60% productivity) and additional performance metrics, including compliance with outcome measures and documentation accuracy.

Action Steps: BHS agrees with this recommendation.

- To align with this recommendation, BHS will take steps to amend the contract to include language requiring that Locum Tenens placed at the BHCs will adhere to all requirements in the Organizational Providers Operation Handbook (OPOH) which includes standards related to documentation, productivity, and compliance with outcome measures.

Planned Completion Date: Effective July 1, 2025, the Statement of Work for BHC Locum Tenens Statement of Work will be updated to include language regarding performance metrics such as productivity expectations, compliance with outcomes measures and documentation accuracy. These expectations will be aligned with BHC protocols.

Contact Information for Implementation: Kristin McHenry, Principal Administrative Analyst

If you have any questions, please contact me at (619) 584-5036.

Nadia Privara Digitally signed by Nadia Privara Date: 2025.06.05 09:24:42 -07'00'

NADIA PRIVARA BRAHMS, MPA, Acting Director
Behavioral Health Services