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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 5 – 7, 2021

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INTRODUCTION

The United States Department of Health and Human Services (HHS), 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). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO 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 Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the San Diego MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Large

MHP Region — Southern

MHP Location — San Diego

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 35,495

MHP Threshold Language(s) — Spanish, Arabic, Vietnamese, Tagalog, Cantonese

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (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 for calculating PMs.

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

(AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary

progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met 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 Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

None noted

Access Recommendations

Recommendation 1: Add language translation capability to the San Diego County Behavioral Health Services (SDCBHS) website. Priority should be given to the following threshold languages: Spanish, Arabic, Vietnamese, Tagalog, and Farsi.

Status: Met

- The MHP webpage is part of the San Diego County over-arching webpage and uses the Google translate plug-in for all threshold languages, as designed by San Diego County.

- The plug-in is prominently displayed at the top of the behavioral health landing page and converts the website and corresponding information to a person's language of choice.

- The MHP continues to research other translation solutions that better capture the complexities of medical language and concepts across multiple languages.

Recommendation 2: Improve website provider directory search capability to include by region; languages served; accepting new referral status; age group served; and specialty services.

Status: Met

- The provider directory is searchable through the browser's inline search function. The directory includes providers' service region, languages, accepting new referral status, age groups served, and specialty services, all of which can be sorted with the inline search function.

Recommendation 3: Streamline the Assertive Community Treatment (ACT) referral process to improve timeliness of these services.

Status: Met

- On January 1, 2021 the MHP implemented dedicated and secure e-mail inboxes for all referrals at each of the 16 service programs. The effectiveness of this strategy is being evaluated.

- The MHP is also working with programs to ensure they are entering requests for services into the Access to Services Journal (ASJ) in order to more reliably capture and report contractor timeliness data.

Recommendation 4: The MHP should review its communication and materials regarding after-hours and crisis services so that this information is available to all beneficiaries and wellness center participants. Follow-up with a pilot test of beneficiaries to determine effectiveness.

Status: Met

- The MHP includes information regarding after-hours and crisis services in the Beneficiary Handbook, the Access and Crisis Line brochures and posters, the Network of Care website, and Optum websites.

- Information and materials are available through the 2-1-1 San Diego help phone line.

- The MHP's service delivery programs are required to include the Access and Crisis Line information in their voicemail messages for after-hour calls.

Recommendation 5: Examine referral processes and support with primary care providers (PCPs) to beneficiaries needing only pharmacotherapy services. Establish methods to provide ongoing training and support to PCPs to increase their capacity and confident serving psychotropic medication-only beneficiaries.

Status: Met

- The MHP is working with Federally Qualified Health Centers (FQHCs) to determine criteria and design a referral process that will support warm transitions.

- The MHP contracts with Vista Hill Smart Care to provide education and support to PCPs and contracted behavioral health providers. Included in the support are a weekly interactive forum for providers and a weekly newsletter on a variety of topics related to behavioral health.

- The MHP contracts with Health Quality Partners to provide on-going training and support to PCPs and behavioral health providers who provide behavioral health services in the context of a primary care facility.

- Health Quality Partners hosts an annual Primary Care Integration and Behavioral Health Summit.

Recommendation 6: Evaluate the distribution of specialty contracted programs throughout the county to maximize access for beneficiaries while minimizing staff travel and potential service delays.

Status: Met

- The MHP offers telehealth services from anywhere in the community to both ensure adherence to social distancing requirements and also provide assistance with mobility issues. Funding for provider telehealth equipment was provided by Coronavirus Aid, Relief, and Economic Security (CARES) Act dollars as well as other San Diego County funds.

- The MHP contracts with Exodus Recovery, Inc. to provide telehealth-based outpatient psychiatric medication services for children, transition aged youth (TAY), adult, and older adult beneficiaries countywide.

- The MHP is exploring the feasibility of restructuring procurements for contracted services by level of care to better address beneficiary service needs throughout the county.

Timeliness Recommendations

Recommendation 7: Complete the analysis comparing the self-report perceptions of clinical line staff to timeliness metrics and determine if there is alignment between the two sources. Include the review of the actual use of the ASJ log to ensure data entered is accurate and reflective of the beneficiary experience. *(This is a partial carryover from a recommendation from FY 2018-19.)*

Status: Met

- The MHP collected feedback from providers on their perception of timeliness of services via the biennial Promoting Cultural Diversity Self-Assessment. The results are currently being analyzed and compared to reports from the ASJ.
- Differences in administrative workflows across all providers pose a challenge relative to consistent use of the ASJ, resulting in inconsistent rates of data accuracy.
- Errors in each program are captured by a Program Integrity report, and the MHP has seen an increase in accuracy over the last year.

Quality Recommendations

None noted.

Beneficiary Outcomes Recommendations

Recommendation 8: Evaluate current communication methods related to informing beneficiaries of opportunities to provide feedback, including committee participation. Identify gaps and implement additional methods.

Status: Met

- The MHP receives beneficiary feedback through committees such as the Program Advisory Groups, the Recovery Innovations International (RI) peer liaisons, the Mental Health Services Act (MHSA) Community Forums, the annual Mental Health Statistical Improvement Program (MHSIP) Consumer Perception Survey (CSP), the grievance process, SDCBHS council meetings**,** and the clubhouses (wellness centers).
- Based on feedback from a MHP beneficiary survey in 2019 in which barriers to service access were identified, the MHP worked with contract providers to develop protocols for appointment reminders and is exploring opportunities to address transportation barriers. Increased use of

telehealth during the COVID-19 restrictions has minimized this issue considerably.

Foster Care Recommendations

None noted.

Information Systems Recommendations

Recommendation 9: Develop a plan to implement the Data Warehouse database that include (Behavioral Health Services) BHS client demographic and clinical service data from both EHR systems, to create a comprehensive dataset of behavioral health beneficiaries served and delivered services.

Status: Met

- The MHP is currently implementing Cerner's HealtheIntent platform to create a comprehensive dataset of beneficiaries and services. The HealtheIntent platform is a shared computing service that aggregates data from disparate systems, creating a longitudinal beneficiary record.
- HealtheIntent supports decision making, quality measurement, and analytics for population management. It provides reports derived from their Cerner Community Behavioral Health (CCBH) outpatient EHR and the inpatient Cerner Millennium (CM) EHR.
- HealtheIntent will be built in phases connecting disparate county systems.

Structure and Operations Recommendations

Recommendation 10: Develop a communications plan to support the mental health outpatient services roadmap with providers that addresses both county-operated programs and contract provider agencies CM implementation requirements.

Status: Partially Met

- The MHP will begin regular meetings with stakeholders to plan for the CM implementation. The first meeting is scheduled for January 2021.

Recommendation 11: Develop CM end-user training strategy as soon as practical and share the information with stakeholders. Consider plans that include regional training classrooms, video training environment, web casting, and train-the-trainer model.

Status: Met

- The MHP contracts with Optum to provide staff training for the current EHR. Optum will use current training protocols to transition staff to the new CM EHR platform.
- Optum will use live virtual trainings, pre-recorded training videos, and asynchronous learning through the Learning Management System. The training is self-paced so that staff may advance as they learn.

Recommendation 12: Evaluate and compare pay, benefit, scope of work and advancement ladder among contracted agencies who hire peers to those of the MHP. Develop a plan and take steps to ensure parity with like industries.

Status: Met

- The MHP established a workgroup to examine submittal requirements for future Request for Proposals (RFPs) to ensure that peer benefits, pay, and scope of work are on par with industry standards.
- The MHP will use language referring to “living wage” to shape contract standards, recognizing that minimum wage in many areas is not necessarily an adequate living wage.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
    - 5A (1&2) Use of Psychotropic Medications
    - 5C Use of Multiple Concurrent Psychotropic Medications
    - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

San Diego MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	165,383	19.6%	10,723	30.2%
Latino/Hispanic	360,834	42.9%	10,645	30.0%
African-American	49,748	5.9%	3,274	9.2%
Asian/Pacific Islander	68,389	8.1%	1,660	4.7%
Native American	3,615	0.4%	265	0.7%
Other	193,719	23.0%	8,928	25.2%
Total	**841,686**	**100%**	**35,495**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

During CY 2019, the MHP experienced claims submission delays for the months of November and December that resulted in a significant number of claim transactions not being included in the analysis below for CY 2019 results.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS Behavioral Health Information Notice (BHIN) 20-070.

For FY 2020-21 CalEQRO utilized data from the DHCS Mental Health Services Division (MHSD) Information Notice (IN) 13-09, which was considered current policy on threshold languages; Cantonese was a recognized threshold language at that time. On December 14, 2020, DHCS issued BHIN 20-070 which utilizes more current Medi-Cal eligibility data to determine threshold languages.

Threshold language data from MHSD IN 13-09 remains, and the following information is added to address the discrepancy:

The MHP adheres to more recent Medi-Cal eligibility data, consistent with DHCS BHIN 20-070, wherein Cantonese is no longer identified as a threshold language, and Farsi is now a threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

San Diego MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	4,894	13.8%
Arabic	996	2.8%
Vietnamese	355	1.0%
Tagalog	84	0.2%
Cantonese	13	0.0%
Other Languages	29,153	82.1%
Total	**35,495**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

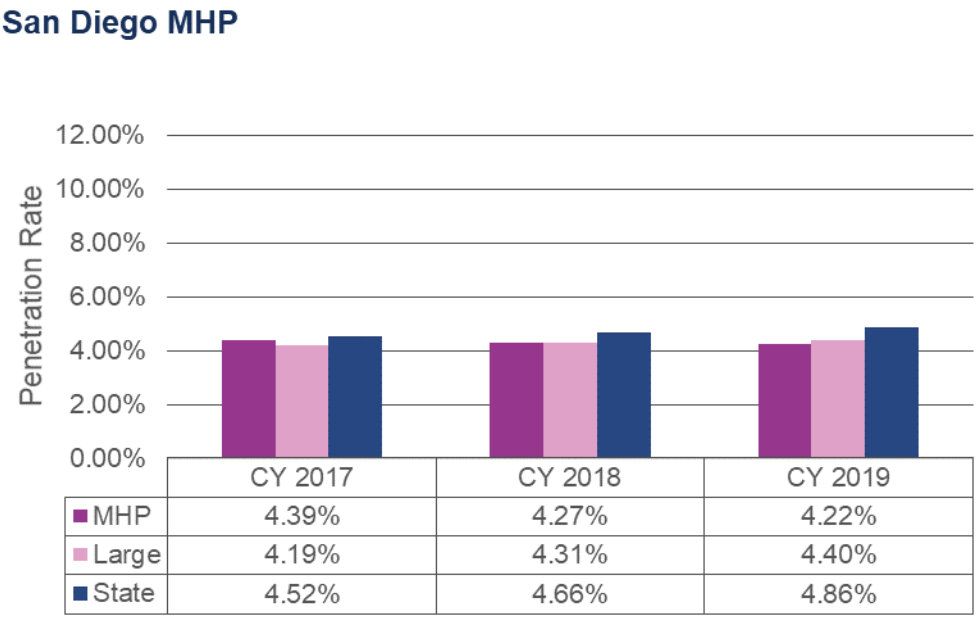
Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

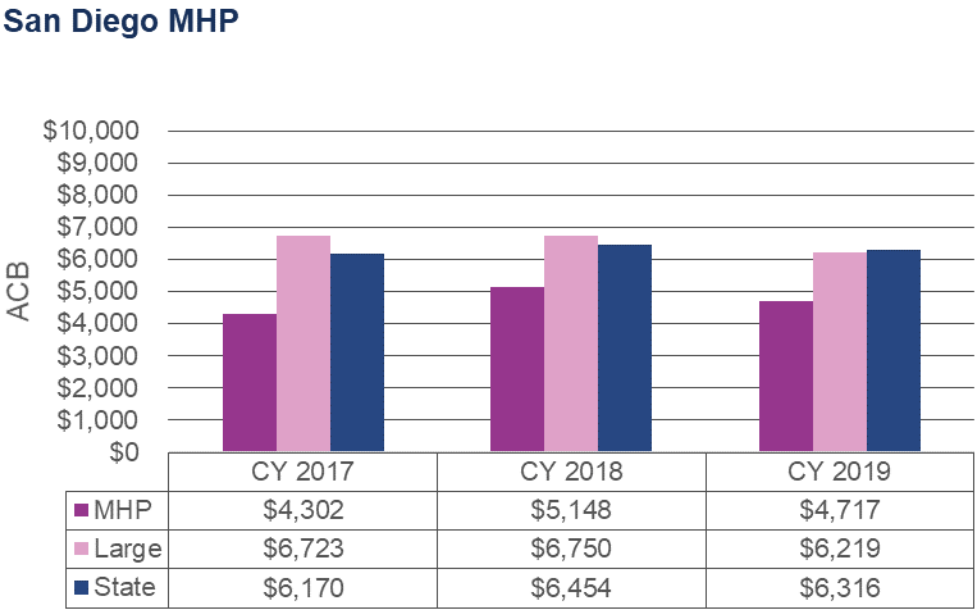
Regarding the calculation of penetration rates, the San Diego MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.39%	4.27%	4.22%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

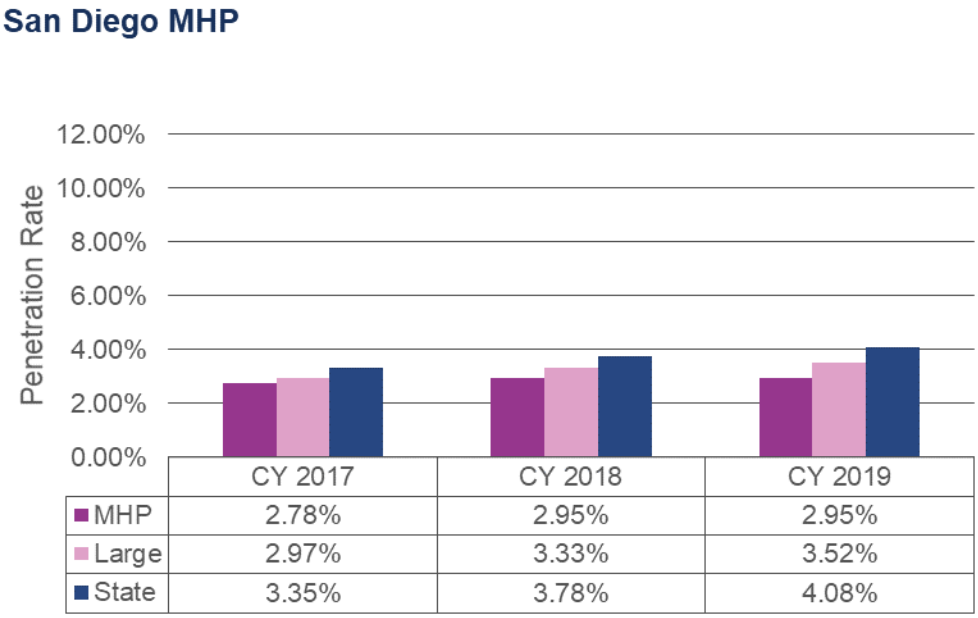
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,302	$5,148	$4,717
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

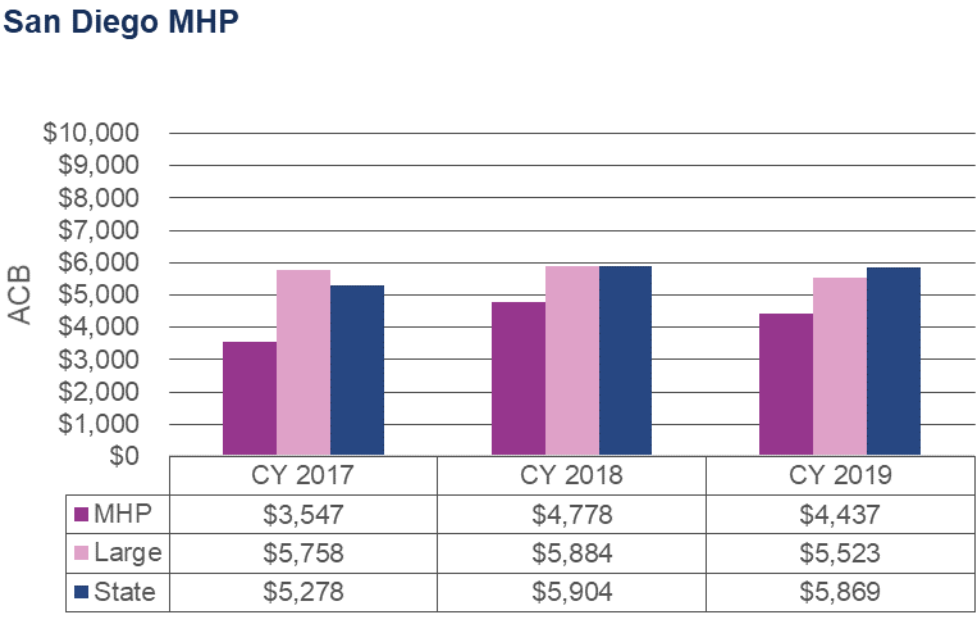
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	2.78%	2.95%	2.95%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

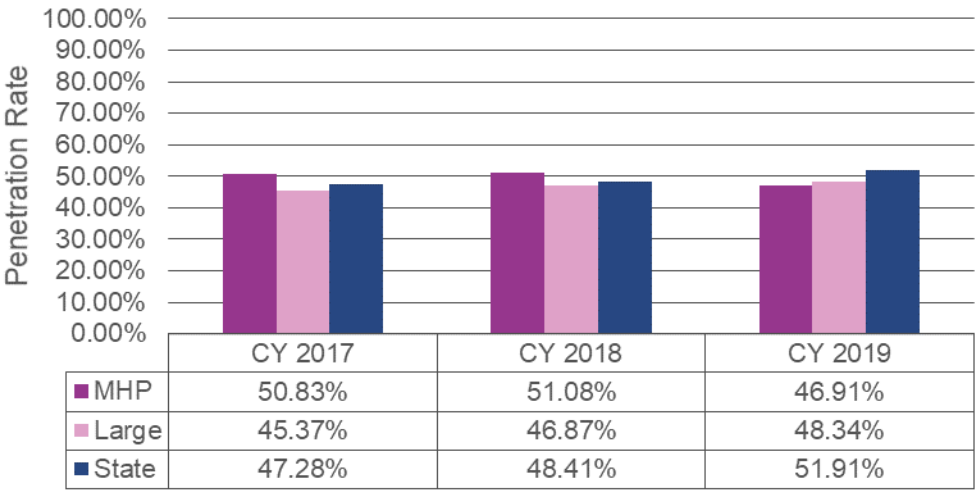
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,547	$4,778	$4,437
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

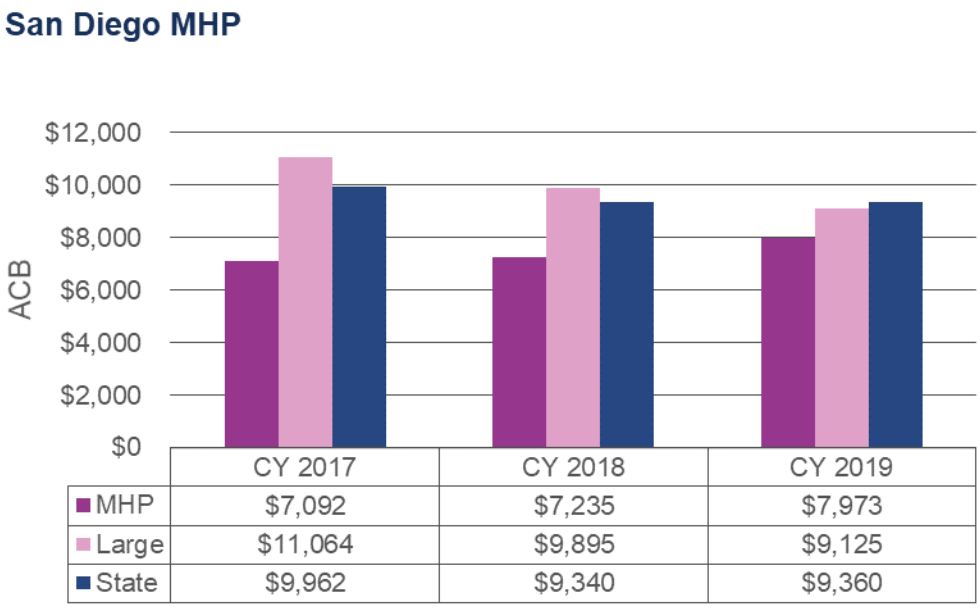
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	50.83%	51.08%	46.91%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

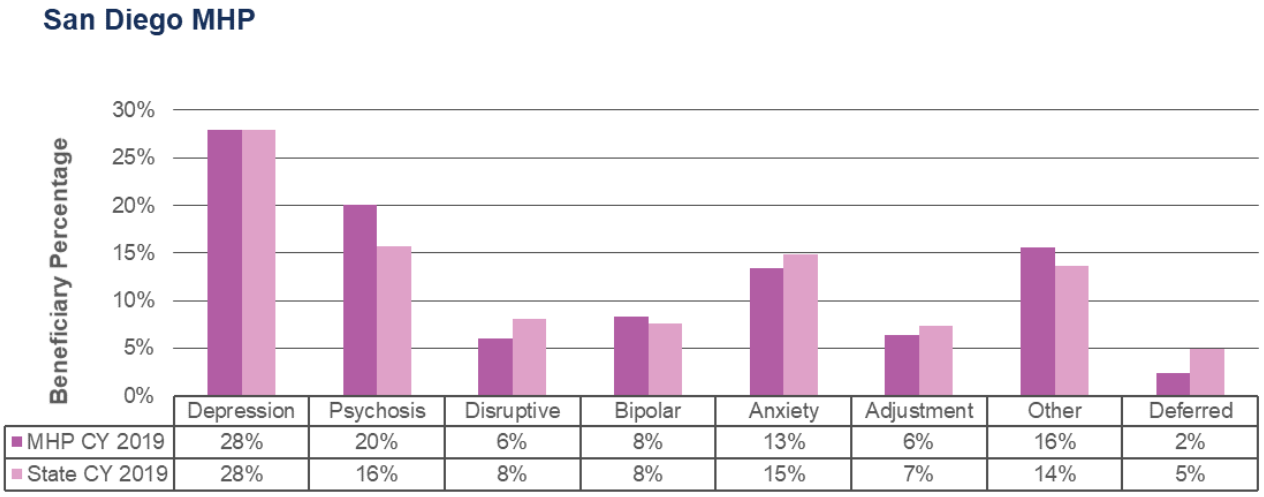


	CY 2017	CY 2018	CY 2019
MHP	$7,092	$7,235	$7,973
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

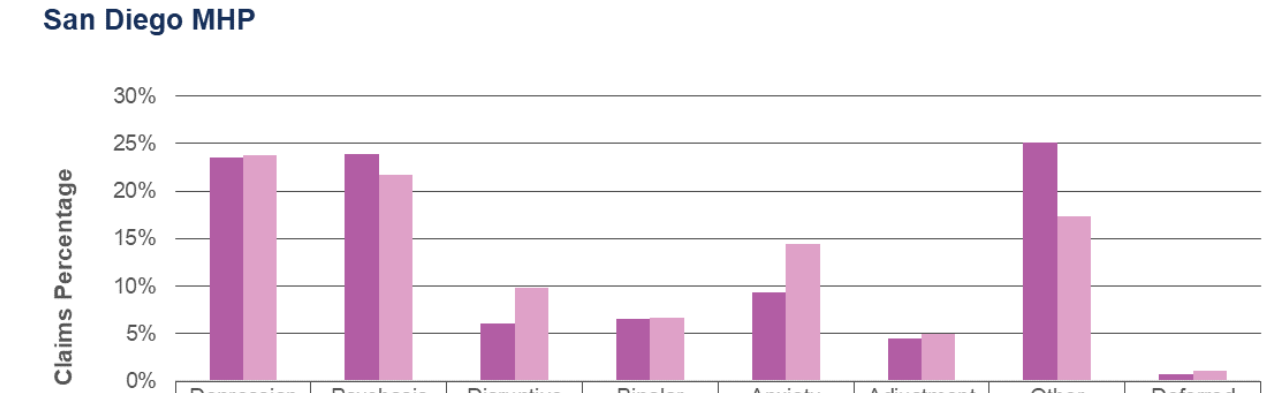
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	28%	20%	6%	8%	13%	6%	16%	2%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	24%	24%	6%	7%	9%	5%	25%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

San Diego MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	750	35,495	2.11%	$51,557	$38,668,116	23.09%
	CY 2018	1,020	37,692	2.71%	$61,786	$63,022,096	32.48%
	CY 2017	746	39,759	1.88%	$48,281	$36,017,617	21.06%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

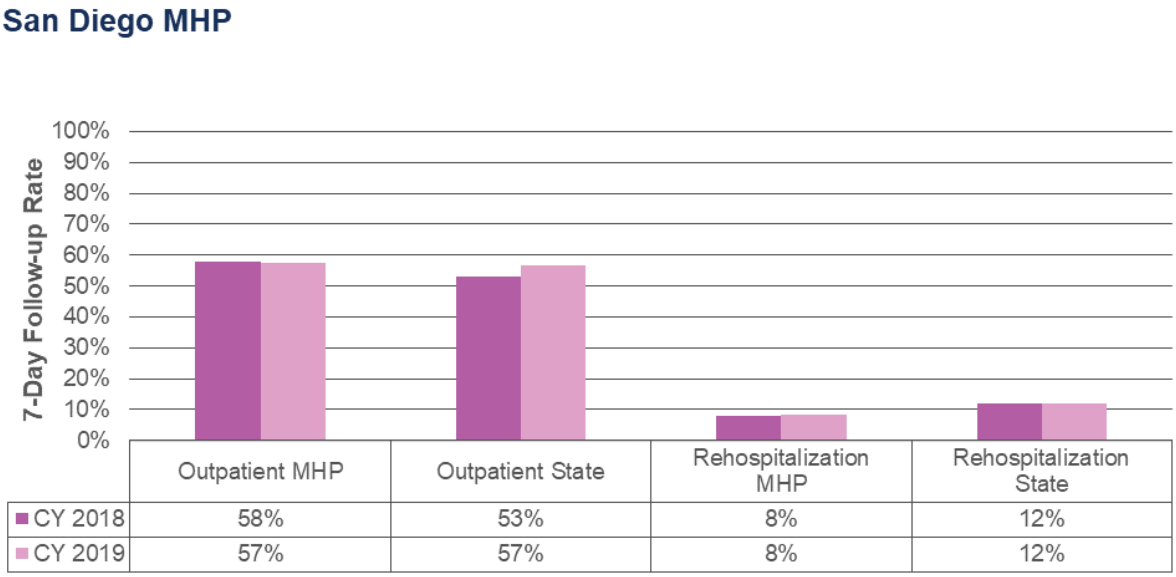
Table 4: Psychiatric Inpatient Utilization CY 2017-19

San Diego MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	3,988	10,432	7.95	7.80	$9,332	$10,535	$37,216,651
CY 2018	5,287	13,893	9.74	7.63	$12,801	$9,772	$67,679,794
CY 2017	4,451	11,895	7.88	7.36	$8,194	$9,737	$36,472,517

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

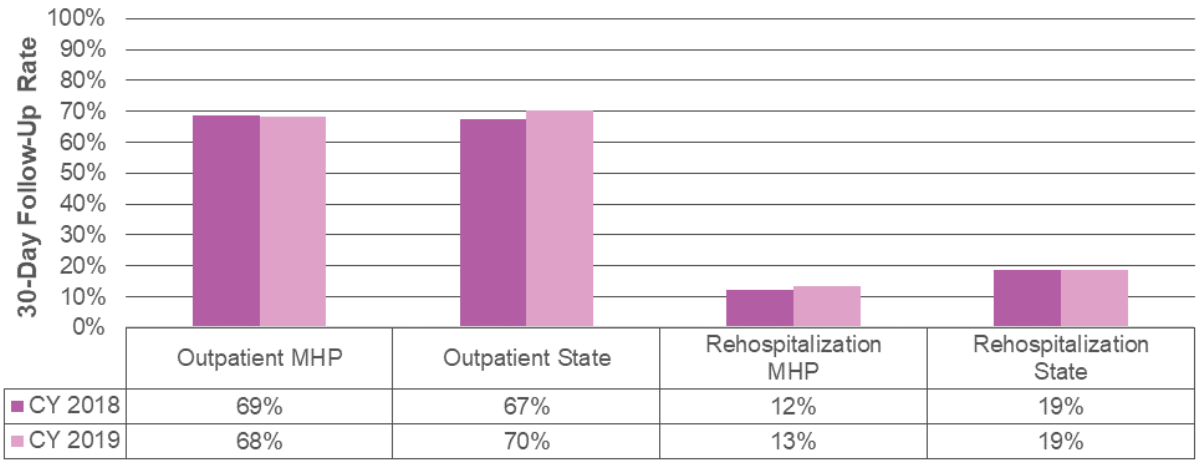
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	58%	53%	8%	12%
CY 2019	57%	57%	8%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	69%	67%	12%	19%
CY 2019	68%	70%	13%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

San Diego MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. San Diego MHP submitted two PIPs, and CalEQRO reviewed and validated two PIPs, as shown below.

Table 5: PIPs Submitted by San Diego MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	"Preventing Crisis Service and Inpatient Utilization among Youth with Depression"
Non-Clinical	1	"Connections After a PERT Contact"

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	San Diego
PIP Title	Preventing Crisis Service and Inpatient Utilization among Youth with Depression
PIP Aim Statement	"Will the use of a therapeutic sleep intervention, delivered to youth with depression receiving outpatient care, lead to a reduction in the use of crisis services and inpatient hospitalization by youth with depression, in the six months following the implementation of the intervention?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	San Diego
☐ Collaborative (multiple MHPs or MHP and Drug Medi-Cal-Organized Delivery System (DMC-ODS) worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The population was defined multiple times, somewhat differently each time, and was always very general. The initial definition was, “youth with a diagnosis of depression”. During a discussion of the intervention, youth with a score of 24 or higher on the Patient-Reported Outcomes Information System (PROMIS) assessment constituted the population to receive the intervention. Because the ages of youth and adults is flexible for various programs, specification of the actual age range would be helpful.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The intervention was the provision of a three-session sleep hygiene educational program, and for those who need it, inclusion of education regarding reducing screen time.
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):

PIP Interventions (Changes tested in the PIP)
n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"Number of youth with diagnoses of depression who receive crisis services and inpatient mental health treatment."	Not specified	n/a	☒ n/a[5]		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
"Change on Depression item on CANS between intake and discharge"	Not specified	n/a	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"Change on Internalizing subscale between intake and discharge"	Not specified	n/a	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
"Change on Sleep item on CANS between intake and discharge"	Not specified	n/a	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
"Change on Sleep item on PSC between intake and discharge"	Not specified	n/a	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"Change on PROMIS Sleep Disturbance Assessment"						(specify):
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No
Validation phase:	PIP status (per DHCS requirement):
☒ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year
Validation rating:	
☐ High confidence[6] ☐ Moderate confidence[7] ☒ Low confidence[8]	

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ No confidence[9] Justification for validation rating: The confidence level would increase with the following changes: 1. The population description needs more detail, including actual age range, time period being studied, length of time in care prior to and post-intervention, and clear distinction regarding all with depression and the subset of those with sleep disturbance. 2. The number and complexity of tools and measures being used to assess results presents a confusing picture of what is actually considered success. 3. Attributing changes in crisis use, depression scales, and sleep disturbance measures to an intervention that can be one, two, or three sessions long, would appear to ignore the myriad intervening variables that could affect those measures, including other services being received, changes in family circumstances, and so forth. 4. The wording of the performance measures related to use of crisis services implies that there is a either a comparison population or a pre-post intervention baseline, neither of which was specified. 5. The data collection process needs additional specificity, including the instruments used for downloading and analyzing the data as well as a pre-determined schedule for downloading and analyzing (language says, “can be collected more frequently if there is a need to do so”). “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: • Address the items above.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of:						

[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• This PIP was not discussed during the review. The MHP was provided with an annotated version of their submission as well as the completed validation with suggestions for changes. • The EQRO reviewed the concept of this PIP in early 2020.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	San Diego
PIP Title	"Connections After a PERT Contact"
PIP Aim Statement	"To increase the rate of connection to an appropriate level of service in the Mental Health System of Care (MHSOC) for clients who receive a Psychiatric Emergency Response Team (PERT) service and require an urgent or routine follow-up referral for MH treatment services."
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)		
Target age group (check one): age group was not specified ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☐ 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):		

MHP Name	San Diego
The PIP did not specify if children would be included. Other characteristics included only that they be eligible for services and have had a PERT service.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Use of a warm hand-off from a PERT clinician to a Peer/Family Support Specialist (PSS) who would be expected to successfully connect the beneficiary to a follow-up outpatient service.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"Number of clients engaged with Peer/Family Support Specialist"	Not applicable as this is a new process		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						Other (specify):
					☐ No test of statistical significance	
"Number of clients engaged with MSOC services"	Not specified	n/a	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
"Number of PERT clients with repeat PERT services within 30 days"	Not specified		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☐ No test of statistical significance	
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☒ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Validation rating:

☐ High confidence[6]
☐ Moderate confidence[7]
☒ Low confidence[8]
☐ No confidence[9]

Justification for validation rating: See recommendations below.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"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: • Increase clarity about problem definition and supporting data; first entry into the system was heavily discussed but is not what the PIP addresses. • Provide more detail about how the intervention was selected (what other possibilities were considered), the difference from previous practice, and why this intervention appears to address the root cause of the problem. • Ensure that the target population and intervention are defined and matched such that there is minimal opportunity for intervening variables to impact the outcome. • Provide more detail about the impact on beneficiary health or functional status. • Define a data collection and analysis plan in detail sufficient to ensure reliability of performance measures. • Define a baseline population and/or a time period against which to measure outcomes (improvement).						
The TA provided to the MHP by CalEQRO consisted of: • This PIP was discussed during the review, including the items above. • CalEQRO provided the MHP with an annotated version of their submission as well as the completed validation tool.						

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
San Diego	8.50%	8.40%	6.10%	5.80%
Large MHP Group	n/a	2.81%	2.59%	2.88%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☐ Allocated to or managed by another county department
- ☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No

Business Operations	Status	
If the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	12.21%
Contract providers	80.39%
Network providers	7.40%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	40	7	5	5
2019-20	10	6	4	0
2018-19	9	4	3	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	39.90	3.50	2	0
2019-20	52.15	10.70	9.50	2.50
2018-19	53	9	6	0

The following should be noted with regard to the above information:

- The MHP states there was a transcription error in the January 2020 ISCA. The January 2021 ISCA IT FTEs appear to have increased; however, staff numbers have remained constant.
- Also due to the transcription error in the January 2020 ISCA, the January 2021 ISCA data analytical FTEs appear to have decreased; however, staff numbers have increased due to the formation and growth of the new Management Reporting and Analysis Team.
- In response to the economic downturn to COVID-19, the County started to require further approval before any vacancy is filled. The slower hiring process resulted in a high vacancy rate.

- To effectively handle the challenges of COVID-19, some MHP staff have been transferred to other divisions and agencies, thus impacting their ability to make progress on MHP projects.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	190	560	750
Clinical Healthcare Professional	335	2,675	3,010
Clinical Peer Specialist	5	235	240
Quality Improvement	30	60	90
Total	560	3,530	4,090

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	40.00	37.85
Total EHR Users Supported by IT (Source: Table 17)	4090.00	2084.00
Ratio of IT Staff to EHR Users	1:102	1:55

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Quality Improvement (QI) staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☐ Yes	☒ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☒	☐	☐	☐
User profile and access setup	☒	☐	☐	☐
Screen workflow and navigation	☒	☐	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☒ Yes	☐ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	150
Number of county-operated telehealth sites	5
Number of contract providers' telehealth sites	145
Total number of beneficiaries served via telehealth during the last 12 months	8,733
• Adults	3,395
• Children/Youth	4,844
• Older Adults	494
Total number of telehealth encounters (services) provided during the last 12 months:	49,883

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒	Hiring healthcare professional staff locally is difficult
☒	For linguistic capacity or expansion
☒	To serve outlying areas within the county
☒	To serve beneficiaries temporarily residing outside the county
☒	To serve special populations (i.e., children/youth or older adult)
☐	To reduce travel time for healthcare professional staff
☒	To reduce travel time for beneficiaries
☒	To support NA time and distance standards
☒	To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of the COVID-19 pandemic on beneficiaries and mental health provider staff.

- Prior to the COVID-19 emergency, telehealth was used primarily to deliver psychiatry services; since March 2020, the majority of all direct services are provided via telehealth.
- As a response to COVID-19, the MHP and community-based organizations (CBOs) purchased laptops and video communication platforms to allow the seamless delivery of services via telehealth from staff homes.
- Of the 49,883 telehealth services provided in the last year 6,458 were provided in a language other than English.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☒	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☒	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☒	Vietnamese	☐	n/a		

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Central Region-Adults	29
Central Region-Children	17
East Region-Adults	9
East Region-Children	12
North Central Region-Adults	25
North Central Region-Children	28
North Coastal Region-Adults	14
North Coastal Region-Children	9
North Inland Region-Adults	17
North Inland Region-Children	14

- The MHP organizes its services by region to align with Network Adequacy data.

Current MHP Operations

- The MHP expanded existing telehealth resources immediately at the onset of the health crisis to ensure ongoing essential services during the COVID-19 pandemic.
- CBOs were provided with funding from the CARES Act to purchase IT equipment to further support telehealth.

- Originally used to present data about the DMC-ODS rollout, the Management Reporting and Analysis team is now utilizing Power BI to merge and display dashboards across the MHP. This data integration project encompasses provider data as well as internal BHS reports, displaying everything in one place to better inform staff and management.
- At the outset of the COVID-19 pandemic, the MHP began support services at the San Diego Convention Center in partnership with the San Diego Housing Commission, City of San Diego, County Public Health Services, Medical Care Services, and homeless services providers.
- The MHP is implementing Cerner's HealtheIntent platform to create a comprehensive dataset of beneficiaries and services for robust reporting. It is a shared computing service that aggregates data from disparate systems, creating a longitudinal beneficiary record.
- The MHP's contractor, Optum, pivoted rapdily to replace previously face - to-face clinical and operational training with an online version. The training is self-paced, consisting of resource packets, videos, and practice exercises.
- To support this new training format, the Management Information Systems and QI teams have given providers live-time assistance after sessions.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Cerner Community Behavioral Health (CCBH)	EHR	Cerner	12	Cerner

Major Changes since Prior Year

- Securing Cerner's HealtheRegistries.
- Transitioned the MHP's Psychiatric Hospital from an obsolete version of the Millennium EHR to Cerner's current version.

The MHP's Priorities for the Coming Year

- Design/build roadmap of CCBH into Millennium.
- Incorporate Cerner Millennium HealtheIntent modules for interoperability with disparate provider systems – Phase I Covid Reporting, Phase II connections.
- Implement, provide access, and monitor CCBH Patient Portal.
- Special Projects (data integrity monitoring, etc.).
- ASJ and other updates for Client Service Information (CSI) reporting.

Other Areas for Improvement

- Complete rollout of electronic prescribing for controlled substances (EPCS).
- Enhance information sharing with contract providers by regularly communicating the phases of transition from CCBH to Millennium.

Plans for Information Systems Change

- The MHP is in the process of transitioning from Cerner's CCBH platform to its Millennium platform.
- The MHP is preparing a roadmap to transition Edgemoor Skilled Nursing Facility to the Millennium platform.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Document Imaging/Storage		☒	☐	☐	☐
Electronic Signature—MHP Beneficiary		☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service		☒	☐	☐	☐
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☒	☐	☐	☐
Treatment Plans		☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		10	1	1	0
FY 2018-19 Summary Totals for EHR Functionality:		10	1	1	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- As the MHP is in the process of transitioning from Cerner's CCBH platform to the Millennium product, there will be no additional investment into upgrading the legacy system.
- The MHP is working on obtaining a sufficient number of tokens to be able to fully roll-out EPCS.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	100%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
n/a		

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☐ No ☒ Implementation Phase

n/a

Expected implementation timeline:

☐ Already in place	☐ Within 6 months
☒ Within the next year	☐ Within the next two years
☐ Longer than 2 years	☐ n/a

Table 28 lists the PHR functionalities available to beneficiaries (if already in place).

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC-ODS staff
- ☐ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

San Diego MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**625,342**	**$141,937,246**	**7,231**	**$2,141,782**	**1.49%**	**$139,795,464**	**$135,206,600**
JAN19	65,418	$14,600,868	800	$235,225	1.59%	$14,365,643	$13,811,814
FEB19	59,670	$13,273,562	628	$204,061	1.51%	$13,069,501	$12,604,911
MAR19	64,306	$14,573,702	772	$239,169	1.61%	$14,334,533	$13,762,164
APR19	66,647	$14,598,291	787	$214,584	1.45%	$14,383,707	$13,802,430
MAY19	65,643	$14,491,953	849	$217,386	1.48%	$14,274,567	$13,715,772
JUN19	55,557	$12,276,078	866	$219,258	1.75%	$12,056,820	$11,514,470
JUL19	60,763	$14,026,992	702	$238,649	1.67%	$13,788,343	$13,438,728
AUG19	60,921	$14,214,561	681	$214,919	1.49%	$13,999,642	$13,685,640
SEP19	57,637	$13,485,595	515	$171,384	1.25%	$13,314,211	$13,041,623
OCT19	65,322	$15,491,969	577	$164,140	1.05%	$15,327,829	$15,054,422
NOV19	1,785	$472,266	27	$9,947	2.06%	$462,319	$394,661
DEC19	1,673	$431,410	27	$13,060	2.94%	$418,350	$379,966

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

- During CY 2019 the MHP experienced claims submission delays for the months of November and December which resulted in a significant number of claim transactions not being included in the analysis for CY 2019 results.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

San Diego MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible.	3,008	$803,971	38%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	2,591	$798,158	37%
Medicare or Other Health Coverage must be billed before submission of claim.	1,416	$398,752	19%
Beneficiary not eligible or non-covered charges.	70	$97,326	5%
Service line is a duplicate and a repeat service procedure code modifier not present.	101	$18,039	1%
Total	7,231	$2,141,782	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reasons “International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code, beneficiary demographic data, or rendering provider identifier is missing, incomplete, or invalid”; “Medicare or Other Health Coverage must be billed before submission of claim”; and “Service line is a duplicate, and a repeat service procedure modifier is not present” are generally re-billable within the state guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For San Diego, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted key informant interviews during the review process to identify any problems or barriers for the beneficiaries relating to access and timeliness issues. The key informants included beneficiaries and family members, MHP staff, contracted providers, and other stakeholders.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	2
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	4
NPI Type 1 number reported is associated with two or more providers	4

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	3
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	8

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The 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 the CFM focus group participants.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. Attendees included adults of multiple ethnicities, both English- and Spanish-speaking, none of whom had initially accessed services within the last 12 months. The group was held virtually on Zoom.
Total number of participants	Six adults attended this focus group.
Number of participants who initiated services during the previous 12 months	None of the participants had initiated services during the previous 12 months.
Interpreter used	No
Summary of the main findings of the focus group: All participants expressed satisfaction with their services and feel involved in their care planning.	

Topic	Description
Access - new beneficiaries	There were no new beneficiaries in attendance.
Access – overall	Most participants use public transportation, and most were aware that services are available in multiple languages.
Timeliness	All participants reported satisfaction with the frequency of their services.
Urgent care and resource support	All participants knew how to access either a clinician or the crisis line; two were aware of the warm line.
Quality	All participants reported being involved in their care planning, and most reported knowing that their psychiatrists coordinated care with other providers.
Peer employment	All reported having been offered job services, and job courses are available at the clubhouses.
Structure and operations	Most participants were not aware of MHP efforts to improve the system of care, nor of a quality improvement committee.
Recommendations from this focus group	• A request was made to open the clubhouses despite the pandemic. • More affordable housing was identified by several participants as a critical need in the community.
Any best practices or innovations (optional)	• None noted.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of parent/caregivers of children receiving services who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. Participants included English- and Spanish-speakers. All of the Spanish speakers receive only or primarily MHSA-funded services. The session was held virtually on Zoom, with Spanish-speakers, an EQRO facilitator, and an interpreter in a separate break-out room.
Total number of participants	There were eight participants in this group.
Number of participants who initiated services during the previous 12 months	Three participants had initiated services in the previous 12 months.
Interpreter used	Yes If yes, specify language: Spanish
Summary of the main findings of the focus group: Because a minority of the participants were Medi-Cal recipients, perceptions of care described in this report cannot be considered representative of those of the entire Medi-Cal population. The comments below reflect the experience of all focus group participants, to the extent that the category is relevant to their engagement with the system.	
Access - new beneficiaries	The new beneficiaries reported almost immediate access to a program once they heard about it and applied.
Access – overall	All participants described easy and timely access to services. All reported knowing that services are available in other languages.
Timeliness	No problems accessing care were reported.
Urgent care and resource support	Some participants reported having a number to call and knowing that the Crisis Center is available.
Quality	All participants reported being satisfied with the services, that the services meet their needs. With COVID-19 changes, some children struggling to stay engaged in virtual groups and sessions.

Topic	Description
Peer employment	There was minimal knowledge expressed regarding employment support or opportunities.
Structure and operations	Participants were not aware of groups or committees that address system improvement.
Recommendations from this focus group	• No recommendations were provided; participants instead acknowledged the support and help they receive from program and clinical staff.
Any best practices or innovations (optional)	• None noted.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 34 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHPs website is very user-friendly, with a language button, crisis numbers, and click-able access to live chat prominently displayed on the landing page. The current provider directory is searchable.			
1B	Capacity Management	10	10
The MHP has a robust Cultural Competence (CC) program that includes tracking access across ethnicities, languages, and geography. Annual updates and NA analyses provide a basis for understanding the needs of their population across the county. Multiple programs and partnerships with ethnic groups and organizations are designed to reach out and provide support and services to targeted underserved populations. For example, at a community forum Native American leaders expressed their need for services. The MHP reviewed the data, saw the disparity, worked with the tribes, and applied for and was awarded an MHSA Innovation grant to implement mobile services on the reservation. They are working with the University of San Diego			

Component		Maximum Possible	MHP Score
(UCSD) to evaluate the impact, including using questionnaires, in-home interviews, and focus groups of staff and community members. Monthly and quarterly performance dashboards are reviewed by program directors and discussed at unit meetings and with contract monitors; gaps in capacity and beneficiary movement through the system of care are addressed and solutions generated and implemented.			
1C	Integration and Collaboration	24	24
The MHP works closely with the broad range of human service, educational, medical, and faith-based organizations in the county.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
Overall, 83.7 percent of first offered appointments met the ten business-day standard, reflecting the entire system of care. Foster care appointments met the standard 90.2 percent of the time.			
2B	First Offered Psychiatry Appointment	12	12
Overall, 84.1 percent of first offered psychiatry appointments met the 15 business-day standard. The overall average days from first request to first offered appointment was 9.2 days, with FC averaging 6.6 days.			
2C	Timely Appointments for Urgent Conditions	18	15
Overall, 47.7 percent of urgent appointments meet the standard of 48 hours. For this metric, the MHP tracks only newly entering beneficiaries whose first encounter is a billable service. Therefore, the timeliness performance is often impacted by the availability of an initial assessment. Other tracking anomalies described by the MHP bring into question the validity of their reported performance.			

Component		Maximum Possible	MHP Score
The MHP is encouraged to review their documentation and tracking methodology to more accurately and completely measure their performance on this metric.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP sets a standard of three days for this metric. Overall, they reported that 54.1 percent of follow-up appointments met this standard; however, the overall average length of time for a follow-up appointment was 6.2 days, and all subgroups were within the 7-day standard. The MHP is encouraged to review their calculation methodologies.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The readmission rate within 30 days overall was 22.9 percent, with children at 14.2 percent.			
2F	Tracks and Trends No-Shows	10	10
The overall average no-show rate for psychiatrists was 6.7 percent and for clinicians other than psychiatrists, the overall average rate was 15 percent.			

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP described their CC activity as integrated throughout the system, rather than being a set of initiatives "in a box." As partial evidence, there is a strong linkage between the Cultural Competence Resource Team (CCRT) and the Quality Improvement (QI) Unit of SDCBHS. The QI Unit Administrator is a lead member of the CCRT, and other QI Performance Improvement Team staff also participate on the			

Component		Maximum Possible	MHP Score
committee to ensure that a two-way exchange of information is maintained. Additionally, QI is a standing item on the monthly CCRT agenda. Examples of initiatives and activity include the following: • A contract for a Cultural Competency Academy, a six-part series with cohorts that have to produce a project. The first graduation will be in June 2021. • All program managers are surveyed annually using a standard tool, the Cultural and Linguistic Competence Policy Assessment, the results of which are shared with MHP leadership, the Quality Review Council (QRC), and the Training and Education Committee, among other stakeholders. One action item from the most recent survey was the development of a collaboration to bring mental health services into Hispanic faith-based communities. • The BHS Director has announced his intention to form a small internal workgroup and to engage a subject matter expert to address racial equity within BHS. • The MHP demonstrated a new data reporting system currently in development, the Community Experience Project, which aims to make San Diego County's behavioral health disparities data more timely, accessible and actionable. Full rollout is expected at the end of FY 2020-21.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP uses the Child and Adolescent Needs and Strengths-50 (CANS-50), Milestones of Recovery (MORS), and the Level of Care Utilization System (LOCUS) to establish level of care needs as well as the psychosocial assessment completed at intake. All contractors are required to have utilization review (UR) committees that evaluate indicated changes; some difficult situations are referred to the MHP's UR committee. Transitions between levels of care require a single, accountable clinician to facilitate using a warm hand-off and working with the receiving program to ensure that the beneficiary can return to the previous program/service if the change does not work out. The jail system and crisis residential programs use mobile outreach teams to facilitate transition to outpatient or next service, and the Next Step program at the county hospital also designed to connect people to their outpatient team. The MHP is developing a joint venture with UCSD Health System to implement a longitudinal care coordination process that would ensure continuity of case managers across changing programs and levels of care for each beneficiary. Included would be level of care changes to medication-only through the health plans.			

Component		Maximum Possible	MHP Score
3C	Quality Improvement Plan	10	7
The annual QI Work Plan (QWIP) Evaluation is data-driven, documenting achievement of measurable goals. The succeeding year's work plan incorporates some elements of the previous year's evaluation that were not satisfactorily addressed. Goals are primarily driven by MHP identification of quality of care measures identified in ongoing reporting. Minutes of QRC do not reflect routine reporting of QI goals; the MHP reports that data related to those goals are included in multiple reports that are reviewed by a variety of committees, program directors, and QI unit staff.			
3D	Quality Management Structure	14	14
The MHP has a robust QI unit and committees that address a variety of quality- and compliance-related issues. The QRC, which meets quarterly and includes beneficiary representation from Recovery International (RI), reviews some data and program information and is responsible for identifying system issues that need further investigation or remediation planning. Data dashboards capture detail related to penetration and service utilization across ethnicities, ages, geography, and languages; aggregated outcomes reports similarly parse results.			
3E	QM Reports Act as a Change Agent in the System	10	9
Reports are reviewed by the QI unit, QI committees, contract monitors, program managers, and senior leadership, some on ad hoc basis and some on standardized schedules. Optum, their Administrative Services Organization, and UCSD provide the reports and based on trends, make follow-up recommendations. Small-scale Plan-Do-Study-Act (PDSA) initiatives often result from the report reviews. It is not clear that there is a central clearinghouse that tracks QI activity across the system in a predictable and orderly fashion.			
3F	Medication Management	12	10
The provider handbook includes requirements for medication monitoring and reporting as well as the establishment of a Medication Monitoring Committee. Reports are monitored quarterly by the MHP and results provided to the clinical directors and program managers. The chart review reports submitted by the MHP reflect the review of most HEDIS and SB 1291 measures; results are trended year over year, by program, level of care, by each requirement, age, and so forth.			

Component	Maximum Possible	MHP Score
No evidence was provided of QI activity relative to the results of the reviews. No evidence was provided of specific standards for psychiatry service frequency or follow-up or for prescribing practices. Communication from primary care providers continues to be spotty, particularly for adult beneficiaries; pediatrics physicians are in closer touch with the MHP. The MHP consistently emphasizes the expectation of coordination of care.		

Beneficiary Progress/Outcomes

In Table 37, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP has adopted the DHCS-required CANS-50 as well as the Psychiatric Symptom Checklist-35 and the Personal Experience Screening Questionnaire (PESQ) for youth. For adults, they use the Individual Medical Readiness (IMR), the MORS, the LOCUS, and the RMQ. The PESQ and Recovery Markers Questionnaire (RMQ) are beneficiary-completed assessments of their progress.			
4B	Beneficiary Perceptions	10	7
There is no evidence that the results of the Consumer Perception Survey (CPS) and the Youth Services Survey (YSS) are shared with the Behavioral Health Advisory Board (BHAB) or the Children Youth and Family Council. However, the MHP reports providing summaries for posting in contractor and program lobbies and for discussing among staff groups. UCSD produces a one-page hand-out, in English and Spanish, that can be available to staff and beneficiaries. Some stakeholders reported feeling that the CPS is too long, complicated, and difficult to focus on, and they do not learn of the results.			

Component		Maximum Possible	MHP Score
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP contracts for the operation of its wellness centers throughout the county. They are run on a “clubhouse” model and offer a range of classes and groups, and also a place to socialize informally. It is not known if the centers are at least 50 percent peer-run; however, the programs are peer-driven, using input from the center community to design classes and groups. The centers also employ peers in paid positions.			

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	30
The MHP does not provide day treatment programs for adult or youth, basing this decision on research that questions their effectiveness. As an alternative, the MHP transitioned to the clubhouse model for wellness centers, which provide many of the same types of adult groups and classes traditionally offered in day treatment, with the added benefit of being more voluntary and flexible for the beneficiaries. San Diego County BHS is in the process of moving all Regional Clubhouses towards Clubhouse International Accreditation. The MHP does provide day rehabilitation for youth. Adult residential services consist of crisis residential with an eight to nine day length of stay. The MHP reported use of a Psychiatric Health Facility in Los Angeles for children and is developing one in Oceanside, at the north end of the county. The MHP’s contracts with UCSD greatly expand their ability to use data to manage their system; ongoing collaboration between UCSD and the MHP is needed to ensure that data is consistently accurate and complete.			
5B	Network Enhancements	18	18
The MHP offers a full range of service enhancements and co-located services, including providing services in about 400 of the 800 schools in the county. A project is			

Component		Maximum Possible	MHP Score
underway in partnership with the San Diego Department of Education to better estimate the numbers of students they reach, with what services, and to evaluate the impact.			
5C	Subcontracts/Contract Providers	16	15
The MHP interfaces with its contractors in multiple ways, including with contract monitors (called Contracting Officer's Representatives, or CORs), a range of QI and CC committees that include contractors, and routine meetings to discuss general system of care issues. The current clinical PIP was developed in part by a few contractors that will also be involved in the implementation. Stakeholders expressed varying opinions as to the effectiveness of the CORs, citing inconsistencies in expectations and interpretation of contract requirements.			
5D	Stakeholder Engagement	12	10
The MHP receives beneficiary feedback through committees such as the Program Advisory Groups, the Recovery Innovations International peer liaisons, the MHSA Community Forums, the annual Mental Health Statistical Improvement Program (MHSIP) Consumer Perception Survey, the Grievance process, SDCBHS council meetings, and the clubhouses. The MHP reported that representatives from the National Alliance on Mental Illness and RI sit on the QRC, BHAB, and Peer Employment Committee. Contract provider managers participate in multiple QI commitees that address system of care needs. Direct service staff are least likely to be involved or aware of system planning efforts. Limiting beneficiary and family member participation to representatives of formal organizations may limit the breadth and nuance of the information gathered by the MHP and advisory boards as they consider the needs of enrollees.			
5E	Peer Employment	8	8
The MHP does not have designated positions for peers due to concerns raised by their legal department regarding disclosure of mental health history. However, contract providers do have peer positions that include opportunities to advance. The MHP has a cooperative agreement with Mental Health Systems, Inc. to provide vocational rehabilitation services for beneficiaries served by both the Department of Rehabilitation and the MHP. Job training and support is also provided by the wellness centers.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of San Diego MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- Due to the COVID-19 pandemic, the majority of services have been provided via telehealth. The MHP worked closely with their county-operated and contract service providers to facilitate the acquisition of the technology and hardware necessary to provide remote services.
- An emergency operations center was created in the convention center to provide COVID-safe shelter and service access for medical and behavioral health; the MHP re-designed contracts with several community providers to bring services into the center. For example, Telecare Tesoro was co-located at the Convention Center to accept referrals for individuals who met criteria for ACT services and project-based housing vouchers through the San Diego Housing Commission. Beneficiaries who received referrals were transferred primarily to Independent Living Facilities or remained at the Convention Center until they could be placed in more permanent housing.
- The MHP is working with UCSD to develop a Memorandum of Understanding to build a facility on campus devoted to psychiatric inpatient care.
- Funding was procured, and development began for multiple housing and rehabilitation projects due to be completed over the next several years.

Strengths:

- The MHP was able to quickly change direction when the pandemic required moving services to telehealth and providing support and services to at-risk populations in novel settings. The MHP also embarked on an

intensive marketing campaign to inform the community about the changes in service availability necessitated by the pandemic.

- The provision of a full range of services at the COVID-19 Public Health Hotels benefits the homeless beneficiaries.
- The MHP's website is well-designed and easily navigated, providing up-to-date information about accessing services in multiple languages.
- The MHP is developing a timely, accessible, and actionable set of data dashboards, the Community Experience Project, that will allow for flexible queries regarding health equity information. The MHP will produce standard/routine reports for multiple stakeholders and will be able to easily devise ad hoc queries as interest dictates and more detailed investigation is warranted. The goal is to facilitate data-driven service planning and resource allocation.
- The County of San Diego and the SDCBHS have taken proactive steps to identify and address internal challenges in serving underserved populations.

Opportunities for Improvement:

- Beneficiaries do not have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or a third-party PHR.
- Contract providers reported feeling increased pressure to move beneficiaries to lower levels of care regardless of acuity and service needs. Residential facilities, unable to fill all of their beds due to COVID-19 restrictions, put pressure on CBOs to accept their discharges, putting increased pressure on CBO caseloads – a situation that results in higher caseloads and staff turnover during this stressful time.

Timeliness of Services

Changes within the Past Year:

- None noted.

Strengths:

- The MHP's Timeliness Journal captures monthly and annual averages for the entire system of care, by each service delivery entity, for mental health and psychiatry services, for adults/older adults and children separately. A trended graph illustrates annual performance in each category.

- Psychiatry timeliness and no-show rates are well-within acceptable standards. The MHP has developed a centralized contract for psychiatry that ensures that appointments are available and encourages beneficiaries to keep appointments they have scheduled.

Opportunities for Improvement:

- Because the current EHR supports tracking by date, but not by time, the MHP does not track timeliness for urgent appointments for existing beneficiaries; neither do they capture new beneficiaries who are seen the same or next day, whose service is coded as an assessment no matter what the situation was at the time of the initial call.
- The data provided regarding follow-up after inpatient discharge warrants review for accuracy and validity, as the reported performance rates do not make sense.

Quality of Care

Changes within the Past Year:

- To administer the activities of the new county-level Office of Equity and Racial Justice, a Director-level role was recently opened for recruitment. The duties of this Director include collaboration with County departments to strategically align efforts to identify core priorities for process and policy improvement and program development that engages underserved communities.
- Stakeholders reported that the impact of operating under the pandemic restrictions has taken a toll on staffing levels and morale. They reported also that beneficiary response to virtual services has been variable, at least in part related to the availability of, and comfort with technology, family living circumstances, and age.

Strengths:

- Cultural competency as a value and as a measurable process has been incorporated into all MHP activity related to internal relations and service delivery.
- A wide variety of trended reports, produced by UCSD and Optum provide data ranging from individual outcomes through system-wide performance. The reports are reviewed by multiple committees, program managers, clinical staff, and system of care managers and MHP leadership. Contract officers review data routinely with their assigned community-based organizations.

- The core QI committee, QRC, includes the full range of MHP, contractor, beneficiary, and community stakeholder representatives and is responsible for recommending improvement needs based on reports they review and other information brought to the bi-monthly meetings.
- The MHP engages in small-scale PDSA initiatives based on data from the reports.
- The MHP created a detailed provider handbook that specifies requirements for medication monitoring and reporting, including the measures to be tracked and a requirement to have a medication monitoring committee.

Opportunities for Improvement:

- The QI process is complex, as San Diego is a large, diverse county; it is not clear that there is a central clearing house that tracks QI activity across the system in a predictable and orderly fashion.
- A focused or centralized QI process related to medication monitoring would identify system-level issues that should be addressed.

Beneficiary Outcomes

Changes within the Past Year:

- None noted.

Strengths:

- The MHP contracts for a network of wellness centers across the county modeled after the drop-in clubhouses that started many years ago, but with the enhancement of also providing a wide variety of classes and support groups. This model was highly praised by stakeholders and appears to be an effective alternative to standard day treatment.
- The MHP tracks and trends the results of the CPS over multiple years; the reports include interpretation, and brief summaries are provided to all programs and contractors for posting in lobbies and for discussion. UCSD produces a one-page handout in English and Spanish that can be made available as flyers for program lobbies.

Opportunities for Improvement:

- The MHP provided no evidence that the results of the CPS or the Youth Satisfaction Survey are reviewed with the BHAB.

Foster Care

Changes within the Past Year:

- Children, Youth and Families System of Care (CYFSOC) amended the current Foster Family Agency Stabilization and Treatment (FFAST) contract through the San Diego Center for Children to include Therapeutic Foster Care services, effective April 2020. FFAST, which currently provides outpatient SMHS to all foster family agencies (FFAs) in the San Diego region, will also make Therapeutic Foster Care (TFC) available to those youth and families who meet medical necessity and have a Child and Family Team (CFT) in place. Additionally, FFAST will make the TFC training curriculum available to all interested caregivers from the eight local FFAs.

Strengths:

- The MHP tracks the required SB 1291 and HEDIS measures; the managers of the CYFSOC reviews the data on the UC Berkeley website and evaluates their own performance in that context.
- Of the 12 licensed short-term residential therapeutic programs (STRTPs), five have obtained approvals from DHCS, and one additional STRTP has had a site visit by SDCBHS and DHCS and is awaiting final Mental Health Program approval. Additionally, SDCBHS has facilitated STRTP Mental Health Program orientations with five STRTPs to proactively assist them in obtaining Mental Health Program approval from DHCS.

Opportunities for Improvement:

- None noted.

Information Systems

Changes within the Past Year:

- The MHP has leveraged CARES Act dollars to amend its contract with Cerner to implement HealtheRegistries. The HealtheRegistries solution pulls from disparate data sources to create systemwide reports.
- The MHP transitioned the psychiatric hospital from an obsolete version of the Millennium EHR to Cerner's current version.

Strengths:

- The MHP's IT staff coordinated the high-volume shift from in-person services to virtual telehealth treatment for both the county and CBOs.

- The MHP is implementing Cerner's HealtheIntent platform, which will serve as a data warehouse providing robust reporting and also interoperability across multiple disparate agencies throughout the county (e.g., Public Health, DMC-ODS, CBO EHRs, and county hospitals).

Opportunities for Improvement:

- Include Optum in strategizing the complex training requirements for staff that would keep them competent on both the legacy EHR and the new Millennium platform at the same time.

- The reliability of data across the MHP's system varies, which impacts the reliability of reporting. Examination of data entry processes, including timeliness, completeness, and accuracy, would improve the MHP's confidence in the validity of the reports.

Structure and Operations

Changes within the Past Year:

- The MHP began implementing a new Population Health Unit under the Clinical Director's Office; staff will be trained by the County of San Diego's Community Health Statistics Branch, and they expected the first team member to begin in November 2020.

Strengths:

- The MHP has a well-organized administrative structure that promotes collaboration across programs and with the CBOs.

- The MHP's contracts with UCSD effectively expand their ability to use data to manage their system.

Opportunities for Improvement:

- The MHP experienced claims submission delays for the months of November and December that resulted in a significant number of claim transactions not being included in the analysis for CY 2019 results. The MHP also experienced similar claim submission delays for December CY 2018. There is no apparent benefit in delaying monthly claim submission, as the MHP's percent of denied claims is historically low; these delays negatively impact county cash-flow.

- Stakeholders reported communication and contract management inconsistencies that are burdensome and confusing.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: The MHP is advised to use CalEQRO technical assistance (TA) for both PIPs throughout the design and implementation process.

Access to Care

Recommendation 2: The MHP should prioritize addressing the level of care pressure across the system that was identified by the MHP and contractor staff.

Timeliness of Services

Recommendation 3: Review and refine data reliability and calculations for timeliness measures, particularly for urgent appointments.

Quality of Care

Recommendation 4: Develop a focused, centralized quality improvement (QI) process related to medication monitoring in order to identify system-level issues that should be addressed.

Beneficiary Outcomes

- None noted

Foster Care

- None noted

Information Systems

Recommendation 5: Include Optum in strategizing the complex training requirements for staff that would keep them competent on both the legacy EHR and the new Millennium platform at the same time.

Structure and Operations

Recommendation 6: Investigate and address CBO concerns regarding inconsistencies in contract monitoring and communication with contract officers.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

San Diego MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Harriet Markell, Lead Quality Reviewer
Lamar Brandysky, Information Systems Reviewer
Pamela Roach, Consumer/Family Member Reviewer
Kiran Sahota, Quality Reviewer
Bill Ullom, Information Systems 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-site and the post-site meetings and in preparing the recommendations within this report.

MHP Review Sites and Participants

All sessions were held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Ackermann	Kristin	Assistant Program Director	Douglas Young Center
Adams	Hollis	Outpatient Clinician/Program Coordinator	Nueva Vista Family Services
Baez	Margarita	Peer Support Specialist	San Diego Employment Solutions
Bailey	Michael	Medical Director	United Behavioral Health – (Optum)
Baraceros	Mary Ellen	Regional Director	Pathways Community Services
Barounis	Kya	Senior Mental Health Researcher	Child and Adolescent Services Research (CASRC)
Bergmann	Luke	Director	San Diego County Behavioral Health Services (BHS)
Briones-Espinosa	Ana	Director of Finance and Business Operations	Optum
Carrillo	Angelina	Peer Support Specialist	San Diego Employment Solutions
Castro	Sara	Peer Specialist	Mental Health Services (MHS) Inc. / Families Forward Wrap Around program
Chadwick	Amy	System of Care Evaluation Coordinator	CASRC
Conlow	AnnLouise	Program Coordinator	BHS – Management Information Systems (MIS)

Last Name	First Name	Position	Agency
Crader	Kristina	Parent Partner	New Alternatives, Inc. (NAI) Therapeutic Behavioral Services (TBS)
Crandal	Brent	Director, BHQI	Rady Children's Hospital San Diego
Cuomo	Mitch	Clinician	North Coastal Mental Health Center
Davies	Christine	Assistant Program Director, PERT	Community Research Foundation (CRF)
Degroff	Megan	Clinician	Allanza Wellness Center
Edwards	Joseph	Assistant Program Director	Kickstart
Eriksen	Eycleisha	Clinician	Catalyst
Esposito	Nicole	Assistant Clinical Director	BHS – Clinical Director's Office (CDO)
Evans Murray	Cara	Assistant Medical Services Administrator	BHS – Adult Older Adult (AOA)
Fite	Elise	Talent Acquisition Manager	Telecare Corp.
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	BHS - AOA
Giddens	Bill (Twain)	Peer Specialist	New Vistas / Vista Balboa
Guevara	Christopher	Principal Administrative Analyst	BHS – (MIS)
Guingab	Amelia	Principal Administrative Analyst	BHS – Fiscal
Guzman-Wiley	Ana	Therapist	Palomar Family Counseling Service, Inc.

Last Name	First Name	Position	Agency
Hammond	Linda	President & CEO	CRF
Hayes	Skylar	Manager of I.T.	Optum
Hoff	Megan	Assistant Program Manager	North County Lifeline - School Based Full Service Partnership (FSP)
Holder	Judi	Recovery Services Administrator II	Recovery International (RI)
Hollis	Myra	Family Therapist	Foster Family Agency Stabilization and Treatemt (FFAST)
Kemble	Derek	Administrative Analyst III	BHS – QI – Performance Improvement Team (PIT)
Kiviat	Aurora	Assistant Director and Chief Operations Officer	BHS
Knight	Betsy	Behavioral Health Program Coordinator	BHS – AOA
Koenig	Yael	Deputy Director, Children, Youth & Families System of Care	BHS – Children Youth and Families (CYF)
Krelstein	Michael	Clinical Director	BHS
Lagare	Tiffany	Research Associate	CASRC
Lance-Sexton	Amanda	Assistant Medical Services Administrator	BHS - CYF
Lang	Tabatha	Assistant Medical Services Administrator	BHS - QI
Lesher	Ben	Peer Specialist	RI
Llamas	Claudia	Clinician	NAI
Loyo-Rodriguez	Raul	Department Budget Manager	BHS

Last Name	First Name	Position	Agency
Lozada	Rosa Ana	CEO	Harmonium Inc.
Lucas	Lavonne	Medical Claims Manager	BHS – Billing Unit
Marvin	Mark	Vice President, PERT	CRF
McDonald	Kate	Senior Mental Health Researcher	CASRC
McPherson	Julie	Vice President, CYF	CRF
Miles	Liz	Principal Administrative Analyst	BHS - QI - PIT
Murguia	Krystle	Administrative Analyst III	BHS – QI – PIT
Myers	Don	Director of Operations	Palomar Health
Ochoa	Paola	Support Partner – Youth	Family Health Centers of San Diego, Inc.
Panczakiewicz	Amy	Senior Evaluation Research Associate	Health Services Research Center (HSRC)
Parson	Heather	Behavioral Health Program Coordinator	BHS – Quality Management
Patel-Rao	Charmi	Supervising Psychiatrist	BHS – Stabilization Treatment and Transition (STAT) Team
Pauly	Kimberly	Chief, Agency Operations	BHS
Pena	Abel	Licensed Mental Health Clinician	Southeast Mental Health Center
Penfold	Bill	Sr MIS Manager	Optum
Ponzo	John	Mental Health Case Management Clinician	North Central Mental Health Center
Privara	Nadia	Chief, Agency Operations	BHS – Strategic Planning and Operations (SPO)

Last Name	First Name	Position	Agency
Quach	Phuong	Behavioral Health Program Coordinator	BHS – AOA
Ramirez	Blaize	Clinician	Catalyst
Ramirez	Ezra	Administrative Analyst II	BHS - QI - PIT
Ramos	Nilanie	Chief, Agency Operations	BHS - CDO
Robison	Makenna	Outpatient Clinician	Douglas Young Youth and Family Services
Romero	Michelle	Director of Behavioral Health Network & QI	Optum
Rule	Katie	Project Manager	HSRC
Salgado	Johanna	Intensive Care Coordinator	San Diego Center for Children's WrapWorks
Scolari	George	Behavioral Health Program Manager	Optum
Stark	Tamara	Senior VP, San Diego Programs	Exodus Recovery Inc.
Swaggerty	Delrena	Vice President	MHS Inc.
Tally	Steve	Assistant Director of Evaluation Research	HSRC
Thornton-Steans	Cecily	Assistant Director, Departmental Operations (COO)	BHS - QI
Tran	Anh	Research Associate	CASRC
Trask	Emily	Senior Mental Health Consultant	CASRC
Velazquez-Trask	Emily	Senior Mental Health Researcher	CASRC
Vleugels	Laura	Supervising Psychiatrist	BHS - CYF
Wallis	Kristen	Clinician	Catalyst

Last Name	First Name	Position	Agency
Watson	Teresa	Licensed Mental Health Clinician	County Case Management
Welsh	Sara	Program Director	CRF
White-Voth	Charity	Assistant Medical Services Administrator	BHS - AOA
Woods	Mary	Regional Administrator	Telecare Corp

Attachment C—Approved Claims Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

San Diego MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	255,032	10,477	4.11%	$47,233,069	$4,508

Attachment E—ACB Range Distributions

Table E1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

San Diego MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	34,000	95.79%	93.31%	$110,780,462	$3,258	$3,998	66.16%	59.06%
>$20K - $30K	745	2.10%	3.20%	$17,989,974	$24,148	$24,251	10.74%	12.29%
>$30K	750	2.11%	3.49%	$38,668,116	$51,557	$51,883	23.09%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full-Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan