Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2018–19
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 8-10, 2019

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

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 quality, timeliness, and access to 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 takes into account 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) 2018-19 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) 2017 — 39,759

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

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

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.

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:

---

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

- 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 three domains: access, timeliness, and quality. 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.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. 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.

Key Recommendations from FY 2017-18

Recommendation 1: Continue efforts to understand the communication issues with contract organizational providers and implement effective remedies for improvement. Consider the development of a provider-designed survey instrument which will identify the key topics and provide responses guidance to an improved change process. Consider increased contractor involvement in Cerner/EHR forms development and changes, with a focus on reduction of complexity.

Status: Met

- Continued efforts to improve communication between Behavioral Health Services (BHS) and contract providers were evidenced during the past year. These efforts included monthly meetings with the Mental Health Contractors' Association Executive Team, which were re-formatted to prioritize high-value topics for the contractors. This ensures topics of importance are discussed and targeted for resolution.
- Changes also include the Outpatient Redesign Workgroup (ORW), which brings together a diverse group of providers to participate in the development of a more responsive, beneficiary-focused mental health system, which is targeting topics such as discharges, documentation requirements, care coordination, and staff

retention. One of these efforts focused on improving recruitment and retention of psychiatrists.

- Within the Child, Youth and Family (CYF) system, a SurveyMonkey, an online survey development cloud-based software, effort was initiated to discover from program managers what is working well in the meetings. Results indicated the majority of content was meeting their needs but fine-tuning was applied to revise those elements which remained unchanged.

- MHP added a workforce topic to last year's MHSA community forums as a method for additional feedback. As a result of this feedback, and extensive dialog with providers, MHP has updated its contracting process. In new procurements, Offerors propose the rates they deem necessary to complete the scope of work, whereas in the past, MHP indicated the contract maximum and the capacity that Offerors would include in their proposals. Also, a new tool was developed by MHP to conduct a cost analysis for each program to determine the fair cost for programs based on a market rate analysis. The completion of this new template also satisfies the new federal contracting requirement of conducting a market rate salary analysis.

- Specific to Cerner/EHR functions, BHS worked closely with contractor staff during the past year to roll out the Access to Services journal and had several contract programs pilot the module and provide feedback before system-wide implementation.

- BHS has included contractor representatives to participate in workgroups formed to update the discharge summary form in alignment with the non-clinical PIP. It has also worked to increase provider attendance at the monthly Quality Improvement Partners meeting, by ensuring contract staff are aware of the meetings.

- During the next few months, as BHS begins to outline the roadmap to Cerner Millennium (CM), workgroups will be established and will be required to include contract provider representatives to incorporate their input into the process.

Recommendation 2: Continue to assess the impact of Collaborative Documentation (CD) on the engagement of consumers in treatment, including retention and improved treatment outcomes as well as timeliness of documentation.

Status: Met

- The MHP fully addressed all elements of this recommendation, producing an analysis that indicated there was little difference in Adult/Older Adult (AOA) outcome measure results when comparing CD to standard documentation practices.

- The standard of service documentation within seven days of encounter was met 97 percent for CD, versus 80 percent for standard practices. Same-day documentation occurred 63 percent with CD, versus 35 percent for standard

practices. These results reflect an improvement in timeliness for CD documentation practices, particularly for same-day. This could result in more accurate and complete documentation when CD is utilized.

- It is noteworthy that CD is currently limited to 20 percent of all programs. The MHP's Quality Review Committee (QRC) will be making a formal recommendation as to whether CD should be broadly adopted throughout all programs. It is also noteworthy that in the process of testing CD, the MHP has discovered that the anticipated need for and costs of two computer screens is not an essential component. An alternate approach was developed, that of arranging for the computer screen to be shared by the clinician and the beneficiary. This was discovered to be equally effective as the twin screen approach.

Recommendation 3: Along with reviewing contract provider reimbursement rates, evaluate the impact of reimbursement rates on quality and availability of care and retention of staff. A component of this would include tracking the turnover of personnel in, at minimum, contract programs, tracking by discipline/license, as well as other key characteristics such a bilingual status.

Status: Met

- The MHP did update the contractor's contracting process during the past year. For new contracts, the MHP will publish either the contract maximum or the capacity and let the offerors propose the other, thereby allowing them to propose the rates. Previously the MHP would set the contract maximum and capacity, ultimately impacting the rates.

- The MHP developed a new tool to conduct a cost analysis of each program to determine the fair cost for programs based on a market rate analysis. This new tool also satisfies a new federal contracting requirement of conducting market rate salary analysis.

- Hospital contracts were also increased, both acute and administrative day rates for adult and older adults; along with children's acute day rate were increased; ranging from 12 to 17 percent. The day rates were retroactive to July 2018 and the net impact is expected to be about 3 million dollars for current fiscal year.

- During the past year, specific workforce analysis was also completed for San Diego Psychiatric Hospital as it has experienced 28 percent annual turnover of nursing staff. The hospital continues to review this issue and tracks turnover data to assess next steps.

- Also, during the past year, the MHP conducted an analysis of the use of bilingual staff versus interpreters for services in languages other than English. Of the bilingual services provided, 85 percent of services were conducted by contractor provider staff, while 9 percent were conducted by interpreters. To support hiring and retention of bilingual staff, providers offer bilingual premium pay.

Recommendation 4: Prioritize system-to-system integration between the MHP and its contract providers to streamline documentation processes and provide better and timelier access to clinical information.

Status: Partially Met

- The MHP worked with County IT outsource provider, Perspecta, to develop a data exchange solution for interoperability with IBM. It was determined through a series of meetings that additional mapping of data exchange elements is necessary, causing a delay with the system build.

- As a result of IBM build delay, the MHP focused on how the roadmap into CM could support an interoperability solution to connect disparate systems through Cerner Application Program Interfaces (APIs) and Cerner HealtheIntent platform. The MHP is working with Cerner for a contract change order that would include modules and functionality for APIs and HealtheIntent for a system-to-system solution.

Recommendation 5: Analyze the association between penetration rates, costs per beneficiary, number of servicers per beneficiary, and consumer outcomes to better understand the relationship between these indicators to system efficiency, quality and effectiveness.

Status: Met

- Based on Short-Doyle Medi-Cal (SDMC) claims data reports produced by CalEQRO, the MHP believes the CY 2017 overall penetration rate (4.39 percent) aligns closely with other large MHPs (4.19 percent) and state-wide (4.52 percent) parameters that reflect system efficiency, quality and effectiveness. The total claims of 171 million dollars for CY 2017 included 60 million dollars in the Mental Health Services category, which comprised the largest single service category (35 percent) of total claims.

- The MHP's CY 2017 overall average approved claims per beneficiary (ACB) served ($4,302) was significantly lower than other large MHPs ($6,723) and statewide ($6,170) averages. Also, review of ACB service categories noted the MHP was lower than the large and statewide averages in most categories, the exception was Day Treatment Services, which was less than 4 percent of total claims.

- BHS captures the total visits and unique clients by levels of care and by service type for the AOA population, and the average hours per client by service type for the Children Youth and Families (CYF) population in system-wide annual reports. These reports also highlight client outcome measure results at the system level, while there are also program level reports for monitoring outcomes and other indicators at each contracted treatment program.

- Looking forward, the MHP will track and evaluate if changes in procurement rates impact penetration rates. The MHP also believes that the CYF population data is

reflecting the increases in clinical services for children provided by the schools and health plans, which contribute to declining penetration rates for this population.

- When considering services by category, the MHP penetration rates are close to or above other large MHPs and the statewide values. However, ACB dollars by category are significantly lower than other large and the statewide averages for residential treatment, crisis and particularly mental health services (MHS). In the MHS category, the MHP's ACB results of are significantly lower ($1,823) than other large MHPs ($4,429) and the overall statewide ($3,996) average.
- The MHP might develop useful information from targeted efforts to evaluate end-of-treatment satisfaction survey from all beneficiaries and match that data up with outcome information, perhaps by using the improved case closure data that is being developed. This data could help the MHP determine if the lower average costs are obtaining the desired results. Separate analysis of AOA and CYF populations would be important.

PERFORMANCE MEASUREMENT

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 services or inpatient services, 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.

---

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

1. Senate Bill (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:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
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

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (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.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- 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 (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the 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 (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity San Diego MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	188,470	20.8%	11,732	29.5%
Latino/Hispanic	388,614	42.9%	10,804	27.2%
African-American	55,933	6.2%	3,324	8.4%
Asian/Pacific Islander	77,280	8.5%	1,862	4.7%
Native American	3,925	0.4%	295	0.7%
Other	191,743	21.2%	11,742	29.5%
Total	**905,964**	**100%**	**39,759**	**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.				

Penetration Rates and Approved Claims per Beneficiary

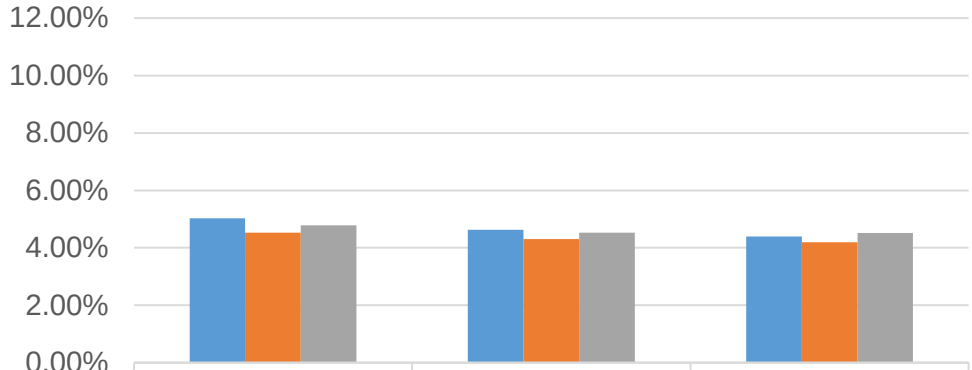
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated 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 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the San Diego MHP uses the same method used by CalEQRO.

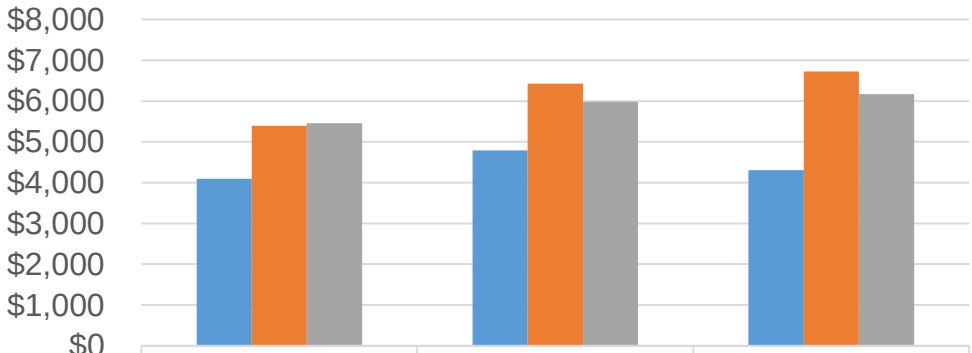
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	5.03%	4.63%	4.39%
Large	4.53%	4.30%	4.19%
State	4.78%	4.53%	4.52%

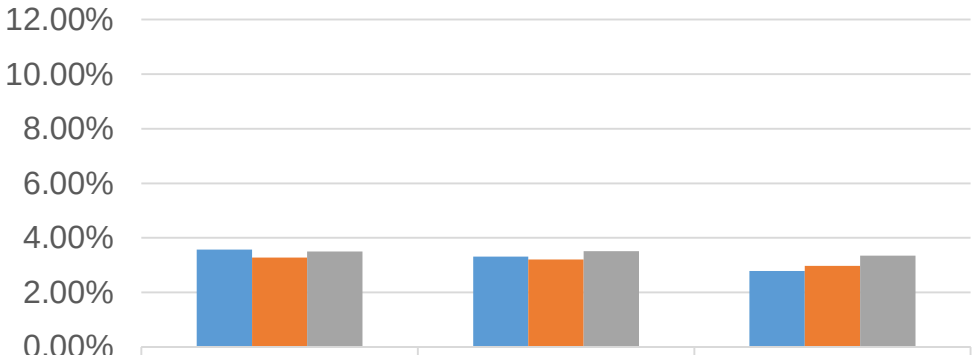
Figure 1B. Overall ACB
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	$4,093	$4,792	$4,302
Large	$5,393	$6,430	$6,723
State	$5,458	$5,978	$6,170

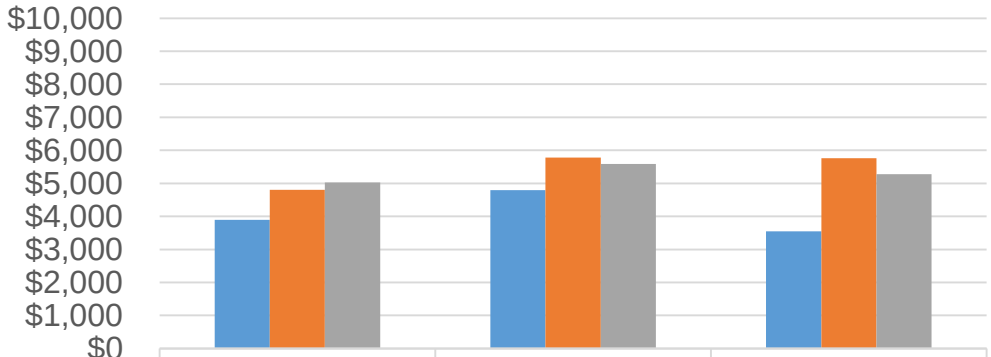
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	3.57%	3.31%	2.78%
Large	3.28%	3.21%	2.97%
State	3.50%	3.51%	3.35%

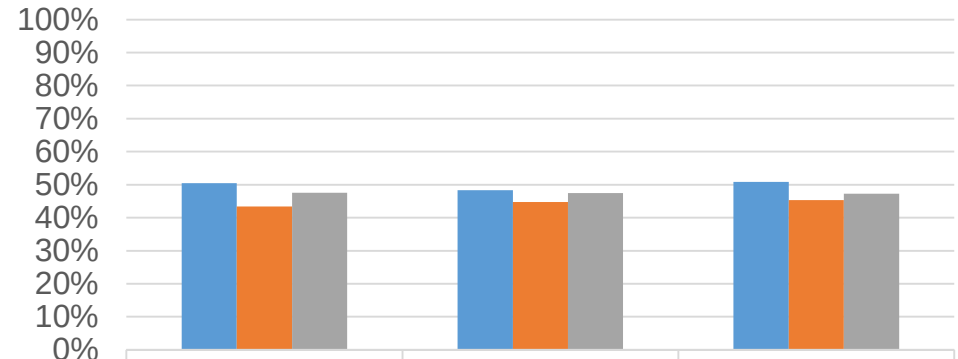
Figure 2B. Latino/Hispanic ACB
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	$3,895	$4,796	$3,547
Large	$4,804	$5,785	$5,758
State	$5,029	$5,588	$5,278

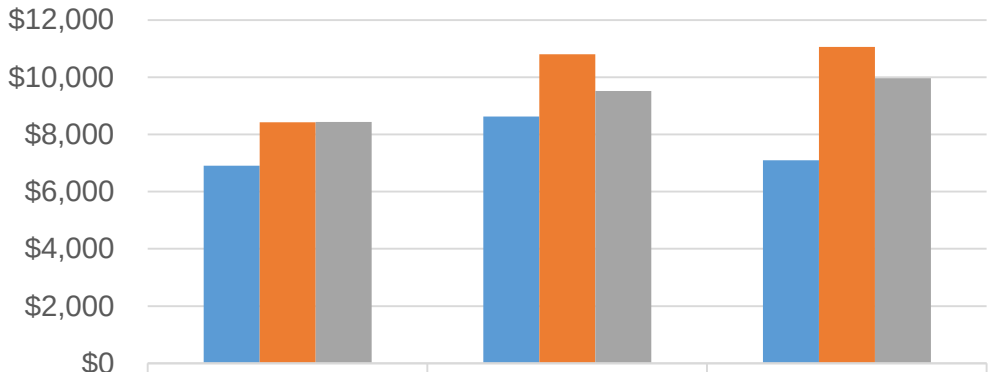
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	50.46%	48.37%	50.83%
Large	43.42%	44.78%	45.37%
State	47.52%	47.48%	47.28%

Figure 3B. FC ACB
San Diego MHP



	CY 2015	CY 2016	CY 2017
MHP	$6,906	$8,627	$7,092
Large	$8,425	$10,805	$11,064
State	$8,432	$9,521	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
San Diego MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	746	39,759	1.88%	$48,281	$36,017,617	21.06%
	CY 2016	1,145	42,415	2.70%	$45,747	$52,380,137	25.77%
	CY 2015	883	43,739	2.02%	$47,284	$41,751,346	23.32%

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 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

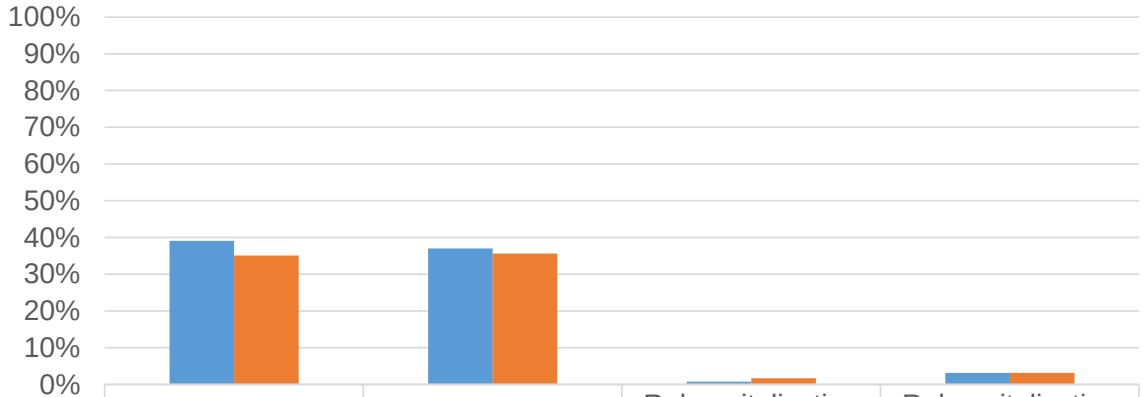
Table 3. Psychiatric Inpatient Utilization - San Diego MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	4,451	11,895	7.88	$8,194	$36,472,517
CY 2016	4,578	12,682	7.86	$7,534	$34,491,875
CY 2015	4,660	14,385	7.47	$5,094	$23,735,811

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

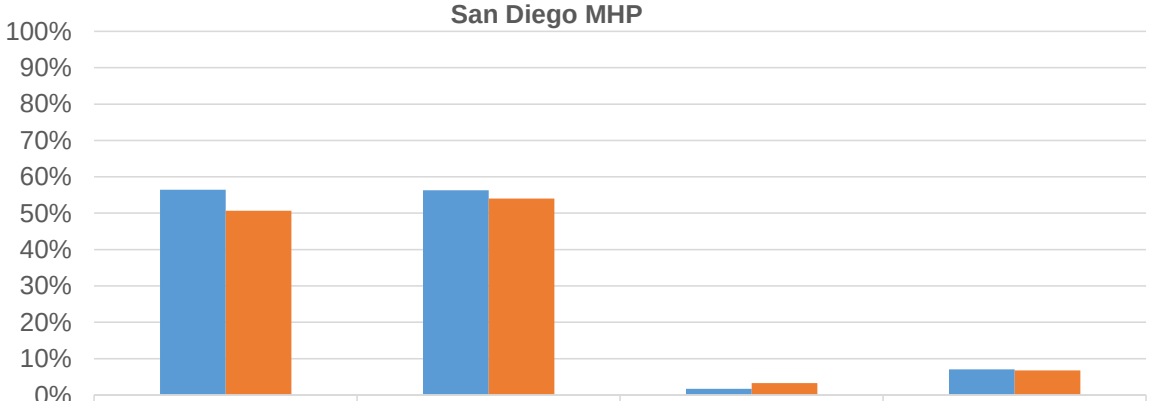
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
San Diego MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	39%	37%	1%	3%
CY 2017	35%	36%	2%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
San Diego MHP



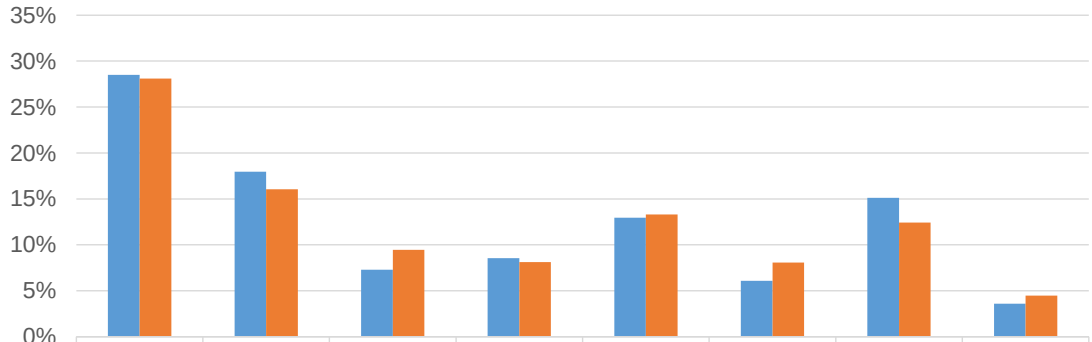
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	56%	56%	2%	7%
CY 2017	51%	54%	3%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

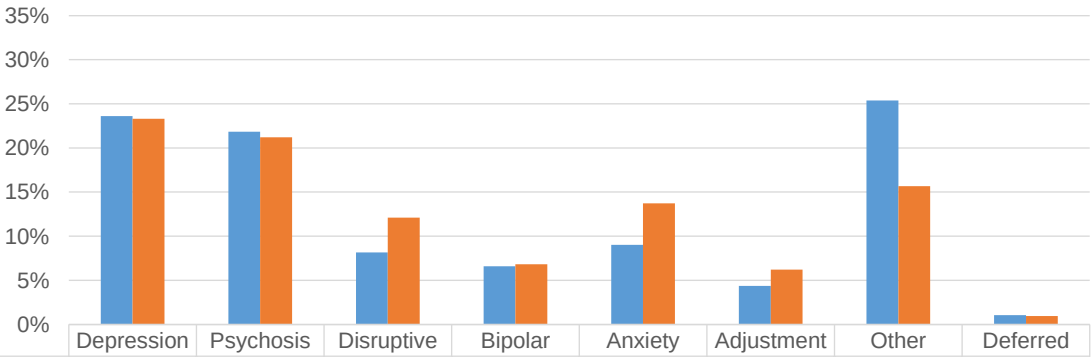
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: Overall, 35.5 percent; Children/Youth, 4.2 percent; Adult/Older Adult, 47 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
San Diego MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	28%	18%	7%	9%	13%	6%	15%	4%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

Figure 5B. Diagnostic Categories, Total Approved Claims
San Diego MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	24%	22%	8%	7%	9%	4%	25%	1%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner.” CMS’ EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

San Diego MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs presented by the MHP, both of which were determined to be concept only as of the date of the review.

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 4: PIPs Submitted by San Diego MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Caregiver Engagement
Non-clinical PIP	1	Improved tracking and retention for patients who are discharged after not returning

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	NR
		1.4	All enrolled populations	NR	NR
2	Study Question	2.1	Clearly stated	NR	NR
3	Study Population	3.1	Clear definition of study population	NR	NR
		3.2	Inclusion of the entire study population	NR	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	NR
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	NR	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NR
		5.2	Valid sampling techniques that protected against bias were employed	NR	NR
		5.3	Sample contained sufficient number of enrollees	NR	NR
6	Data Collection Procedures	6.1	Clear specification of data	NR	NR
		6.2	Clear specification of sources of data	NR	NR
		6.3	Systematic collection of reliable and valid data for the study population	NR	NR

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		6.4	Plan for consistent and accurate data collection	NR	NR
		6.5	Prospective data analysis plan including contingencies	NR	NR
		6.6	Qualified data collection personnel	NR	NR
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NR
		8.2	PIP results and findings presented clearly and accurately	NR	NR
		8.3	Threats to comparability, internal and external validity	NR	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NR
		9.3	Improvement in performance linked to the PIP	NR	NR
		9.4	Statistical evidence of true improvement	NR	NR
		9.5	Sustained improvement demonstrated through repeated measures	NR	NR

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	NR	NR
Number Partially Met	NR	NR
Number Not Met	NR	NR
Unable to Determine	NR	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	NR	NR
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**0%**	**0%**

Clinical PIP— Caregiver Engagement

The MHP presented its study question for the clinical PIP as follows:

"Will educating and providing strategies to the BHS CYF system on increasing caregiver participation in family therapy lead to increases in family participation and reductions in clients' mental health symptoms?"

Date PIP began: March 2018 (as stated by MHP, but not currently considered active)

End date: Spring 2020

Status of PIP: Concept only, not yet active (not rated)

This PIP is oriented to the treatment provided within the CYF system, and the importance of family therapy sessions to the progress of child and youth beneficiaries. Service analysis between FY 2013-14 and FY 2016-17 indicated that family therapy comprised less than 41 percent of all sessions, which did not improve during that period. Within the typical 13 or more sessions for the July 2017 through December 2018 period, approximately 38 percent of children and youth received no family therapy sessions.

The MHP cited literature that supports the importance and efficacy of family therapy in the treatment of children and youth. In addition, the MHP considered data from the May 2018 Youth Services Survey of caregivers that reflected a 44 percent incidence of families reporting not being offered family therapy. Also, 77 percent of caregivers reported that when they met with a therapist, it was without the inclusion of the child or youth in treatment.

The combination of literature on best practices with the CYF population and the data findings resulted in the MHP selecting this topic for a clinical quality of care improvement effort.

To impact this topic, the MHP has identified three strategies, which include: presentation of the topic to program managers, Motivational Enhancement for Engagement in Therapy (MEET) training, and Parent and Caregiver Active Participation Training (PCAPT).

As of the current review, only the first element has been initiated. It involves familiarizing program managers with the relevant data and planned improvement efforts, but does not meet the requirements of a direct intervention that would likely produce the desired change. As such, the PIP must be considered "concept only," which means that it cannot be scored.

Suggestions to improve the PIP: The MHP has all elements of the PIP in place, including indicators and interventions; however, the interventions that are directly focused on creating the changes and improving the use of family therapy have not started yet. This is an important aspect, and is required for a PIP to be considered active. The direct interventions are slated to begin later in the winter and spring of 2019.

Noted during the review is the use of two interventions, MEET and Active Participation Training, which may make it difficult to determine which intervention produces the anticipated changes. Unless these two interventions are universally applied together, the MHP may wish to defer one of the interventions in order to capture resultant data before adding the second intervention.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of providing information to the MHP and its partners in University of California San Diego (UCSD) clarifying that interventions which will affect the increase in family therapy are not yet active, and the discussion about the multiple intervention strategy potentially creating confusion as to which element is creating the effect.

Non-clinical PIP— Improved tracking and retention for patients who are discharged after not returning

The MHP presented its study question for the non-clinical PIP as follows:

"Could focus and improvements on the discharge planning process reduce the number of clients who are discharged after not returning for services and who re-enter services through crisis or emergency levels of care?"

Date PIP began: April 2018 (as stated by MHP, but not currently considered active)

End date: December 2019

Status of PIP: Concept only, not yet active (not rated)

The MHP examined the data related to case closings and the distribution of closure reasons. Examination of FY 2016-17 discharge reasons indicated that nearly 40 percent of beneficiaries discharged were categorized as “client/family did not return.” Of these closed beneficiaries, 47 percent received no further services, but 13 percent re-entered care in the following year due to a crisis or Psychiatric Emergency Response Team (PERT) contact.

Although not emphasized by the MHP, another 25 percent re-entered services through routine outpatient care. While the routine re-entry status individuals may present less critical needs, the disruption to treatment is certainly not ideal.

The MHP’s data from prior periods of beneficiaries who “did not return” may or may not have been useful confirming whether the recent data is consistent with or differs from historic data.

The MHP also administered a beneficiary survey as part of the Spring 2018 Consumer Perception Survey (CPS), which was utilized to provide baseline satisfaction information for those who discontinued services due to provider/clinician dissatisfaction (19 percent). This also captured information from discontinuing care beneficiaries regarding the extent to which transportation was a barrier to care (29 percent).

As common to this type of study, technical issues were identified and addressed to ensure accuracy of discharge coding data. This included training to the proper use of the discharge summary form and process. The MHP also prioritized emphasizing beneficiaries’ right to change providers, and providing information about transportation assistance.

The interventions proposed by the MHP include program manager educational work groups (November 2018), and development of a beneficiary survey pre- and post-intervention (May 2018; May 2019).

However, from the point of this current review, the requirement for a specific, unique intervention has not been met, one that would reasonably produce a change in spontaneous discontinuation with treatment. The existent strategies that the MHP has identified are certainly important and helpful in preparation for the application of a specific, new strategy. The existence of a unique and ongoing intervention is missing.

Suggestions to improve the PIP: The MHP needs to create a new and unique intervention. Possible examples of this could include a process to query beneficiaries before or after each session regarding their experience with the quality of care and satisfaction with the provider, as well as seek to identify transportation needs. This inquiry would be paired with a menu of specific actions to resolve whatever needs were identified. This survey could be administered by front office staff, or by the clinician. Such an approach would comprise a new, direct and ongoing intervention to improve engagement of consumers. The MHP also might opt to develop an intervention that

improves and augments the existing process of no-show follow-up, which is broadly applied.

Considering the scale of this MHP's operations, piloting interventions at a limited number of sites might be an effective approach to testing out a number of interventions.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The TA provided to the MHP by CalEQRO consisted of discussion about the need to create a unique intervention that the MHP hypothesizes will improve engagement and reduce unplanned service termination.

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 response 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 Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 6.1 percent.)

☐ Under MHP control
☐ Allocated to or managed by another County department
☒ Combination of MHP control and another County department or Agency

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	6.76%
Contract providers	85.91%
Network providers	7.83%
Total	**100%***

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

Table 8 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 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Not used
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of remote sites currently operational: 99

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

- Telehealth services are available with English, Spanish and Arabic speaking practitioners (exclusive of the use of interpreters or language line).
- Approximately 129 telehealth sessions were conducted in languages other than English.
- For FY 2017-18 bilingual services, the MHP reported a total of 8,346 unique beneficiaries (59 percent CYF and 41 percent AOA) received services in a language other than English.

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 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
BHS-9	4	3	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
53	9	6	0

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

- Table 9 information reflects direct-reports within the MHP organization chart. It does not include technology support services provided by County IT or external Contractors, Cerner, or Optum San Diego.
- Table 10 information includes Optum San Diego, UC San Diego – Child & Adolescent Service Research Center (CASRC), and AOA data analysis provided by UC San Diego Health Services Research Center (HSRC).

- The MHP anticipates adding additional technology and subject matter experts as the CM project proceeds. The MHP has added 12 contracted staff such as Health Informatics and technical positions to aide in the roadmap from Cerner Community Behavioral Health (CCBH) to Cerner Millennium (CM).

Current Operations

- Cerner continues to host Cerner Community Behavioral Health (CCBH), and the MHP periodically measures end-user response times. Both MHP and end-users found good system availability and response times during the past year.
- The MHP is current with the installation of CCBH promotions (software updates). Plans are in place to install future promotions timely as they implement the CM roadmap.
- The MHP reported 6.1 percent of annual budget is dedicated to support IT operations for FY 2018-19 (hardware, network, software license, and IT staff).
- The MHP continues to expand outpatient services delivered by their contract provider network. However, providers who have their local EHRs continue to do double data entry as there is no process to electronically transfer data from local EHRs to CCBH system.

Table 11 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 (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
CCBH	Client Data and Managed Care	Cerner	10	County of San Diego (CoSD)
CCBH	Appointment Scheduling	Cerner	9	CoSD
CCBH	Assessment and Treatment Plan (ATP)	Cerner	8	CoSD
CCBH	Clinical ATP - Client Plans and Progress Notes	Cerner	7	CoSD
CCBH	Doctor's Homepage e-Prescribing and Meds Management	Cerner	6	CoSD

Table 11: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
CM	Hospital Inpatient	Cerner	7	CoSD
CM - CareTracker	Care Documentation	Cerner	6	CoSD
OnBase	Imaged Records	Hyland	4	CoSD

The MHP's Priorities for the Coming Year

- Implement CCBH to CM EHR system roadmap.
- Incorporate CM modules for interoperability with disparate provider systems.
- Implement Access to Services journal Phase 2 to capture additional State Client Service Information (CSI) data elements to support timeliness requirements.
- Implement and provide beneficiary's access to Patient Portal, and monitor and provide training and support.
- Special projects to support data integrity and monitoring.

Major Changes since Prior Year

- Completed change order to San Diego domain for CM.
- Implemented Access to Services journal.
- Initiated interoperability module for Ultra-Sensitive Exchange.
- Initiated the pilot for Electronic Prescription of Controlled Substances.

Other Areas for Improvement

- The MHP provides clinical staff an extensive array of EHR trainings that are conducted frequently throughout the month, which include: Assessments, Doctors Homepage, Client Plans, and Progress Notes. During the clinical line staff interview session, from their perspective, a need for a higher level of EHR training exists that provides guidance for documentation of complex care conditions.
- Planned Go Live for the roadmap from CCBH to Millennium is scheduled for fall of 2020. Extensive project planning and identification of resources necessary for this large project is complete. BHS has added to the Cerner contract by standing up a San Diego Domain hosted by Cerner that will contain Millennium for all of BHS including the San Diego County Psychiatric Hospital, outpatient services,

and Edgemoor long-term care. In addition, BHS added eight contracted staff at the time of this review with plans for an additional six contracted staff to be in place within two months. These staff will provide subject matter expertise in large scale implementations and health informatics. Additional staff have been identified and will be contracted as the project expands. Executive leadership assuring the project's success include Dr. Luke Bergmann, Director, and other key leadership members who have specific area responsibility.

- Project planning to support federal CMS Final Rule and DHCS, MHSUDS Information Notices (IN) for the CM system build and ongoing development proceeds needs to be a priority.
- The San Diego County Health and Human Services Agency (HHSA) Contract Monitor training academy uses the federal government contract as the primary tool to instruct and provide guidance for trainee staff. BHS includes a California focus that incorporates relevant DHCS INs and implement required enhancements into the system.
- The County of San Diego is working with San Diego Health Connect (SDHC) for an interface with Health Information Exchange (HIE) initiatives, with current plans to be operational sometime during FY 2019-20. The MHP needs a strong collaboration with SDHC to implement HIE projects after the CM system is live and stable.

Plans for Information Systems Change

- New system selected, using current system vendor (Cerner).
- The planned transition from CCBH to CM is not a straightforward system "lift and shift" conversion effort. Significant system improvements and functionalities will be added to support California's clinical data reporting requirements, DHCS reporting requirements, and developing outcome data standards. This process also requires attention to efficient use for healthcare end-users to minimize EHR navigation "click-throughs".

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	CCBH		X		

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	CCBH	X			
Care Coordination	CCBH	X			
Document Imaging/ Storage	CCBH	X			
Electronic Signature—MHP Beneficiary	CCBH	X			
Laboratory results (eLab)				X	
Level of Care/Level of Service	CCBH	X			
Outcomes	CCBH	X			
Prescriptions (eRx)	CCBH	X			
Progress Notes	CCBH	X			
Referral Management	CCBH	X			
Treatment Plans	CCBH	X			
Summary Totals for EHR Functionality:					
FY 2018-19 Summary Totals for EHR Functionality:		10	1	1	0
FY 2017-18 Summary Totals for EHR Functionality*:		10	1	1	0
FY 2016-17 Summary Totals for EHR Functionality:		7	2	1	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

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

- Completed implementation of Access to Services journal.
- Initiated interoperability module for Ultra-Sensitive Exchange (prescriptions).
- Initiated a pilot project of Electronic Prescription of Controlled Substances.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☐ Within the next year
☒ Within the next two years	☐ Longer than 2 years

- Personal health record functionality to be implemented as the CM roadmap is disclosed.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Microsoft Excel

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims
San Diego MHP

Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
739,216	$142,041,888	**6,562**	$1,467,358	1.03%	$140,574,530	$2,386,716	$138,187,814

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent.**

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial San Diego MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed prior to submission of claim.	2,252	$479,660	33%
Beneficiary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	2,002	$440,412	30%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	1,395	$365,402	25%
TOTAL	6,562	$1,467,358	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with denial reason description “Medicare or other health coverage must be billed prior to submission of claim” are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted four 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 4 focus groups with 8 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 CFMs for their participation.

CFM Focus Group One

The first consumer focus group requested was to consist of culturally diverse parents and caregivers of children and youth receiving treatment, the majority of whom initiated services within the prior 6 to 12 months. The session was conducted at the North Coastal Live Well Center, located at 1701 Mission Avenue, Oceanside, California.

The majority of session participants initiated services within the last year. The group was comprised of varied ethnicities and cultures, and met the requested composition. All participants were English speakers.

Number of participants: Four

The four participants who sought services for their children and youth in the past year described their experiences as the following:

- Wait times for initial services were very brief for both clinician and psychiatrist services.
- Those whose previous contact was with Child Welfare Services (CWS) reported difficulties getting referrals for mental health treatment. In addition, once services have been initiated, they felt there was a rush to discharge when a brief period of stability occurred.
- Wraparound services have provided excellent support to these families.

Participants' recommendations for improving care included the following:

- Increase the time dedicated to transition when a change of providers or level of care is required.
- Caregivers would like to see BHS be the primary decision maker about treatment and services, not CWS. These participants believed that CWS does not

understand the treatment needs of children and their families, and may fail to make timely needed treatment referrals.

Interpreter used for focus group one: No

CFM Focus Group Two

Focus group two was requested to be a culturally diverse group of 8 to 10 adult consumers, the majority of whom initially accessed care within the past 6 to 12 months. The session was conducted at the North Coastal Live Well Center, located at 1701 Mission Avenue, Oceanside, California.

The session was attended by ten adult consumers, meeting the requested composition, the majority male with a small component of females. In the course of this session, three participants departed the group early.

Number of participants: Ten

The two participants who entered services within the past year described their experiences as the following:

- Exodus Recovery, the program which accepts same-day walk-ins, was described as providing quick access for an assessment, medications, and a clinical visit.
- For one individual, a psychiatrist was seen within a month, for another it took two months.
- One individual has been waiting a year for supportive services, and was told their insurance does not cover this type of care. The individual will soon start at the Catalyst Assertive Community Treatment (ACT) program.

Participants' general comments regarding service delivery included the following:

- Participants noted that police officers have been more helpful than they had expected when encountered in crisis.
- Some identified the benefits of having a peer advocate to assist them until they are feeling better.
- Those with Kaiser Medi-Cal or other insurance may be hospitalized and upon discharge referred to a variety of services that may not be covered by their insurance. It developed that those services were not part of the Kaiser system, which created confusion and challenges in accessing the needed care.
- The Mariposa Clubhouse was seen as a helpful resource for participants. It offers job training, resume development help, and food handler certificate training. The program seeks input for what consumers need to be included in programming. All participants report taking part in clubhouse activities.

- Post-hospitalization, participants noted that some of the resources had inaccurate or out of service phone numbers, and sometimes programs are found to be closed or relocated.
- Beneficiaries report, on occasion, being told they are too sick to be eligible for a specific program, and in other instances, some have been told they are not sick enough to qualify. This predicament is discouraging for those seeking treatment, and lack a strong advocate, and was experienced by quite a few of the participants.
- Wellness Recovery Action Plan (WRAP) training is occurring for some, and is available twice a week.
- The majority knew who to call if help was needed between scheduled appointments. They are aware of the crisis and warm lines. Some have had positive experiences with 211, and being transferred to helpful resources.
- Some of the specific helpful resources identified include: Esperanza, Turning Point, and Halcyon, and Mental Health America (MHA). The National Alliance on Mental Illness (NAMI) is also considered a useful support.
- The majority feel that their mental health has improved since first starting services.
- Information about available programs and services is presented in a variety of inconsistent ways, with the resources or contact numbers often out of date when using hardcopy abbreviated handouts. The most reliable mechanism seems to be consumers sharing information among each other.

Participants' recommendations for improving care included the following:

- Add more Psychiatric Emergency Response Teams (PERT), so there is always sufficient coverage that averts law enforcement alone responding to crisis events.
- Create One-Stop locations that provide Social Security Administration, Supplemental Nutrition Assistance Program (SNAP), job training, dental care, bill paying help and mental/physical treatment in one location.
- Enhanced transportation assistance is needed.
- Increase coordination and follow-up post hospitalization.
- More classes and groups at the clubhouse, such as self-esteem and WRAP. More social activities provided outside of the Clubhouse, in community venues.
- Help beneficiaries access regional resource lists in hardcopy form that are derived from the regularly updated online resources, such as that maintained by Optum San Diego.

Interpreter used for focus group two: No

CFM Focus Group Three

The third requested focus group was to be comprised of culturally diverse Transitional Age Youth (TAY) beneficiaries, the majority of whom initially accessed care within the past 6-12 months. The session was conducted at the North Coastal Live Well Health Center, 1701 Mission Drive, Oceanside, California.

Session participants were all consumers, and English speakers. They were culturally and gender diverse.

Number of participants: Two

None of the participants entered services within the past year.

Participants' general comments regarding service delivery included the following:

- Although not accessing care within the last year, the time to first service was within two weeks, following release from jail for one, and from hospitalization for the other. Both felt they received quick services.
- The NAMI Next Step program provided help to those discharging from a hospital episode.
- One participant now sees a psychiatrist every three months, and offered no complaints about the frequency.
- Initial access to enrolling in programs and assessment was experienced as easier than actual access to ongoing services. The help within the first two weeks included temporary housing, but the workers that provided assistance were not heard from again.
- Neither could recall being asked to provide feedback on services before this focus group.

Participants' recommendations for improving care included the following:

- Quicker communication about services and programs.
- Shorten the time from program intake to the provision of definitive care and case management.
- Ensure continuity and continuing contacts occur once services are started.

Interpreter used for focus group three: No

CFM Focus Group Four

The fourth focus group consisted of 13 hearing impaired consumers, who receive services from Deaf Community Services (DCS) Clubhouse, at 205 National City Blvd., National City, California.

All participants were young adult or TAY consumers, with the majority Hispanic/Latino, followed by Caucasian/White beneficiaries, and lastly including a small number of African American/Black participants. The gender distribution was nearly equal. All communication occurred via American Sign Language (ASL).

An ASL interpreter was offered; however, the focus group facilitator was able to directly communicate using ASL.

Number of participants: 13

There were no participants known to have entered services within the past year.

Participants' general comments regarding service delivery included the following:

- All of the deaf consumers reported early and timely access to care through DCS. The only issues with access related to when seeking services directly from non-DCS programs, as most programs lack ASL interpreters.
- DCS has a WRAP program that provides case management when needed, as well as a support group.
- In this treatment environment psychiatrists and therapists tend to change each year, requiring a restart of the treatment process. This is experienced as disruptive to treatment.
- Participants feel isolated from the hearing community because, with the exception of major public events, ASL interpreters are not routinely available for mental health public planning sessions. These participants were also not aware or informed of planning sessions intended to include beneficiaries.

Participants' recommendations for improving care included the following:

- Develop ASL mentors that help when psychiatric hospitalizations occur, or when appointments are needed with non-signing practitioners, such as physical health care.
- The deaf community would like to see the MHP make a special effort to reach out to the hearing-impaired community and routinely incorporate them in public planning events, assisted by an ASL interpreter.
- Update therapeutic resource information with identification of those programs with the capacity to directly communicate with hearing impaired individuals.

Interpreter used for focus group four: Yes Language(s): ASL

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 an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides 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 15: Access to Care Components

	Component	Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	M

The MHP's overall penetration rate is above the large MHP average, and slightly below the statewide average. When considering race/ethnicity, the MHP's overall penetration rate for the White race/ethnicity category is slightly greater than the large MHP and statewide average, as reflected in the approved claims for CY 2017. The Asian/Pacific Islander (API) penetration rate also slightly exceeds the large MHP and statewide averages. For the remainder of the race/ethnicities, the MHP is below other large MHPs and statewide numbers.

The MHP utilizes a Cultural Competence Handbook to describe the various ethno-cultural populations of the county, the Cultural Competence Plan, and provide information about expectations of providers to meet these needs. This includes a checklist that can be used for a self-assessment.

The Cultural Competence Resource Team (CCRT) reviews the disparities reports formulated by UCSD, which presents data on penetration rates, long-term engagement and retention among age groups and race/ethnicities. The CCRT also provides recommendations for other efforts to improve access and care.

Table 15: Access to Care Components		
Component		**Quality Rating**
This past year has seen the MHP improve access and address cultural needs. This includes the January 2018 launch of the Roaming Outpatient Access Mobile (ROAM) program that targets rural areas where 5,300 Native Americans (NA) live in 193 square miles of reservation land. This program increases access through the use of two mobile clinics, and integrates NA culture in practices, within a population that tends to experience high levels of trauma and post-traumatic stress disorder (PTSD). A specific area of focus this review cycle was upon services to hearing impaired beneficiaries. The clubhouse and clinical services provided through Deaf Community Services were reviewed and received very positive feedback.		
1B	Manages and adapts its capacity to meet beneficiary service needs	M
The Long-Term Care Continuum project is focused on reduction of institutional care, and reducing time spent out of county by improving local supportive residential treatment options. Efforts to improve engagement with homeless, which includes the TAY population are receiving support from the Short-Term Bridge Housing for TAY. The telemedicine project is intended to provide greater access to follow-up psychiatry care subsequent to crisis or inpatient treatment, but is not yet available. For children and youth, a medication clinic that was started in July 2018 provides ongoing medication support to those who have completed therapy and require long-term stabilization. It also provides child psychiatry consultation to children and youth with medical problems, and are served in a pediatric setting. The challenges related to recruitment and retention of psychiatrists also emerged during this review, which some key participants framed as a problem that cannot be resolved by continual escalation of salaries. The psychiatry resource issue requires a rethinking of the model of psychiatry/prescribing services. The suggested model is one that strongly integrates mid-level practitioners with psychiatrists, wherein the psychiatrist functions as a unit medical director, and provides strong supervision. Katie A./Continuing Care Reform (CCR): In April of 2018 a program manager and two licensed clinician positions were established to staff the MHP's CCR program, a component of which will assist group homes that need to transition from group homes to short-term residential treatment programs (STRTP) status. The completion of the California Child and Adolescent Needs and Strengths-50 (CANS-50) in therapeutic foster care (TFC) was raised as a topic of concern by a number of clinicians, who expressed desire for more training as to the integration of this requirement into the workflow without posing a disruption to treatment.		

Table 15: Access to Care Components		
Component		**Quality Rating**
Regarding access, identification of Katie A. subclass members appears to be climbing, with a total of 486 in Q1 of FY 2017-18 and for Q1 of FY 2018-19 557 have already been identified. Intensive Care Coordination (ICC) is also slightly higher for Q1 between the two fiscal years, while Intensive Home-Based Services (IHBS) is very slightly lower. The MHP prefers a model of TFC provision which would add a TFC element to the current foster family agency stabilization and treatment (FFAST) contractor that serves all foster family agencies (FFAs). This would build upon existing capacity and provide a coordinated training and service provision approach to the eight existent FFAs. Currently, 13 TFC parents are estimated as needed.		
1C	Integration and/or collaboration with community-based services to improve access	M
With 85.91 percent of services delivered by contract organizational providers, collaboration and engagement with regional and specialized resources is core to this MHP's practices. An additional 7.83 percent of services are delivered by network providers, with oversight by Optum San Diego. The individual contract agencies are too numerous to mention, but they cover the full range of service levels and populations, including both Medi-Cal reimbursed and non-Medi-Cal services. The level of contracting out that exists requires the MHP to be engaged in efforts to continually communicate with contract providers, and perform oversight and compliance functions. This responsibility brings with it inherent communication challenges, particularly in the methods of providing trainings and conveying changing requirements. As part of the MHP's role in overseeing services, the MHP utilizes a managed care, structured session-limited format for service authorization. This model, in the Children, Youth and Families System of Care, authorizes an initial 13 sessions with approval of an additional 13 sessions easily obtained. Over the period of a number of EQR cycles, this authorization process has often been identified as challenging for treatment staff, taking time away from treatment to provide clinical justification for continued care; however, that said, these participants did mention that a second authorization was not difficult to obtain. They do mention the challenges that occur in justification by established standards, which seem to be based on the assumption of clinical progress, which often does not occur within the allotted sessions.		

Table 15: Access to Care Components	
Component	**Quality Rating**
Some review participants would like to see beneficiaries be able to receive services until they no longer feel the need for treatment. However, there also did not seem to be an alternate model that was proposed to replace the current system. It is noteworthy that the MHP has, over time and particularly in the last year, worked to improve many aspects that relate to providers, such as improving the contracting process and working to establish cost of living increases.	

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	PM
The MHP states it is able to track the date and time of initial services requests for both telephonic and walk-in beneficiaries. Also tracked are those referrals from primary care, school-based settings PERT referrals, and federally qualified health center (FQHC) referrals. During this period, the MHP followed standards of eight days for adults, and five days for children and youth. For the review period, FC timeliness data is not available. As of July 2018, the MHP has aligned its standards with the ten business-days established by the state. During the review period, adult initial access demonstrated a mean of 2.9 days, and a 94 percent achievement of standard. Children and youth services reflected a mean of 8.7 days and a 74 percent achievement of standard. The children and youth standard deviation of 13.4 suggests a need for further exploration and understanding as to whether this variance is related to specific referral pathways or is an overall system issue.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
The MHP's initial offered clinical appointment tracking needs to expand to include FC.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
For the current review period, the MHP reported time from initial contact to first psychiatric appointment, utilizing a 30-day standard. As of July 2018, the MHP adopted the 15-business day parameter as per IN 18-011. For this review period, the MHP reported means of 6.8 and 16.2 days respectively for adults and children and youth. FC was not reported. Achievement of the 30-day standard was quite high, with 95 percent for adults and 85 percent for children and youth. Both figures have fairly large standard deviations of more than ten. The MHP will need to track timeliness for FC children and youth. The fairly significant variances should receive study and improved understanding regarding the involved factors.		
2C	Tracks and trends access data for timely appointments for urgent conditions	NM
The MHP began tracking urgent care timeliness as of July 2018. Data for the period under review was not available.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
The MHP utilizes a three-day standard for post-hospital follow-up contacts, besting the seven-day HEDIS value. The MHP was able to report data on adults, children, and FC. The adult mean was 6.02 days, children and youth were 5.68 days, and FC was 6.59 days. Achievement of standard ranged from 55 percent for adults, to 50.6 percent for children and youth, and 42.6 percent for FC. Lower attainment of standard percentages is not an uncommon phenomenon, but seems to merit follow-up exploration of reasons that relate to each specific tracked population. This is particularly surprising for the FC population due to the expected closer monitoring this population typically receives. The MHP's established high standard of three days is a very positive step, and reflects awareness of the importance of rapid post-hospital care.		
2E	Tracks and trends data on rehospitalizations	M
The MHP does track readmission rates, which reflect fairly low rates for FC (13.2 percent), moderate rates for children and youth (15.7 percent), and somewhat higher rates for adults (22.8 percent).		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
Further analysis of the adult readmissions may reflect useful and actionable information relating to subpopulations served, specific hospital trends, or some other issues that may be responsive to specific interventions.		
2F	Tracks and trends no-shows	PM
The MHP has yet to establish no-show goals or standards for psychiatry and other clinicians. Psychiatry no-shows range from a high of 18.1 percent for adults to a much lower rate of 8.7 for children and youth, with FC at 2.9 percent. Other clinical staff reported a 6.5 percent no-show rate for adults, 3.7 percent for children and youth, and 2.5 percent for FC. These are rather low no-show rates, and could reflect efforts to identify and address factors such as transportation, recall of appointments, and other contributing factors. It may be beneficial for the MHP to consider establishment of standards or goals for no-show rates, and initiate tracking and reporting of no-show reasons for adult consumers so as to develop interventions that improve the utilization of this important service.		

Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including CFM staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M

The MHP devotes significant resources to quality improvement, quality assurance (QA) and compliance activities. With the vast majority of services provided by contract agencies, frequent monitoring and consultation is woven into the fabric of MHP operations. The MHP has many different subcommittees within QI and compliance areas.

The evaluation of the FY 20017-18 QI work plan (QIWP) identified a 26.6 percent increase in quality of care types of grievances, but reflecting relatively low overall grievance numbers. With the changes in criteria from Network Adequacy and Final Rule standards, there will likely be significant increased numbers going forward, making comparison difficult until a new baseline is established.

However, the MHP has performed extensive breakdown of the current subset of quality of care grievances, with staff behavior, treatment issues, and medication issues the highest areas of dissatisfaction. The MHP has examined these areas and sought to provide relevant information and training to programs.

Throughout the review process, information about various aspects of the quality system were discussed. Consistently, three areas were identified: training, QA, and compliance.

There is an often-stated desire for in-vivo trainings provided in a decentralized or regionalized manner. This would decrease clinician time away from work and the notable travel challenges throughout the region. Regional trainings also decrease the impact on available clinical time and loss of productivity time, which is minimized when long travel times are avoided.

Many of the trainings discussed related to implementation of requirements, such as the CANS-50, which the initial online training element lacks helpful guidance as how to integrate with the clinical workflow. For clinical topics, rapid follow-on trainings are seen as helpful, if not essential, to ensure that staff are provided with strategies to incorporate these changes into the clinical workflow. Review participants believe regional trainings provide the best learning environment and results.

Communication of compliance and utilization management changes, often in response to DHCS INs, would also benefit from regional presentations that furnish the opportunity for questions and answers (Q&A), and include examples which meet requirements. In the view of some participants, significant revenue dollars can be lost because these changes do not get presented directly to staff in a venue and format that supports rapid understanding of the changes. Recently there has been some

limited willingness to respond to that need, but that it should be expanded. The experience of program staff is that there is currently some reluctance to give examples of correct documentation due to a variety of apprehensions, including that these would be repeatedly copied and pasted.

While the scale of this MHP may be too great to reach an individual program level presentation, some other forum, such as regional presentations, might be effective.

Noteworthy during this review is that virtually all topics that were identified by stakeholders as challenges were issues that MHP leadership was aware of and has made efforts to improve. That said, the above areas are common themes for this MHP over the years and continues to merit continued efforts to obtain information from clinical programs as to how to most effectively provide trainings and convey compliance standards.

Senate Bill 1291 (SB 1291) medication monitoring occurs via a sampling process that identifies a percentage of prescriber charts for the medication monitoring review process. This does not enable a 100 percent review of FC prescribing patterns but does identify prescribing trends. The MHP's challenges include the provider network and many prescribers who are employed by contract agencies do not use e-prescribing that is furnished with the CCBH system. The MHP does have a contractor who specifically reviews all JV220s, and can identify clinical concern areas. Lastly, the MHP believes timely access to all state DHCS reimbursed medications for their FC beneficiaries would present an opportunity to perform an automated and comprehensive tracking of prescribing for this vulnerable population.

3B	Data used to inform management and guide decisions	M

Evident throughout this review was the extent to which the MHP utilizes available data. Reports are created by various partners such as UCSD, Optum San Diego, and the QI division itself.

The MHP has added an analysis to reports that are generated, providing assistance to readers in interpreting significance. Data is tracked and reported monthly or quarterly, depending upon the need. Optum San Diego supports the data extracts, and UCSD generates the dashboard.

Some of the reports are available on the website. Research of importance can be redacted and made available to the clinics. Trends are shared with providers on an annual basis. The information is used to identify focus topics for the next year.

They are now able to match mental health outcomes management systems (mHOMS) outcome data with Cerner data in order to produce reports. A program data book is generated annually, which summarizes the characteristics of beneficiaries. Data books now include timeliness metrics, service types, procedures, goals met at discharge, units of service, productivity, and more. These are used to assist in contract monitoring.

For 2018, 11 new reports were created to cover a wide span of programs and produce the information needed for proper analysis and decision-making.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
A recommendation from this past year, as previously discussed, focused upon improving communication with contract providers. An element of this effort was a reconfigured Mental Health Contractors Association Executive Team meeting format with MHP leadership, and also brought together the manager for the ORW. Numerous areas were covered in other efforts to improve communication. Program managers receive an email "blast" of information frequently, including a quarterly newsletter, which identifies new programs, and other changes. Mentioned during this review is that these messages can come from many different sources, and it can be difficult to know that which is of the most importance. It is clear that the MHP is making efforts to improve communication, as evidenced by feedback in numerous sessions that highlighted these efforts. An issue that continues to be mentioned is the approach to sharing QA and compliance changes and communication of utilization management information, for which contract providers continued to mention the need to improve. There were strong recommendations for trainings and compliance/quality updates presentations regionally and having less reliance upon email messages or recorded trainings. In another communication area, both staff and beneficiaries believe information about the types and locations of available services is daunting to understand and still needs more work. While the current online resource is comprehensive and updated regularly, often programs, staff and beneficiaries use printed material, or call 211 to determine which resources are actually available. This review discovered little use of the web listing of resources by beneficiaries. Furthermore, the printed material often contains programs that may be closed, may have moved, or have outdated phone numbers. The use of the updated provider directory may benefit from small-batch regional printings so as to ensure that resources are correct and current. It would benefit system efficiency to develop a mechanism of insuring that printed resources contain the most accurate and current regional information. The other communication challenges occur when individuals are discharged from an acute psychiatric setting and are provided with resources that do not align with their benefits – mentioned was the example of those who have Kaiser Medi-Cal and then may not be able to utilize MHP resources.		
3D	Evidence of a systematic clinical continuum of care	M
Directed by the local board of supervisors, the MHP engaged in an evaluation of crisis response and acute inpatient care in the county driven by the closure of the Tri-City Crisis Stabilization Unit (CSU) and psychiatric inpatient units located in Vista, California. Other efforts to improve care include a focus on the long-term care		

continuum process, which is intended to increase residential treatment beds as both alternatives to Institute for Mental Disease (IMD) and state hospital step-downs.

Efforts to improve the recovery aspect of care involve a partnership with San Diego Workforce and supported employment. This expansion is part of the BHS Five-Year Strategic Plan (2014-19), and builds upon existing supported employment services. This expansion also involves a shift to the individual placement and support (IPS) model, and has brought, in the FY 2018-19, ten full-time equivalent (FTE) of staff to eight clinics.

CYF staff also mentioned the relocation of the child crisis stabilization to a more central area has improved access for their north county beneficiaries. Concerns about the loss of the Tri-City acute inpatient service and crisis stabilization continued to emerge. There is also the sense that breadth of resources in outlying areas are not as robust as the central area.

The immediate access of the Walk-In Assessment Exodus Recovery program in Escondido was identified as a strong support to consumers who cannot wait for the typical clinic assessment and psychiatry access system. Some participants did note that co-locating all levels of care at one site would improve services in those locations wherein walk-in services were not across the street from regular care.

3E	Evidence of peer employment in key roles throughout the system	PM

The current workforce development redesign is under discussion for internal approval and will include the current Peer Support Programs: RI-I Peer Specialist Training, Peer Liaison, and Client Operated Peer Support Services. All programs will procure in FY 2019-20, to have an effective date of 7/1/2020.

The redesign contains a career ladder. There are no plans to create distinct peer supervisory positions, and instead the MHP anticipates peers will apply for mainstream system supervisory vacancies.

This review included a session to discuss supported employment, involving beneficiaries, representatives from Clubhouse International, Pathways, and the Department of Rehabilitation. The session covered how the program services have helped beneficiaries return to the work force, and the recent enhancements.

For beneficiaries, a practical barrier to employment is the recent increased expense of bus passes, and that only certain diagnoses are eligible for a discounted rate. Some beneficiaries must pay the full 72 dollars out of pocket.

The supported employment session yielded recommendations for more extensive discussions between the MHP and contract providers to review the expectations of greater employment focus without any additional funds. Also, strategies for addressing the transportation barriers due to costs, for some consumers, is another important issue to be addressed.

3F	Peer-run and/or peer-driven programs exist to enhance wellness and recovery	M

The MHP contracts for the provision of 14 clubhouse programs throughout the county. These programs are strategically located to meet specific needs, including the API Discovery Clubhouse, Deaf Community Services, the needs of TAY through the Oasis Clubhouse, and numerous others. These programs may not be operated directly by beneficiaries, but the programs ensure that the voice of participants drives and directs services. These programs have staff that speak English and Spanish. The Oasis and Deaf Community Services staff can communicate in ASL. The Eastwind Clubhouse is able to communicate with Spanish, Hmong, Cambodian and Vietnamese speakers.

3G	Measures clinical and/or functional outcomes of beneficiaries served	M

The MHP locates outcome information data in the mHOMS for both AOA and CYF services. A partnership with the Health Services Research Center at UCSD has long existed for training, tracking and analysis of this data.

AOA instruments include the Illness Management and Recovery Questionnaire (IMR), completed by clinicians to track recovery progress; the Milestones of Recovery Scale (MORS), a single-item instrument, is also completed by clinical staff; The Level of Care Utilization system (LOCUS); and the Recovery Markers Questionnaire (RMQ) that is completed by the beneficiary, and contains a possible total of 35 total items.

The CYF system utilizes the CANS-50; the Pediatric Symptom Checklist (PSC-35 and PSC-Y); and the Personal Experience Screening Questionnaire (PESQ).

3H	Utilizes information from beneficiary satisfaction surveys	M

The MHP's partnership with UCSD is utilized to assist with the analysis of the twice annual CPS. In October of 2018, the results of the Spring 2018 AOA CPS administration were published. These results reflected a high level of satisfaction with services, comfort with asking questions about services and medications, and respect for their wishes. Also noted was the variance in results between levels of care, as well as for demographics. Greater assistance was identified for improving housing, reducing symptom severity, and increasing feelings of belongingness.

Write-in comments were also received during the CPS process that included needs to improve communication about changes in program resources and policy information.

This area found general correspondence with review feedback that called out confusing and dated information sometimes being furnished to beneficiaries. Needs for greater consistency in service access was also mentioned by review participants, and was also reported in the CPS as needing improvement. Long intervals between sessions to see a needed practitioner was a topic identified as counterproductive. Overall, comments were positive about staff, but experiences that related to over-taxed system resources were evident.

The MHP is open in sharing this information regarding CPS survey results and publishes it widely.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of San Diego MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Concept only, not yet active (not rated)

Non-clinical PIP Status: Concept only, not yet active (not rated)

Recommendations:

- As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The Caregiver Engagement clinical PIP requires the application of an intervention that will directly impact the caregiver engagement problem to achieve active status.
- As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The non-clinical PIP requires the development and routine application of an intervention that is likely to impact beneficiary abandonment of treatment to attain active status.

Access to Care

Changes within the Past Year:

- The loss of the north county Tri-City Medical Center's acute psychiatric inpatient and crisis stabilization units have impacted the availability of acute beds and crisis services. This change has also had an effect upon law enforcement, as trips to mid-county are now more often required.
- A board of supervisors' conference subsequent to the Tri-City changes has resulted in direction to add a consultant to guide collaborative efforts, involve other stakeholders, and work to enhance the continuum of care from crisis stabilization through long-term care.
- Other long-term care enhancements targeted increased residential instuttion for mental disease (IMD) step-down capacity, and greater availability of alternatives to IMD use from acute care. Associated with this approach is the expansion of treatment with housing strategies that provide lower level alternatives to acute and IMD care.

Strengths:

- In January 2018 the Roaming Outpatient Access Mobile (ROAM) program was launched to provide increased access to Native American communities in rural areas through the use of two mobile clinic units that serve the north inland and east county reservation areas. These clinics provide the services of licensed mental health professionals, cultural brokers, and incorporate traditional Native American healing practices. The initial program is slated to run through June 2020.

- The MHP's commitment to serving hearing-impaired beneficiaries is evident in the Deaf Community Services partnership, which furnishes clinical services and a clubhouse environment to those who communicate with American Sign Language (ASL).

- Bilingual services were extensively available during FY 2017-18. The MHP reported a total of 8,346 unique beneficiaries received services in a language other than English (59 percent children/youth and 41 percent adults).

- The MHP has established an innovations telehealth project to improve timeliness of psychiatric follow-up after an emergency visit or hospitalization. The intent is to augment capacity to timely follow-up care, and promote both stability and wellness. Currently, this project is in the procurement phase.

- A number of initiatives seek to improve access to housing resources, and includes: Urban Street Angels' Just Be U, Short-Term Bridge Housing for transitional age youth (TAY). No Place Like Home, the state program, supports efforts to expand critical housing resources for homeless individuals who experience chronic mental illness.

- During this past year, a program manager and two licensed clinician positions were established to staff the continuing care reform (CCR) program, and provide assistance to group homes transitioning to short-term residential treatment program (STRTP) status.

- The MHP has progressed in selection of a therapeutic foster care (TFC) model which adds to the contract of an existing agency to support all foster family agencies (FFAs), and has experience and contracts in this area. This should create a more efficient and reliable support to FFAs and TFCs.

- Clinical/psychiatric leadership has a vision for a model for psychiatry/prescribing services that incorporates expanded use of mid-levels and could potentially stabilize the staffing of that key aspect of care which involves medications.

- A children and youth medication clinic program started in July 2018, which is focused on accessible medication support services for beneficiaries who have completed psychotherapy treatment but require continued medication monitoring. This program also provides psychiatric services to children in the pediatric specialty area who have with complicated medical problems. Program elements include:

- A centrally located psychiatric clinic for direct services and psycho-educational services;
- A special needs pediatric clinic and a developmental behavioral pediatric clinic;
- In conjunction with primary care medical offices or other diverse locations, the project intends to staff two locations per region (total of 12 sites) via telehealth.

Opportunities for Improvement:

- Participants in numerous review sessions observed that the full breadth of clinical and recovery resources are not present in the north and other non-central regions of the county.
- The programs and services are often dispersed in non-central regions, instead of co-located in a single building or one area, as is the case with the North Coastal Live Well Health Center. Specifically, siting walk-in programs in areas that are distant from other levels of care and club houses can be problematic to engagement and retention of beneficiaries. This dovetails with the overall lack of one-stop health and human services resource locations.
- Frequent review comments were made regarding the perceived limited capacity in all locations, specifically targeting program staffing numbers as restricting the ability to adequately serve all consumers in a timely manner, and with the full breadth of clinical services, for an appropriate duration of treatment.
- Transportation assistance continues to be a discussion topic for beneficiaries who identify this issue as critical to attending needed treatment sessions.
- Efforts to reach out to potentially isolated beneficiaries such as the hearing impaired are not currently of adequate scope to ensure these individuals feel invited and assured if they participate in planning activities that the ASL interpretive needs will be met. This population has recommendations that would make services much more effective in supporting their treatment needs, but currently do not feel adequately included.

Recommendations:

- When performing system redesign or adding new program elements or rebidding contract program elements, consider a process that seeks to locate all levels of care in close proximity. This will ease transitions in levels of care and provide easier access to resources. For some review informants, this takes the form of requesting one-stop locations be created for all health, mental health, SUD, and human services assistance sites. This is a long-term, strategic planning issue and not included in recommendations for this current review and coming year.

- Continue to explore innovations to the transportation issue that presents a barrier to care, particularly targeting the issue of short-notice transport needs which cannot be met by physical health plan transport services.

- Develop a liaison with special needs beneficiary groups, including the hearing impaired, to ensure they are aware of opportunities to participate in MHP public planning activities, and that their interpretive needs will be met.

Timeliness of Services

Changes within the Past Year:

- The MHP initiated efforts during the last year, in concert with its contract providers and Optum San Diego partners, to prepare for and meet Network Adequacy Certification Tool (NACT) certification for FY 2018-19. With the exception of contracts with American Indian Health Facilities (AIHF), the MHP was successful. Optum San Diego will oversee credentialing functions, establish a contract with a primary source verification organization, and build a database for reporting and tracking purposes.

- As of July 2018, the MHP aligned its first offered clinical service timeliness standards and tracking with the State 10 business days, 15 business days for first offered psychiatry services, and tracking of urgent services.

Strengths:

- For the review period, the MHP utilized a first offered timeliness standard for clinical access that was more stringent than that required by network adequacy standards, eight days for adults and five days for children and youth. Attainment of standard was above 70 percent for both populations during the review period.

- The MHP utilized a three-day standard for post-hospital timeliness during the review period, including foster care (FC) youth, and achieved an overall mean under six days. This is a better standard than the HEDIS seven-day standard.

- No-show results for psychiatry (2.9 percent) for FC and child, youth and family (CYF) services (2.9 percent) are very low.

- Clinical services no-show rates are, for all populations, low (6.5 percent or lower).

- Input from direct service staff provided some conflicting timeliness information. From numerous sources, reports of wait lists and, in some regions, much longer initial access times, was reported. Those areas which have dedicated walk-in clinics, such as Exodus Recovery in north county, the anecdotal report is that quicker initial access for both clinical and psychiatry services occurs.

Opportunities for Improvement:

- The MHP was unable to report first offered FC initial access timeliness for the review period, but is tracking it now.
- The MHP was unable to report urgent access timeliness for the current review period, but is tracking it now.
- The MHP has not established no-show standards for psychiatry and other clinical services.
- The MHP's adult rehospitalization data (22.8 percent), is rather high, and merits analysis.

Recommendations:

- Obtain feedback from program line staff that assists in identifying how the initial timeliness data compares to the actual experience of access to care for beneficiaries.
- Identify remedies that would improve the access experience and alignment with beneficiary experiences, including the extent to which colocation of service levels and/or establishing separate regional walk-in services would be of help.
- Study the adult rehospitalization data (22.8 percent), by hospital, outpatient region of residence, race and ethnicity, and other relevant elements, to identify interventions under the MHP's influence.

Quality of Care

Changes within the Past Year:

- In October 2018, the new Director assumed his position, with a six-month transition period with the outgoing director, Alfredo Aguirre. The overlap is designed to improve the leadership transitions.
- The MHP has started working with University of California San Diego (UCSD) in the development of statistical masking that is responsive to the direction of DHCS de-identification guidelines for materials that are made available to the public.
- San Diego Behavioral Health Services (BHS), in collaboration with Los Angeles, Orange, and Solano counties, are seeking approval from the Mental Health Services Oversight and Accountability Commission (MHOAC) to use innovation funds to develop the infrastructure for a sustainable Learning Health Care Network (LHCN) for existing early psychosis (EP) programs in order to increase the quality of services and improve outcomes. The LHCN will utilize an application to gather real-time data from clients and their family members in existing EP clinic settings, and will also include training and technical assistance to EP program providers.

- A nursing staff workforce analysis was conducted for the San Diego Psychiatric Hospital as it experienced 28 percent annual turnover of nursing positions, with continuing evaluation occurring going forward.

- The MHP is in compliance with the requirement of beneficiary provider resource directory online, posted and maintained by Optum San Diego, and updated monthly. This resource can be sorted for regional resource listings.

Strengths:

- The MHP worked on improving communication with contract organizational providers and the Mental Health Contractors Association during the past year. Additional activities were established that included an ORW, with intentions on improving how the system works for beneficiaries, and included topics such as discharges, documentation requirements, care coordination and staff retention.

- The MHP has evaluated the CD project, and will make a determination if this merits rollout to programs system-wide. Thus far, while actual outcomes impact seems very minimal, the results for timely documentation is apparent, and there may be other positive results with beneficiaries that have yet to appear, such as improving engagement and retention.

- In partnership with San Diego State University, the MHP provides the Responsive Integrated Health Solutions (RIHS) program [previously known as: Behavioral Health Education Academy (BHETA)], which offers numerous online trainings and continuing education (CE) courses. Contract providers have access to these training courses.

Opportunities for Improvement:

- The mental health services category represents the largest proportion (35 percent) of total claims and experiences a significantly lower ACB ($1,823) than other large MHP's ($4,429) and the overall statewide average ($3,996) averages.

- There is significant reliance upon efficient online education and training through the RIHS, which provides extensive online access to essential trainings and continuing education units (CEUs) but may not always meet the needs of program staff who require advanced and in-person second level trainings to maximize their knowledge. While the MHP has adjusted some of the programs to include more in-vivo aspects to trainings, review participants feel the follow-ups can take too long to occur and have the staff operating on the digitally provided information for too long.

- Compliance and Utilization Management requirements are frequently promulgated in email messages, in what is often described as email blasts that tend to not be well-integrated or coordinated and may present competing priorities. Many of the important topics are believed by review participants to be

best delivered in direct, regional presentations that support Q&A, and present examples.

- The tendency is to present clinical trainings at centralized locations, which have large numbers of participants, and involve significant travel burden. This approach presents challenges to staff who are also trying to meet productivity requirements.

Recommendations:

- Analyze nursing staff turnover data to identify and propose solutions to address hospital staff retention. (*This recommendation is a partial carry-over from FY 2017-18.)*
- Investigate and analyze the MHS category ACB by age groups to assess if AOA or CYS are differentially impacted by this low MHS ACB phenomena. A pilot effort at one or two large sites would be an appropriate scope initially. (*This recommendation is a modified carry-over from FY 2017-18)*
- Assess the subject matter of RIHS digital training to determine which topics would logically require a secondary, in-vivo higher level of training. A topic identified in this review is the training to support medical necessity documentation for complex care conditions, which was related to the CYF population initially.
- Pilot decentralized, regional clinical and compliance trainings to determine if effectiveness and attendance are improved when travel requirements are reduced and direct conversations are possible. The MHP may also wish to incorporate the development of examples to further improve comprehension of the changes.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP implemented the CANS-50 and PSC-35 to measure child and youth functioning and comply with state requirements. Initial reporting to the State was completed in October 2018. The data is available in the mHOMS database, and the MHP is working in collaboration with UCSD to establish baseline data and reporting.
- In the last fiscal year, the MHP increased the number of personnel dedicated to providing supported employment assistance in the outpatient clinics to ten FTE in eight clinics. For FY 2018-19, the IPS model has been adopted, which includes standardized caseload size for those who provide support to beneficiaries with serious mental illness and are seeking competitive employment. Coaching and fidelity review are occurring, as well as ongoing outcome tracking of employment within 90 days.

- The MHP began the development of a ClubHOMS in 2018, a secure, web-based data collection system for San Diego County Clubhouses. This collaboration with UCSD Health Services Reach Center provides improved tracking of the usage and effectiveness of clubhouse programs, and will be fully implemented in July 2019. The work involved four focus groups with staff and members, so as to obtain the input and perspective on the standardized outcomes to be measured.

Strengths:

- The MHP is guided by the BHS Five-Year Strategic Employment Plan (2014-19), which created two toolkits for supported employment. One toolkit is for beneficiaries seeking employment, and the other is for employers who are exploring the employment of these individuals in their workforce. While the MHP has included supported employment for many years, it continues to receive additional and more focused attention.

- The MHP's Home Finder Program, assists beneficiaries with navigating housing, including location and tenant support, with close connections to the North Central Mental Health Clinic and the Areta Crowell Center. The program has engaged 102 landlords to expand housing options for clients, resulting in 68 new units. Interested landlords are linked to the Housing Resource Hub (HRH) where they are able to list their housing unit vacancies. Other assistance includes roommate matching for those individuals whose income is an issue with sustaining housing.

Opportunities for Improvement:

- As already noted, the MHP currently lacks a formal process for the incorporation of individuals with lived experience in the workforce with varied employment options and a career ladder, but is in the process of developing a comprehensive plan.

Recommendations:

- Continue efforts to expedite the development of a diverse process for the inclusion of individuals with lived experience in the workforce.

Foster Care

Changes within the Past Year:

- New this year is the addition of a Child and Family Team (CFT) Facilitation Program that has a joint Probation, CWS, BHS function for organizing and facilitating CFT meetings.

- The MHP has added a new Continuing Care Reform (CCR) unit, comprised of a supervisor and two clinician positions.

- The CANS-50 was implemented this year.

- The CFT survey form was added this year to gain new information.
- In the prior year seven licensed clinicians served as liaisons, this year there are six.
- Improvements in accomplishing appropriate administrative closings have resulted in slightly lower and more accurate numbers.
- There are four STRTP applications, of which three submitted complete MHP program statements. One year after STRTP designation, the program must have a contract with the MHP.
- The MHP has selected a model which has a single agency to provide treatment to all TFCs, of which the current need has been identified as an average of 13 each month.

Strengths:

- Optum San Diego furnishes regular reports on FC entering and leaving the county.
- Monthly reports are generated for total beneficiaries, total subclass, total class and total non-class.
- Wait time has slightly reduced from 9.2 days in FY 2016-17 to 8.7 in FY 2017-18.
- The online training resource, RIHS, contains trainings on Pathways to Well-Being.
- Forums for multi-agency involvement and coordination are maintained, in conjunction with other stakeholder input occur regularly.
- The MHP has initiated a PIP (currently concept-only) to improve family engagement and participation in family therapy.
- The MHP is able to track and report psychiatrist and clinician no-show rates for FC during the review period.

Opportunities for Improvement:

- The MHP was unable to report the FC average length of time from first request for service to first offered appointment in FY 2017-18.
- The MHP was unable to report the FC average length of time from first request for psychiatry service to first offered appointment in FY 2017-18.
- The MHP was unable to report the FC average length of time from urgent appointment request to actual encounter in FY 2017-18.

- The MHP continues to explore issues that may relate to the discrepancy between the number of identified subclass members and ICC recipients.
- The MHP review for SB 1291 HEDIS measures occurs via JV220 reviews, provided by a contractor, and sampling chart review of prescribers. The diversity of methods used by prescribers, some of whom are on the provider network and others who work for contract agencies, to generate prescriptions prevents any universal, automated monitoring review.
- The MHP's post-hospital follow-up three-day standard showed the lowest attainment value of all tracked populations, at 42.6 percent. Considering the close monitoring that typically occurs with FC, this seems unusual.

Recommendations:

- Track and report the FC average length of time from first request for service to first offered clinical appointment.
- Track and report the FC average length of time from first request for psychiatry service to first offered appointment.
- Track and report the FC average length of time from urgent request for urgent appointment to actual encounter.
- Develop reporting for SB 1291 FC HEDIS measures and consider incorporating JV220 oversight process and direct chart review so that FC results are disaggregated from the other medication monitoring results.
- Study the post-hospital follow-up process for FC, and determine if there are factors that have occurred that have created lower rates than other populations.

Information Systems

Changes within the Past Year:

- The modified Cerner contract to include a San Diego domain to be hosted by Cerner to support interoperability solutions with disparate EHR systems. This domain will house modules and functionality for a system-to-system functionality, and include Millennium for the psychiatric hospital, outpatient services and long-term care.

Strengths:

- BHS has a master plan to implement Cerner Millennium on a San Diego County domain hosted by Cerner. This domain will contain Millennium for all of BHS including the San Diego County Psychiatric Hospital, outpatient services, and Edgemoor long-term care. The domain will also allow access for Public Health Services and other County departments. Leadership team members involved

with ensuring success of this project include:the director, clinical director, and other leader designated for outpatient services and long-term care.

Opportunities for Improvement:

- Detailed descriptions of leadership and key staff positions involved in the CM project were not available at the time of this review.
- Currently project management support for CM project lacks sufficient levels of clinical program and health informatics subject matter experts for start-up phase and to expeditiously stand-up a functional EHR.
- An updated, written CM communications plan is warranted to provide stakeholders with ongoing and timely information, as over 80 percent of outpatient services are provided through contractor who will daily will use CM system.

Recommendations:

- Identify specific CM workgroup members and area of responsibilities for the following roles: Overall Project Director, Technology Project Director/Manager, and Clinical Project Director/Manager.
- Identify and assign staff, from both contract and county programs, who possess clinical operations and documentation expertise to core workgroups. Provide structure for workgroups that includes: scope of work, objectives, and workgroup end date.
- Document and publish CM project Charter Plan that identifies and outlines scope of work, objectives, communications plan, and tasks timelines.
- Develop CM communications plan to inform stakeholders of CM developments and key project milestones, recognizing the variety and diversity of those who serve the various target populations may have divergent needs.
- Create a social media application or secure website to share information and inform stakeholders of developments and key milestones.

Structure and Operations

Changes within the Past Year:

- A new cost analysis template has been developed by the BHS fiscal unit, which streamlined the process within the department. The tool is utilized for all funding increases, new programs, and re-procurements to determine the fair and reasonable pricing for services/programs based on a market rate analysis. This tool complies with the pricing requirements of federal funding sources. The effect of this template on new program solicitations includes a change to state either maximum contract amount or required capacity/units of service – but not both.

The prior approach, which often included both, required amendments to address issues with one of those elements.

- The required credentialing of providers for the MHP is contracted out to Optum San Diego, which also currently serves as the ASO for BHS, and performs this function for the network providers as well. Optum San Diego and BHS are looking to identify a credentials verification organization to perform primary source verification.

- Mental Health Contractors Association Executive Team meetings were re-formatted per the contractor's request. Now high priority topics identified by the contractors are discussed at each meeting to ensure dialogue and to identify next steps.

- Additional contractor workgroups have been identified to enhance collaboration and communication between MHP and contractor association. An example is the outpatient redesign workgroup (ORW), the purpose is to build a more responsive outpatient mental health clinic system with a beneficiary-centered focus.

- As a result of feedback and extensive dialog with providers, the MHP has updated its contracting process. In new procurements, offerors propose the rates they deem necessary to complete the scope of work, whereas in the past, MHP indicated the contract maximum and the capacity that offerors would include in their proposals. Also, a new tool was developed by MHP to conduct a cost analysis for each program to determine the fair cost for programs based on a market rate analysis. The completion of this new template also satisfies the new federal contracting requirement of conducting a market rate salary analysis.

- The MHP developed a new tool to conduct a cost analysis for contractors to determine the fair cost for programs based on a market rate analysis. The new tool also satisfies a new federal contracting requirement of conducting market rate salary analysis.

Strengths:

- A SurveyMonkey tool was used to poll contractors for feedback regarding communications and collaboration. The results were generally positive, and efforts were made to improve the problematic areas.

Opportunities for Improvement:

- The Cerner Millenium (CM) project requires the inclusion of contract agency representatives in the CM project, so as to have the benefit of their diverse experience and input.

Recommendations:

- For the CM EHR implementation, recruit contractor representatives who are knowledgeable of EHR operations, from a contract organizational provider perspective, to participate in workgroups.

Summary of Recommendations

FY 2018-19 Recommendations:

- Develop a liaison with special needs beneficiary groups, including the hearing impaired, to ensure constituents are aware of opportunities to participate in the mental health plan (MHP) public planning activities, and are assured their interpretive needs will be met. Continue to explore innovations to the transportation issue that presents a barrier to care, particularly targeting the issue of short-notice transport needs which cannot be met by physical health plan transport services.
- Study the adult rehospitalization data (22.8 percent), by hospital, outpatient region of residence, race and ethnicity, and other relevant elements, so as to identify interventions under the MHP's influence.
- Obtain feedback from program line staff that assists in identifying how the initial timeliness data compares to the actual experience of access to care for beneficiaries. Seek to identify barriers and remedies that would improve the access experience and alignment with beneficiary experiences.
- Pilot decentralized, regional clinical and compliance trainings to determine if effectiveness and attendance are improved when travel requirements are reduced and direct conversations are possible. The MHP may also wish to incorporate the development of examples in compliance messages to further improve comprehension of the changes.
- Continue efforts to expedite the development of a diverse process for the inclusion of individuals with lived experience in the workforce.
- Perform an analysis of the adult psychiatry no-show rates, and test action plans for those elements that appear within the MHP's influence.
- Assess the subject matter of Responsive Integrated Health Solutions (RIHS) online training to determine which topics would logically require a secondary, in-vivo, higher level of training. A topic identified in this review is the training to support medical necessity documentation for complex care conditions, which was initially identified with the child, youth and family (CYF) population.
- As part of the system redesign process, consider options for co-locating levels of care so as to provide efficient and effective transitions between service levels. The inclusion of dedicated walk-in, immediate intake, clinical and psychiatry services should also be a priority in each region for the redesign process.
- Identify specific CM workgroup members and area of responsibilities for the following roles: Overall Project Director, Technology Project Director/Manager, and Clinical Project Director/Manager.

- Identify and assign staff, from both contract and county programs, who possess clinical operations and documentation expertise to core CM workgroups. Provide structure for workgroups that includes: scope of work, objectives, and workgroup end date.

- Document and publish CM project Charter Plan that identifies and outlines scope of work, objectives, communications plan, and tasks timelines.

- Update CM communications plan to inform stakeholders of CM developments and key project milestones, recognizing the variety and diversity of those who serve the various target populations may have divergent needs.

- Create a social media application or secure website to share information and inform stakeholders of developments and key milestones.

- For the CM Electronic Health Record (EHR) implementation, recruit contractor representatives who are knowledgeable of EHR operations, from a contract organizational provider perspective, to participate in workgroups.

FY 2018-19 Foster Care Recommendations:

- Track and report the foster care (FC) average length of time from first request for service to first offered clinical appointment.

- Track and report the FC average length of time from first request for psychiatry service to first offered appointment.

- Track and report the FC average length of time from urgent request for urgent appointment to actual encounter.

- Develop reporting for SB 1291 FC Healthcare Effectiveness Data and Information Set (HEDIS) measures and consider incorporating results of the JV220 oversight process and direct chart review so that FC results are disaggregated from the other medication monitoring results.

- Investigate the lower attainment of post-hospital follow-up for FC beneficiaries and determine if there are systemic causes that can be impacted.

Carry-over and Follow-up Recommendations from FY 2017-18:

- Complete the nursing staff turnover data analysis to identify issues and propose solutions to hospital staff retention.

- Investigate and analyze the mental health service (MHS) category average cost per beneficiary (ACB) by age groups to assess if adults and older adults (AOA) or child, youth and family (CYF) are differentially impacted by this low MHS ACB phenomena. Seek to obtain satisfaction feedback and outcomes of beneficiaries and caregivers from those whose annual treatment dollars are at the MHS ACB level to explore if there exist potential adjustments to policy that may be

indicated. A pilot effort at one or two large sites would be an appropriate scope initially.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, 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
Consumer Satisfaction and Other Surveys
Primary and Specialty Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Family Member Focus Group(s)
Consumer Employee/Peer Employee/Parent Partner Group Interview
IS Manager/Key IS Staff Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Community-Based Services Agencies Group Interview
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Hands-On Observation
Final Rule and Network Adequacy
Wellness Center Site Visit
Contract Provider Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, RN, MPA, Lead Quality Reviewer
Gale Berkowitz, DrPH, Deputy Director
Bill Ullom, Chief Information Systems Reviewer
Nosente Uhuti, Consumer-Family Member

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.

Sites of MHP Review

MHP Sites

San Diego County Behavioral Health Services
3255 Camino Del Rio South
San Diego, CA 92119

Mission Trails
1 Father Junipero Serra Trail
San Diego, CA 92119

North Coastal Live Well Health Center
1701 Mission Avenue
Oceanside, CA 92058

Contract Provider Sites

Deaf Community Services Clubhouse
205 national City Blvd.
National City, CA 91950

South Metro Career Center
4389 Imperial Avenue – Perkins Room
San Diego, CA 92113

Optum San Diego
3111 Camino del Rio North
San Diego, CA 92108

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Aguirre	Alfredo	Director	BHS
Alcorta	Miguel	Senior Business Analyst	Optum
Alvarez	Iraida	Family Therapist	Youth Enhancement Services
Alvarez-Ron	Ingrid	Program Associate	NAMI
Anselma	Domquel	Medi-Cal Billing Unit	Fiscal Services
Aranjo	Alicia	Therapist	Para Las Familias
Bailey	Michael	Optum Medical Director	Optum
Barton	Myesha	Program Manager	MHS Inc.
Beam	Payal	Vice President, North County	MHS Inc
Bergmann	Luke	Director	BHS
Bersabe	Junida	Principal Administrative Analyst	BHS, Fiscal
Block	Kathryn	Program Manager	Vista Hill LAC North Inland
Boysen	Megan	Psy.D.	Project Enable
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum
Bucher	John	Regional Manager	WrapWorks
Capra	Natalie	Licensed Mental Health Clinician	BHS, CYF
Carruso	Bernard	LMFT	Project Enable
Centeno	Valerie	Program Director	SBCS School Based OP
Chadwick	Amy	System of Care Evaluation Coordinator	UCSD, CASRC
Chamberlain	Sharifa	Family and Peer Support Specialist	NAMI

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Clark Manson	Minola	Program Director	BHETA
Conlow	AnnLouise	Program Coordinator	BHS, QI
Connors	Ashley	Assistant Program Director	Crisis Action & Connection
Cookson	Renee	Director, Community Development	NAMI
Cooper	Fran	BH Program Coordinator	BHS, CYF
Cunningham	Micaela	Community Development Specialist Trainer	NAMI
Dean	Robert	CEO	Vista Hill
Dolson	Nicole	Supervising Probation Officer	Probation Dept.
Eftekhari	Alisha	BH Program Coordinator	BHS, AOA
Eisenberg	Marci	Clinical Supervisor	North Inland Mental Health Center
Esparza	Sophia	Lead Clinician	Douglas Young Youth and Family Services
Esposito	Nicole	Assistant Clinical Director	BHS, CDO
Evans	Patricia	Regional Manager	San Diego Center for Children
Garcia	Frank	WIAC - Vista	Exodus
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	BHS, AOA
Garcia	Rosemarie	Clinician	Crisis Action & Connection
Gehler	Tara	Senior Director, Wraparound	Fred Finch Youth Center
Gonzalez	Andrea	Program Manager	Para Las Familias
Green	Mike	Protective Services Program Manager	CWS Residential Services
Guevara	Christopher	Administrative Analyst III	BHS, QI

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Guzman	Anna	Therapist	North Inland/North Coastal FSP
Hayes	Skylar	Optum Reporting Manager	Optum
Herrera	Angel	Therapist	FFAST
Hodges	Evan	CYF Liaison Community Developer Trainer	NAMI
Holder	Judi	Recovery Services Administrator	RI International
Johnson-Taylor	Casie	COSD QM Supervisor	BHS QI
Jones	Darron	Sr. Parent Partner	WrapWorks
Jones	Jessica	Program Director	Telecare Corp
Jones	Steven	BH Program Coordinator, Quality Management	BHS, QI
Kaufman	Amanda	BH Program Manager	BHS, CYF
Kemble	Derek	Administrative Analyst II	BHS, QI
Kennedy	Erin	Peer/Family Support Specialist	NAMI
Ketterer	Linda	Lead Trainer	NAMI
Kneeshaw	Stacey	BH Program Coordinator	BHS, AOA
Knight	Betsy	BH Program Coordinator	BHS, AOA
Koenig	Yael	Deputy Director, Children, Youth & Families System of Care	BHS, CYF
Krelstein	Michael	Clinical Director	BHS, CDO
Krelstein	Michael	BHS Medical Director	BHS
Kruvi	Sharon	Program Manager	North Coastal/North Inland FSP, Palomar

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Family Counseling Service (CYf)
Labelle	Robert	Peer Support Specialist	RI International
Laidlaw	John	Director of Clinical Services	NC Lifeline
Lance-Sexton	Amanda	BH Program Coordinator	BHS, CYF
Lang	Tabatha	Chief, Quality Improvement	BHS, QI
Leal-Olmos	Arlyn	Clinical Supervisor	Nueva Vista Family Services
Leon	Ana	Peer Support Specialist, Next Steps	NAMI
MacKinnon	Cory	Peer Liaison	RI International
Magos	Daniel	North Inland Mental Health Center	NIMHC
Meyers	Don	Director of Operations	Palomar Health
Miles	Liz	Principal Administrative Analyst	BHS, QI
Mockus-Valenzuela	Danyte	Health Planning & Program Specialist	BHS, PPU
Montague	Mallory	Therapist	FFAST
Myers	Don	Director	Palomar Health
Nacario	Cathryn	CEO	NAMI SD
Nickelberry	Melinda	Deputy Director, Administrative Services	BHS
Nowlin	Aaron	Care Coordinator	Wraparound
Opsal	Sandy	Peer Liaison	RI International
Parker-Pittman	Lozen	Family Specialist, Next Steps	NAMI

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Parson	Heather	Utilization Rev Qlty Imp Supervisor	BHS, QI
Penalba	Chona	Principal Accountant	Fiscal Services
Penfold	William	Sr IT Manager	Optum
Preston	Kristie	Director of Clinical Operations	Optum
Quach	Phuong	BH Program Coordinator	BHS, AOA
Quinn-O'Malley	Eileen	BH Program Coordinator	BHS, CYF
Ramirez	Ezra	Administrative Analyst I	BHS, QI
Raymond	Rebecca	BH Program Coordinator	BHS, CYF
Reisert	Brian	Lead Training Specialist, Career Pathways Program	NAMI
Riediesel	Ava	North County MH Center	NCMHC
Rincon	Norma	Deputy Director, Departmental Ops	CCWS
Robbins	Kathy	Program Manager	BPSR Vista
Roberts	Susan	Outreach Specialist	NAMI
Rocha	Carissa	Clinician	North County Lifeline School-based FSP
Rodriguez	Alyssa	Research Analyst	BHS, QI
Rodville	Kacie	Peer Liaison	RI International
Romero	Angela	Program Director	Exodus WIAC Vista (A/OA)
Romero	Michelle	Director of Behavioral Health Network & QI	Optum
Rupp	Kristine	BPSR - Vista	BBSR - Vista
Sabo	Elena	Peer Liaison	RI International
Salazar	Holly	Assistant Director, Departmental Ops	BHS

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Sandles-Palmer	Sasha	Clinician	SBCS School Based OP
Segovia	Yessenia	Clinician	SBCS School Based OP
Sims	Danielle	Clinician	Nueva Vista Family Services
Smallwood	Kaitlin	Clinical Supervisor	North Coastal Mental Health Center
Stark	Tamara	Vice President	Exodus Recovery, Inc.
Stephenson	Oscar	Peer Support Specialist	RI International
Strows	Christopher	Principal Administrative Analyst	BHS, AOA
Sullivan	Liane	Administrative Analyst III	BHS, AOA
Tally	Steve	Senior Project Manager	UCSD, HSRC
Terrazas	Nohemy	Protective Services Supervisor	CWS Residential Services
Terrell	Justin	Optum Mngr Training	Optum
Thornton-Stearns	Cecily	BH Program Coordinator	BHS, AOA
Torres	Zugiel	Assistant Director	Crossroads Family Center
Turner	Lisa	Executive Director	Palomar Family Counseling
Turov	Joshua	Program Manager	North County Lifeline School-based FSP
Umanzor	Krystle	Administrative Analyst III	BHS, QI
Vasquez-Mota	Josclyn	Therapist	Para Las Familias
Villa	Kelly	Program Manager	MHS Inc.
Vleugels	Laura	Supervising Psychiatrist	BHS, CYF

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Walker	Sten	Children, Youth, and Family Liaison Technology Engineer	NAMI
Wells	Steven	Protective Services Program Manager	CWS
White-Voth	Charity	BH Program Coordinator	BHS,AOA
Williams	Seth	BH Program Manager	BHS, CYF
Woods	Mary	Regional Administrator	Telecare Corp
Woods	Rose	BHETA Assistant Program Manager	SDSU
Wright	Pam	Clinical Director	SBCS School Based OP
Zayas	Mario	Family Therapist	Youth Enhancement Services

Attachment C—Approved Claims Source 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 (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 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	3,816,091	147,196	3.86%	$703,932,487	$4,782
Large	1,848,772	68,086	3.68%	$362,898,987	$5,330
MHP	269,393	11,298	4.19%	$43,157,556	$3,820

Table C2 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 C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band
San Diego MHP

ACB Cost Bands	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	38,155	95.97%	93.38%	$114,146,533	$2,992	$3,746	66.74%	56.69%
>$20K - $30K	858	2.16%	3.10%	$20,871,710	$24,326	$24,287	12.20%	12.19%
>$30K	746	1.88%	3.52%	$36,017,617	$48,281	$54,563	21.06%	31.11%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
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
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Diego	
PIP Title: Caregiver Engagement	
Start Date 03/01/18: **Completion Date** Anticipated- Spring 2020: **Projected Study Period**: 24 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** 01/08-10/19: **Name of Reviewer**: Walton/Berkowitz	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP is seeking to increase the provision of family therapy to the beneficiaries served in the CYF system of care, with a goal of improving outcomes.	
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY	

STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Broad participation included program staff, QI, UCSD analytic partners, and family advocate.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☐ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The focus was on increasing the provision of family therapy to children and youth receiving services.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CYF and their caregivers are the target of this activity.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will educating and providing strategies to the BHS CYF System on increasing caregiver participation in family therapy lead to increases in family participation and reductions in clients' mental health symptoms?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CYF beneficiaries and their caregivers are the target of this activity.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Entire population covered.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Average caregiver report of child's symptoms of mental health problems discharge score (Pediatric Symptoms Checklist) 2. Percent of therapy sessions that are coded as "family therapy" 3. Percent of clients that had at least one family therapy session during a full treatment episode (at least 13 sessions) 4. Percent of caregivers who respond "Not at all" to the question: To what extent has your child's therapist asked you about things that might prevent you from participating in your child's treatment? (Youth Services Survey)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused. ☒ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1) PSC 2) Percent of sessions that are Family Therapy 3) Percent of consumers that received at least one family therapy session 4) Percent of caregivers who do not report being asking to participate in family therapy
Totals		**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** NA **N/A** UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? 1. The average total scores at discharge on the Pediatric Symptom Checklist (PSC) 2. The percentage of all therapy sessions offered in outpatient programs that are coded as family therapy 3. The percentage of outpatient clients with 13 or more sessions (In CYFBHS which uses a short-term treatment model, 13 or more sessions is defined as a full treatment episode), that have at least one family therapy session. 4. The number of caregivers who respond “not at all” to the question, “To what extent has your child’s therapist asked you about things that might prevent you from participating in your child’s treatment?” on the caregiver version of the Youth Services Survey (YSS).	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	After administering the PSC assessment, each agency will enter their own PSC data into the web-based CYFBHS mHOMS Data Entry System (DES**).** The second two data points come from the CYFBHS medical record system. Downloads from this system will be used for data analysis. The fourth data point comes from the caregiver version of the Youth Services Survey. This survey is given bi-annually to caregivers who bring their children to treatment during the two-week survey period. The survey

		responses are collected and scanned into an electronic database. The administrative data is applicable to the entire consumer population. The PSC is administered at intake and discharge to all caregivers of clients who begin outpatient treatment in CYFBHS. The PSC is used in many service systems and is considered a reliable and valid measure of children's mental health problems (see the question below). The family therapy billing code is an objective measurement that is a valid indicator of whether family therapy took place and answered in the same way for the entire consumer population. The data from the YSS is not available for the entire consumer population, but the respondents are representative of the entire population.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PSC data and family therapy session data will be collected at six time points. Before and after the November 2018 presentation to the program managers, before and after the MEET training, and before and after the PACT training. In order to measure the effectiveness of the presentation, data will be taken from the entire population of clients who have outpatient services. In order to measure the effectiveness of the MEET and PACT trainings, we will identify comparison clinics serving clients who have similar demographic and diagnostic profiles to the clients served by the clinics who receive the MEET and PACT trainings. The PSC and family therapy session data for both the clients from the comparison clinics and the clients from the clinics that participate in the trainings will be compared prior to and following the trainings. If data indicate that the trainings have a negative impact on child mental health or family therapy rates (untoward results) CYFBHS administration will meet with the staff of the clinics who participated in the trainings in order to uncover the source of the problem and resolve it.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP has been able to apply one preparatory activity, a presentation for program managers. No post-intervention data has been collected yet.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Kya Barounis, Ph.D., Senior Mental Health Researcher, UCSD Tiffany Lagare, M.P.H., Research Associate, UCSD Anh Tran, B.S., Research Assistant, UCSD Bill Ganger, M.A., Data Manager, SDSU Shellane Villarin, M.P.H., Research Associate, Rady Children's Hospital-San Diego	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Presentation to Program Managers 2. MEET (Motivational Enhancement for Engagement in Therapy) Training 3. (Parent and Caregiver Active Participation Toolkit) Training	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	The interventions that are intended to affect the desired changes are yet to be applied – MEET and Parent and Caregiver Active Participation Toolkit. Application of two distinct interventions potentially clouds the results as to which element is responsible for any progress that occurs.
	Totals	**N/A**Met **N/A** Partially Met **N/A**Not Met **N/A** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Lacking the intervention application, it is too soon to address data analysis.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described: N/A* *Conclusions regarding the success of the interpretation: N/A* *Recommendations for follow-up: N/A*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A**Met **N/A** Partially Met **N/A** Not Met **N/A** NM **N/A** UTD	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** NA **N/A** UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	Not applicable.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

Not applicable.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Recommendations: Not applicable.
Check one: N/A ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☐ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: San Diego

PIP Title: Improved tracking and retention for patients who are discharged after not returning

Start Date: 04/01/18

Completion Date (anticipated): 12/01/19

Projected Study Period: 19 Months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 1/8-10/19

Name of Reviewer: Walton/Berkowitz

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☐ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☒ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):
Development of strategies to improve retention and reduce number of consumers who abandon treatment.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Beneficiary input was obtained vis the Spring 2018 survey, which was a query about reasons for not returning to treatment. NAMI San Diego furnished additional beneficiary focused input. A wide variety of clinical program representatives were included.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Discharge reasons for outpatient services. Data from the results of next services for those who discharged categorized as “did not return” furnished other information.
Select the category for each PIP: *Non-clinical:* ☐ Prevention of an acute or chronic condition ☐ Care for an acute or chronic condition ☒ Process of accessing or delivering care ☐ High volume services ☐ High risk conditions		
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The focus was not on a specific condition, but on the retention of beneficiaries in treatment.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is looking at all populations served for unplanned discharge events.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Could focus and improvements on the discharge planning process reduce the number of clients who are discharged after not returning for services and who re-enter services through crisis or emergency levels of care?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	It appears that the areas being targeted could benefit from including more than the discharge process alone. Likely attention to mid-treatment issues, such as quality of care, and continuously assessing for emerging barriers to care such as transportation and/or child care could also benefit this process.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Outpatient clients discharged from a SCHBHS Outpatient program during the study period with the discharge reason "did not return." or who had not "satisfactorily achieved goals."

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Consumer perception survey	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The consumer perception survey only captures a convenience sample of those who attend services during two, two-week periods each year. This is a fairly large number, but does not include all.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1) Discharged due to the reason "did not return" 2) Re-Entry into system for above clients: Future Services 3) Client-reported reasons for discontinuing services: Satisfaction 4) Client-reported reasons for discontinuing services: Transportation	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators reflect various aspects of consumer related changes, barriers and challenges.
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP identifies the use of sampling as related to data collection from Consumer Perception Survey. This seems to be related to the inability of the MHP to effect 100 percent collection. From the EQR perspective, this is not an intentional process of sampling. Thus, it is concluded this is not sampling.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** NA **N/A** UTD	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☒ Met ☐ Partially Met ☐ Not Met	

• *May 2018 and May 2019 MHSIP Consumer Satisfaction Survey Discharge Supplemental Questions* *The question being used for this client-reported data is provided in Appendix A. The samples collected at each Consumer Survey collection period will utilize the same questions and all other methodology to ensure uniformity and constancy across time-points.* • *SDCBHS MHS and Cerner Community Behavioral Health (CCBH) system to look at discharge summary information and pre- and post-discharge service utilization* *The system data provides consistent and accurate data at the system level and provides sample sizes for 3 months for the post-intervention endpoint analysis. It will be sufficiently large to be representative (25% of entire system data for the year).* ☒ Member ☒ Claims ☐ Provider ☒ Other: Consumer Perception Survey	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	With some specified limitations.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* • Debbie Malcarne, BHS A/OA System of Care • Liz Miles, BHS Quality Improvement Performance Improvement Team • Christopher Guevara, BHS Quality Improvement – Performance Improvement Team • Steve Tally, Ph.D. Contractor, Research and Statistical Methods in Mental Health Expert. UC San Diego Health Services Research Center (HSRC) • Mark Metzger, Contractor, Database and SQL Analytical expert. UC San Diego Health Services Research Center (HSRC)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1) Program Manager educational workgroups 2) Design, implement and analyze client survey pre- and post-intervention	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	This area is key to the "concept only" status finding, and to whether this activity is an actual PIP or a one-time improvement effort. The interventions listed are each important and valuable, but do not constitute an active and ongoing process to target issues related to beneficiaries unplanned discontinuance of care. The additional items the MHP discusses - such as informing beneficiaries of their rights to change provider/clinicians, and of transportation assistance options – appear to be one-time efforts and not part of a structured ongoing process. An example of an ongoing intervention might include: providing beneficiaries at each visit a handout that underscores how to resolve quality of care issues and identifies who is the contact if change of provider is needed. The handout could also contain instructions regarding how to obtain transportation assistance, and also ask if there were specific approaches to appointment reminders that would be most helpful. It could also provide an opportunity to provide feedback about services.
	Totals	**N/A**Met **N/A** Partially Met **N/A** Not Met **N/A** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP should develop a structured, specific intervention targeting this problem before follow-up data collection is appropriate.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A**Met **N/A** Partially Met **N/A** Not Met **N/A** NA **N/A** UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**N/A** Met **N/A** Partially Met **N/A** Not Met **N/A** NA **N/A** UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	Not applicable

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Not applicable		
Recommendations: Not applicable		
Check one: N/A	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	