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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SAN LUIS OBISPO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "San Luis Obispo" may be used to identify the San Luis Obispo County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 23-24, 2024

MHP Size — Medium

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	0	4	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	0	6	0
Quality of Care	10	4	6	0
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**10**	**16**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Martha's Place Fast Improved Access	Clinical	03/2023	First Remeasurement	Moderate
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Non-Clinical	10/2022	First Remeasurement	Low

Table D: Summary of Plan Member/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The Quality Improvement Committee (QIC) reviews several data sets aggregate for Spanish speakers.
- The MHP's penetration rates (PR) are higher than statewide rates for all age categories, indicating greater service accessibility. Regarding Intensive Care Coordination (ICC) and Intensive Home-Based Service (IHBS) services for youth, the MHP's PR and the approved claims per member are more than statewide and other medium-size counties. The MHP appears to have a strong implementation of Pathways to Well-Being (PWB) across youth services.
- There is a robust service for youth in juvenile Hall and the associated Coastal Valley Academy including dedicated therapists, one therapist dedicated to Spanish-speaking youth in detention, and medication services via telehealth.
- The MHP has counselors placed in all but one middle school, and in many elementary and high schools. In some cases, services are provided at the school during school hours to reduce transit needs or other barriers to care access.
- There is a growing host of services co-located at the San Luis Obispo clinic location.

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

- The MHP does not have a level of care (LOC) nor an outcome measure for adults but is collecting California Child and Adolescent Needs and Strengths (CANS) data, so it seems reasonable to begin monitoring LOC and/or outcomes within the youth member population.
- There is a history of recommendations around timeliness data reporting. Now that the MHP and many of its outpatient contractors will use the same electronic health record (EHR) tools, it is expected that this will be resolved by the time of next year's review.
- The MHP did not address the recommendation regarding tracking, trending, and improving continuity of access between initial appointment and the first follow-up. Members reported a sense of waiting long to enter care in both adult and youth programs.
- There is a history of PIPs being terminated prior to completion and with little shown data tracking. A PIP recommendation is being carried forward to encourage progress in this area.
- The MHP reported no requirement for changing system passwords on a regular basis.

Recommendations for improvement based upon this review include:

- Establish a formal LOC and/or an outcome measure for adult members and plan to monitor this data aggregately. Until this can be established in the EHR, begin by tracking and trending the currently available CANS data.
- Improve accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of SmartCare tools and/or other developed methods.
- Create policies and workflows to address first follow-up within ten business days of the initial appointment. Begin to track performance to support not just accurate timeliness data, but also a report of a timely access experience from members.
- Ensure two active PIPs throughout the year, one clinical and one nonclinical, with broader system involvement and clearly established and regular data collection.
- Implement a policy requiring the change of passwords on mandated intervals.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for San Luis Obispo County MHP by BHC, conducted as a virtual review on January 23-24, 2024.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

As part of the pre-review process, each MHP is provided a description of the source of the Medi-Cal approved claims data and four summary reports of this data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; TAY; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment D.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding PR percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

The MHP did not experience any significant issues affecting its operations.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- The MHP implemented the California MH Services Authority's (CalMHSA) semi-statewide EHR and performance management system, SmartCare by Streamline Healthcare Solutions, Inc. on July 1, 2023. This process is ongoing and poses significant disruption to key data collection and analysis.
- The MHP experienced significant leadership changes including a new Behavioral Health (BH) Director, Drug and Alcohol Services Division Manager, Prevention and Outreach Division Manager, and MH Services Act Coordinator, and two part-time, interim Medical Directors after their Medical Director retired. The position of BH Deputy Director was newly added and filled.
- At the beginning of the year, San Luis Obispo became one of the first to implement Senate Bill 43. The MHP also implemented the new Medi-Cal benefit of mobile crisis, contracting a new mobile crisis team available to the whole community, 24/7 for all ages.
- The Psychiatric Health Facility (PHF) was moved to a contracted provider, Crestwood Behavioral Health. Initial data reportedly indicates a roughly doubled daily census and length of stay (LOS).
- A new 5-year strategic plan is expected in February 2024, based on consulting reports aimed at identifying gaps in both adult and youth services, to include community feedback. There is alignment between the consulting reports and recommendations made by CalEQRO.
- The MHP reported that all three regions of the county have seen increases in the number of Medi-Cal members served. During CY 2022, South County saw a 6% increase, while North County saw 7% and Mid County saw 10%.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Staffing recruitment and retention, contracted staffing, and tele-workforce staffing opportunities to improve access, timeliness, and availability of services for routine outpatient access.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has been working with their County Human Resources department to improve their hiring process and has expanded their contract with telehealth to increase provider availability. Further, the MHP reported attending events at the university to attract new graduates and trainees. The MHP reported that roughly there are still 6 clinical vacancies, but that this is vastly improved from 13 in the past. The MHP also expanded their contract with Iris Telehealth.

- As part of their PIP for Martha's Place, their program for children under age five, the MHP successfully adjusted staffing and improved timeliness for access.

- Due to changes to the access process and implementation of the new EHR, reliable capacity and timeliness tracking is not currently available. Validation sessions indicate long wait times, lack of psychiatric providers, and low staffing

particularly for bilingual staff while also indicating very recent, significant improvements.

- This recommendation is considered partially addressed and the MHP is encouraged to continue prioritizing these efforts. Considering the progress made and in favor of other priority recommendations, this is not carried forward as a recommendation for this report.

Recommendation 2: Improve accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of a new EHR and/or other developed methods.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP implemented the SmartCare EHR on July 1, 2023, and reports that most of the contractors moved to SmartCare as well. The same tools will, thus, be used for collecting timeliness data. The widget for entry of access data went live January 17, 2024, however the timeliness reporting functionality is not yet available.
- While approximately 38 percent of services are provided by contract providers, contract provider timeliness data was only included in timeliness calculations for follow-up after psychiatric hospitalization.
- The MHP identifies and tracks urgent services only for the sub-population of those members released from the crisis stabilization unit (CSU).
- Accurate timeliness analytics inclusive of contract providers has not yet been fully developed. Thus, the efforts for this recommendation are ongoing and will be continued for another year to allow the MHP time to develop key processes.

Recommendation 3: Track, trend, and improve the continuity of timely access to therapist and psychiatric services after initial assessment.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- During the period submitted on the Assessment of Timeliness Data (ATA), the MHP was still monitoring this using manual tracking logs for new members entering care, a process that is in flux with the new EHR implementation. Significant data entry errors on the ATA form are reported by the MHP for this review and may not reflect current capabilities.
- The MHP reported a 24-day average to first delivered clinical service with 59 percent of delivered services meeting their 21-business-day standard. Further, the MHP did not track timeless to the first delivered non-urgent psychiatric service during the period reported on the ATA.
- The MHP notes a need to continue defining what services after the initial appointment look like after No Wrong Door implementation. This would include ensuring standards are in alignment with Behavioral Health Information Notice 23-041, training staff, and beginning to routinely track.

- All validation sessions indicated long wait times, citing one to four months, and loss of engagement with members during the wait, particularly for those needing translation services. All caregiver members in the focus group expressed that it was both generally difficult and a long wait to get into services.
- As clinical processes, data collection, and California Advancing and Innovating Medi-Cal (CalAIM) changes are rolled out, this recommendation continues to be relevant. It is considered not addressed while supportive components, such as timeliness reporting in the EHR and policies about No Wrong Door, remain in development. This recommendation will be carried forward in this report with updated language to increase the ability to measure MHP progress and to account for changing requirements.

Recommendation 4: The implementation and maintenance of the current PIPs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP did not maintain one the two PIPs; it instead began a new one, and continued progress on the FUM PIP, but changed it from clinical to nonclinical.
- Efforts and staffing to maintain PIPs seem improved when compared to the prior year. However, one PIP-assigning Quality Support Team (QST) staff was resigning at the time of the review.
- Historically, PIPs seem to terminate prior to culminating data and results being analyzed and submitted through the PIP Development Tool's chart 8.1. Thus, this recommendation is considered partially addressed and will be carried forward in this report with updated language.

Recommendation 5: The MHP's plan to implement the new EHR, SmartCare, in July 2023 to provide an opportunity to address several areas of need for data, timeliness tracking, and additional analytics to monitor current and CalAIM initiatives.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is considered partially addressed, as the MHP did implement SmartCare in July 2023, although continues to anticipate component rollouts. It is still in the early stages of necessary data collection tools and most reports are not yet available, including those for timeliness and productivity. Also, at the time of the review, the MHP had not yet been able to start any internally-derived reports based on the SmartCare database.
- Most outpatient contractors also began with SmartCare and reported during the review that they did not have the key capacity reports or other data needed for contract negotiations. Further, the newly contracted PHF is not using SmartCare, which reportedly causes disruption to continuity of care.
- Although partially addressed, this recommendation is not carried forward in favor of an IS recommendation more indicative of the current circumstances.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 62 percent of services were delivered by county-operated programs, and 38 percent were delivered by contracted providers. Overall, approximately 73 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff during business hours and contractor-operated staff after hours, over weekends, and on holidays. Members may request services through the Access Line as well as through the following system entry points: outpatient clinics, a children's early intervention center, a homeless outreach program, and some full-service partnership (FSP) programs. The MHP operates a centralized access team that is responsible for applying the CalAIM Adult and Youth Screening Tools then scheduling members for assessment at the appropriate service location. There is also decentralized access for youth who may receive services from within or be screened and referred by counselors in the schools. The MHP has behavioral health counselors in almost all middle schools, some elementary, and many high schools. There is also a robust MH program within the Juvenile Hall and its Coastal Valley Academy program.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth and mobile services to youth and adults. Telehealth is available for all services except for group therapy. In FY 2022-23, the MHP reports having provided telehealth services to 1817 adults, 855 youth, and 488 older adults across seven county operated sites and six contractor-operated sites. Among those served, 142 members received telehealth services in a language other than English.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual BHIN.

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

Table 1A: MHP Alternative Access Standards, FY 2022-23

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

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

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- A new Diversity and Inclusion Coordinator started within the last year and has taken action to begin assessing cultural representation, beyond language services, for members and staff. The county has also hired a cultural representative for their media outreach efforts and is able to measure some early success. This key component is considered met, although review informants suggest that ongoing efforts are necessary to address cultural representation and to address the evolving needs for staff training.
- The MHP has strong collaborative efforts particularly within schools and Juvenile Hall which improves access for youth and families. Coordination of care through effective collaborations is considered met; however, the MHP should consider expanded coordination with primary care, which was clearly indicated as lacking based upon review sessions.
- The MHP has started to track and trend service utilization data for ICC, IHBS, and therapeutic behavioral services (TBS) through its QIC and anticipates expansion of these efforts after full implementation of the new EHR. However, it does not seem to be using it to inform staffing decisions. Review sessions indicate a need for more case managers, bilingual staff, and clinicians. The MHP is in transition and is encouraged to ensure that efforts to monitor system demand including caseloads and admission flows grow as a priority. For this reason, Manages and Adapts Capacity is partially met again this year.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

The following information provides details on Medi-Cal eligibles, and members served by age, race/ethnicity, and threshold language.

PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar-size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, San Luis Obispo demonstrates fewer challenges to access to care than were seen statewide.

Table 3: San Luis Obispo MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	70,140	3,652	5.21%	$23,721,265	$6,495
CY 2021	65,337	3,428	5.25%	$26,028,263	$7,593
CY 2020	58,909	3,295	5.59%	$32,352,544	$9,819

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- Total members eligible increased 19.1 percent from CY 2020 to CY 2022, and despite an increase in numbers served, the PR declined 6.8 percent in this time period.
- The AACM decreased 14.5 percent from $7,593 in CY 2021 to $6,495 CY 2022.

Table 4: San Luis Obispo County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	7,132	198	2.78%	1.15%	1.82%
Ages 6-17	15,962	957	6.00%	4.80%	5.65%
Ages 18-20	3,734	156	4.18%	3.47%	3.97%
Ages 21-64	37,503	2,148	5.73%	3.60%	4.03%
Ages 65+	5,810	193	3.32%	1.98%	1.86%
Total	**70,140**	**3,652**	**5.21%**	**3.49%**	**3.96%**

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The largest eligibility group by age was adults ages 21-64, followed by youth ages 6-17. The MHP's PRs are higher than both the similar-sized county and statewide rates for all age groups, as it is overall.

Table 5: Threshold Language of San Luis Obispo MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	283	7.93%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had one threshold language, Spanish, and 7.93 percent of those served identified Spanish as a preferred language.

Table 6: San Luis Obispo MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	23,686	1,009	4.26%	$4,950,154	$4,906
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. The MHP's ACA PR follows this pattern, with lower ACA PR and AACMs when compared to the overall PR and AACM.

- The MHP's ACA PR is lower than its overall PR, 4.26 percent compared to 5.21 percent, but exceeds both the medium county and statewide ACA rates.
- The MHP's ACA AACM is lower than that of its overall AACM, $4,906 compared to $6,495, and is less than the ACA AACM for both medium county and statewide averages.

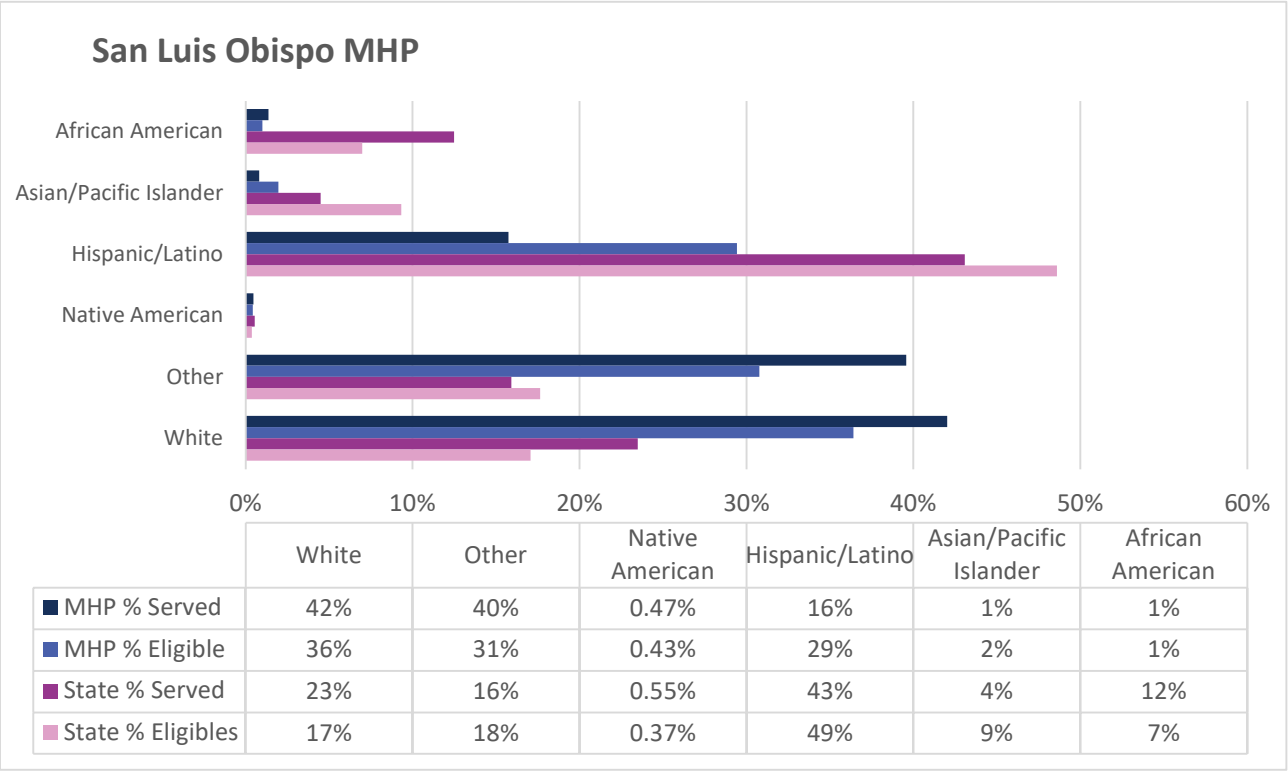
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: San Luis Obispo MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	710	50	7.04%	7.08%
Asian/Pacific Islander	1,379	30	2.18%	1.91%
Hispanic/Latino	20,640	575	2.79%	3.51%
Native American	299	17	5.69%	5.94%
Other	21,580	1,445	6.70%	3.57%
White	25,533	1,535	6.01%	5.45%

- The MHP PR was lower than the corresponding statewide PR for Hispanic/Latino, while the African American PR was comparable to the statewide rate.
- The Hispanic/Latino population comprises 29 percent of total MHP eligibles and has the second lowest PR. While exceeding the statewide rate, Asian/Pacific Islander members had the lowest PR of any group in the MHP.

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022

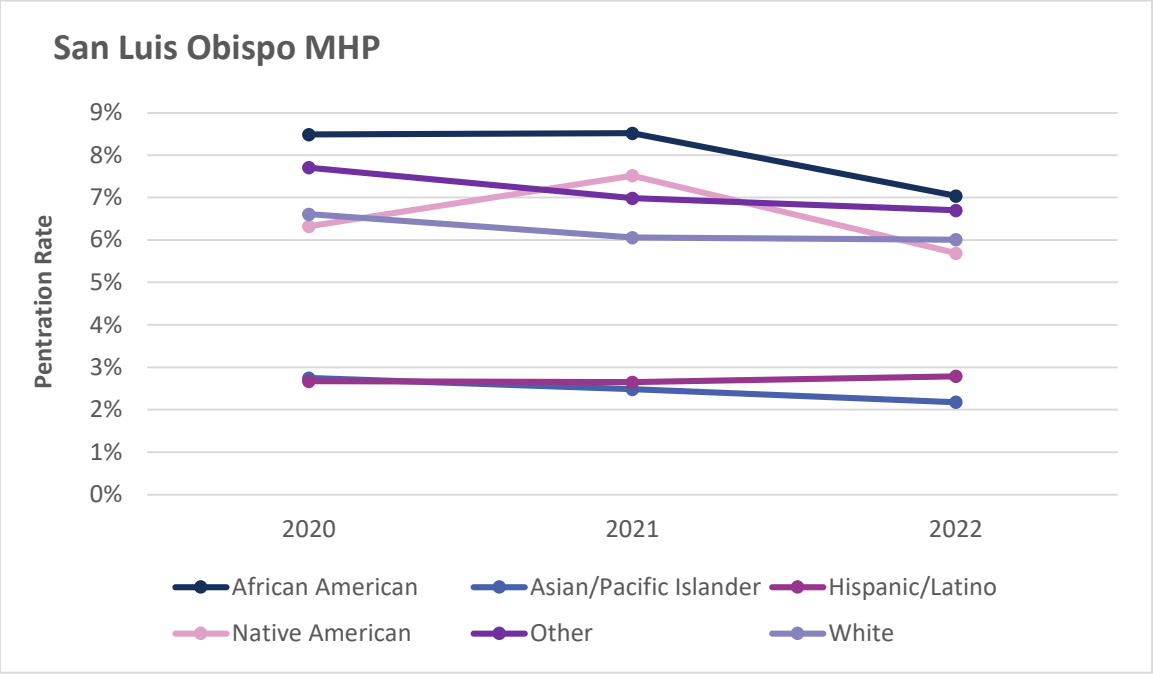


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	42%	40%	0.47%	16%	1%	1%
MHP % Eligible	36%	31%	0.43%	29%	2%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- While White and Other were the most proportionally overrepresented racial/ethnic groups in the MHP, the most proportionally underrepresented groups were Hispanic/Latino and Asian/Pacific Islander.
- The MHP had a notably lower percentage of Hispanic/Latino eligibles than the state, 29 percent compared to 49 percent.

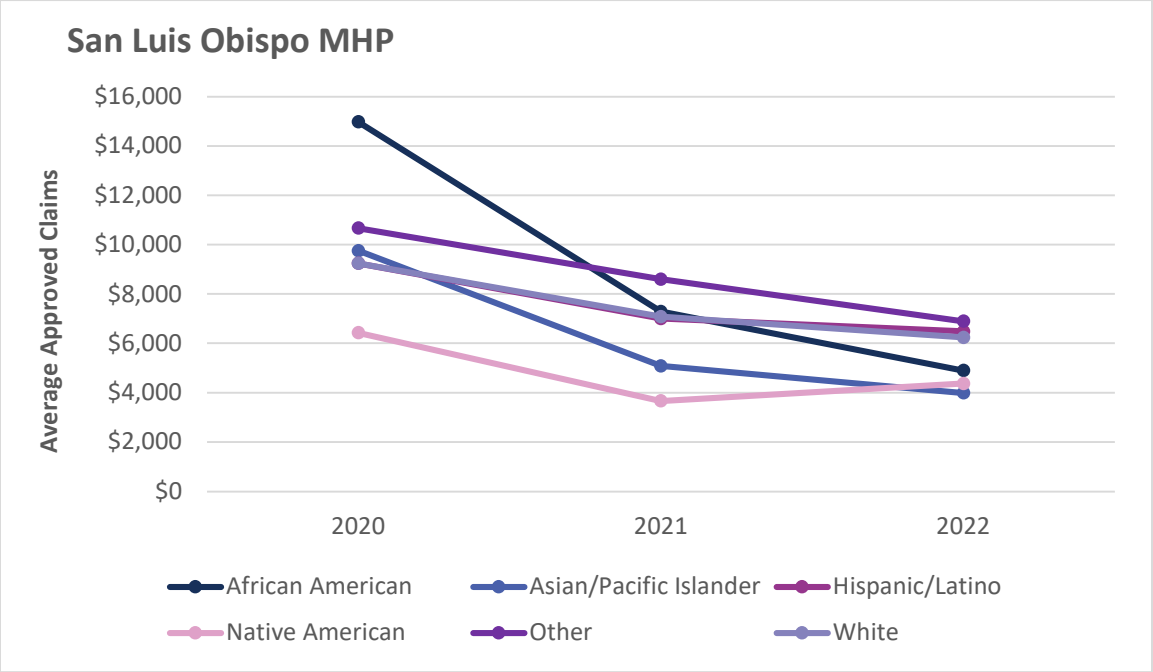
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



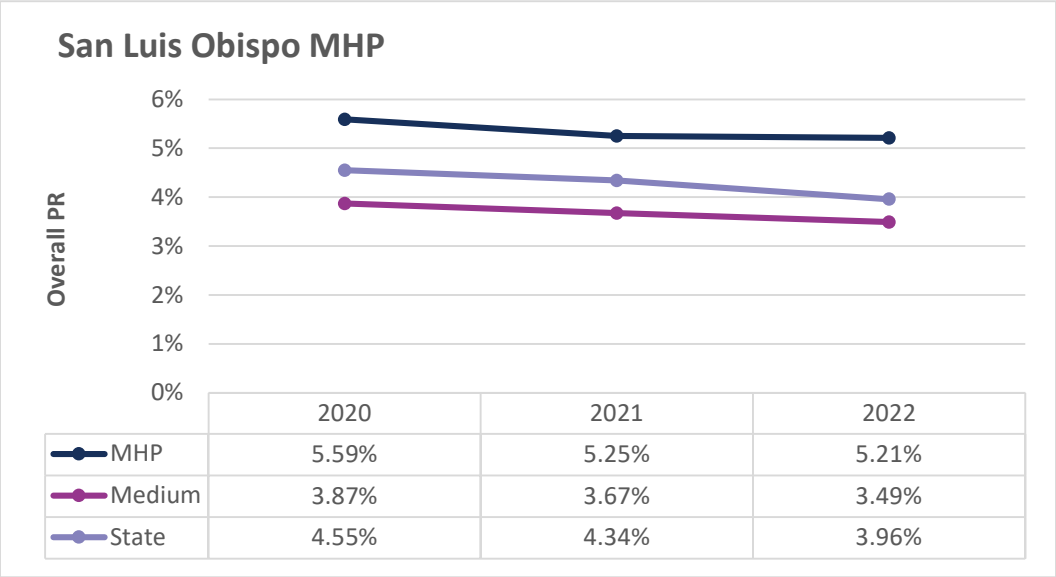
- PRs for African Americans have consistently been the highest over the past three years, whereas PRs for Asian/Pacific Islanders and Hispanic/Latinos have consistently been lowest.

Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



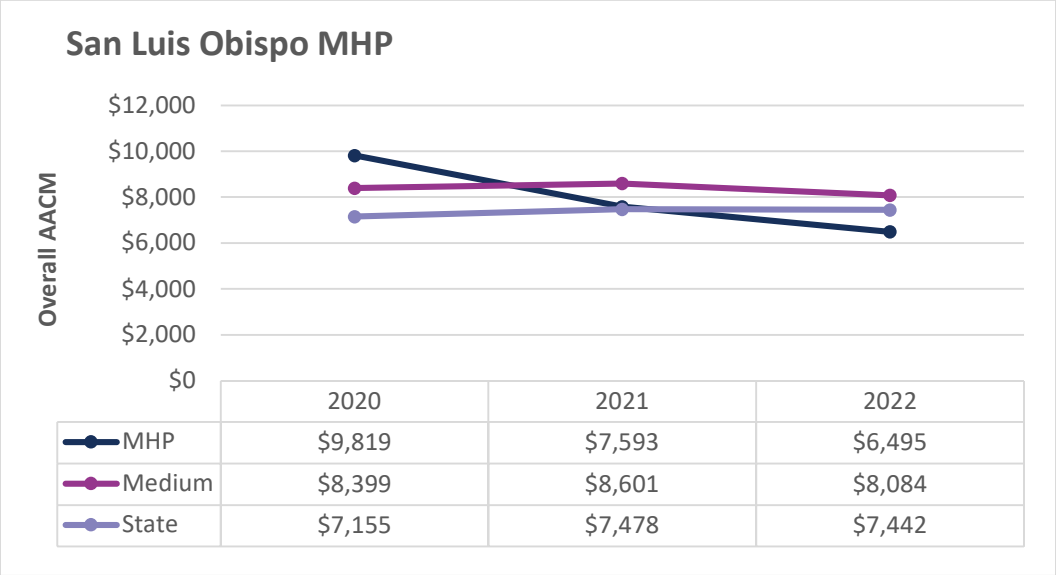
- Declining AACMs can be seen for all groups from CY 2020 to CY 2022. The African American and Native American groups were each less than 1 percent of those served in CY 2022, and small populations can be the cause of more dramatic year over year shifts in data.

Figure 4: Overall PR CY, 2020-22



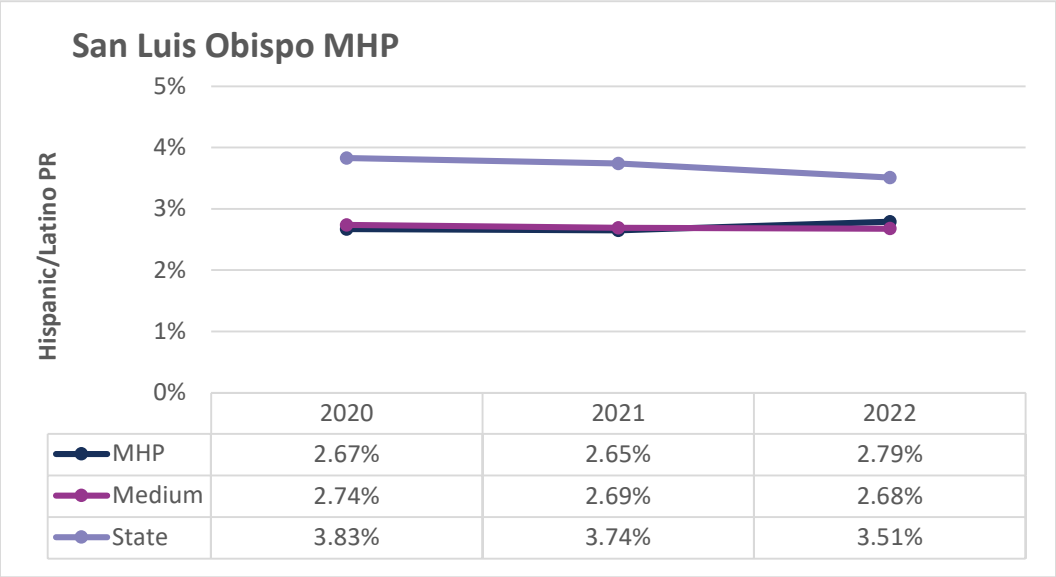
- From CY 2020 to CY 2022, the MHP's PR was higher than both medium county and statewide rates.

Figure 5: Overall AACM, CY 2020-22



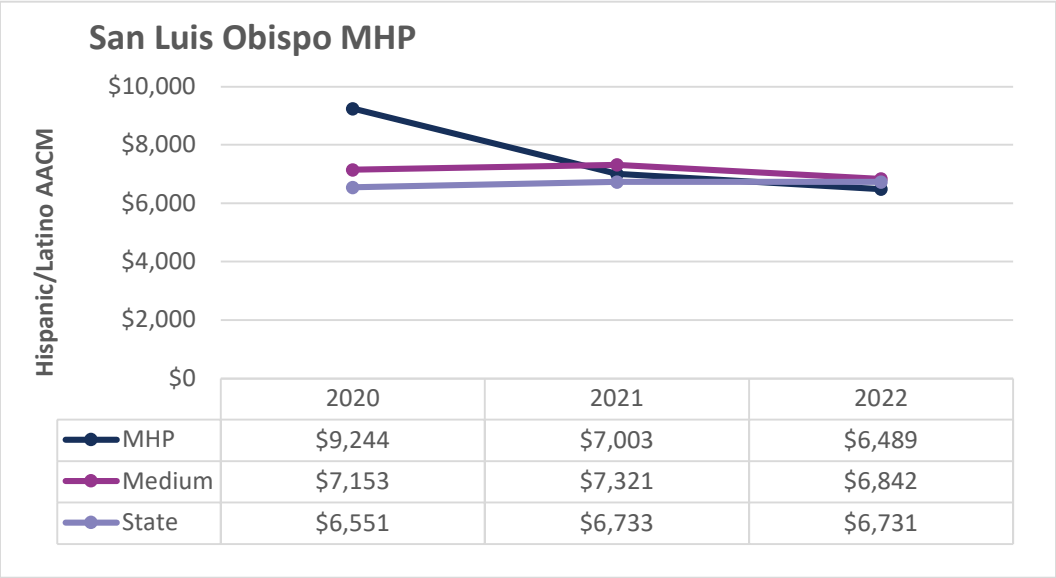
- The MHP's overall AACM declined each year from CY 2020 to CY 2022. While the MHP's AACM was greater than that of medium county and statewide AACMs in CY 2020, the MHP's AACM was less than medium county and statewide AACMs in CY 2022.

Figure 6: Hispanic/Latino PR, CY 2020-22



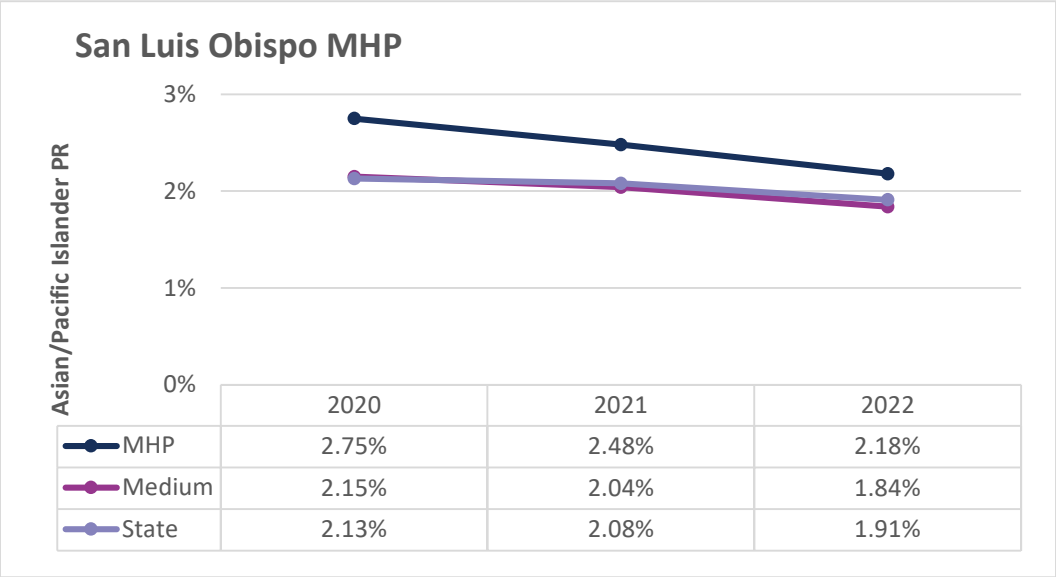
- While the MHP's Hispanic/Latino PR increased from CY 2021 to CY 2022, it remains just above the medium county rate and lower than the statewide rate in CY 2022.

Figure 7: Hispanic/Latino AACM, CY 2020-22



- The MHP's Hispanic/Latino AACM decreased each year from CY 2020 to CY 2022. While the MHP's Hispanic/Latino AACM was greater than that of medium county and statewide in CY 2020, the MHP's AACM dropped to be in line with medium county and statewide AACMs in CY 2022.

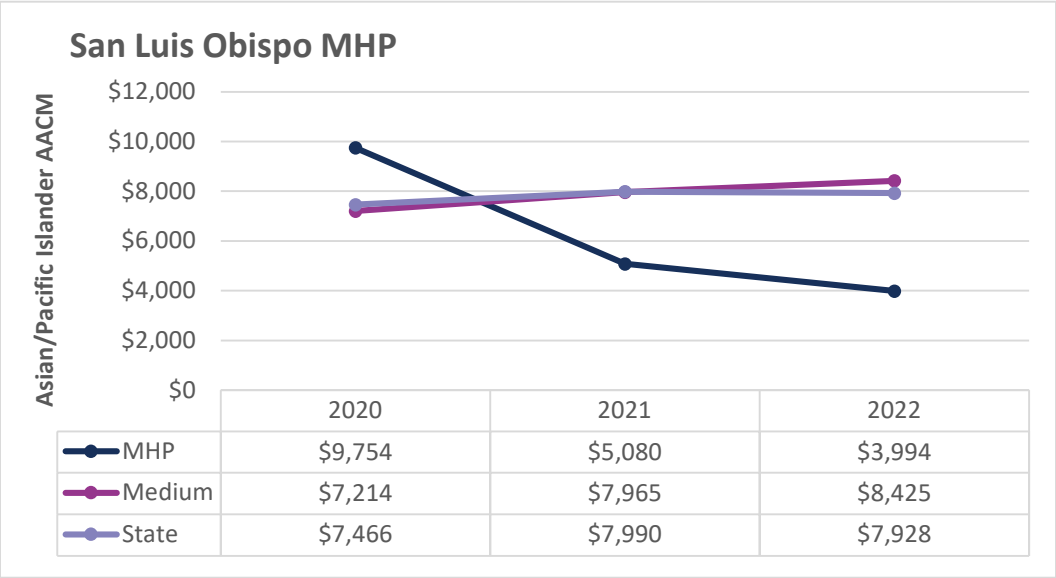
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.75%	2.48%	2.18%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%

- While the MHP's Asian/Pacific Islander PR declined each year from CY 2020 to CY 2022, it remained greater than medium county and statewide rates for all three years.

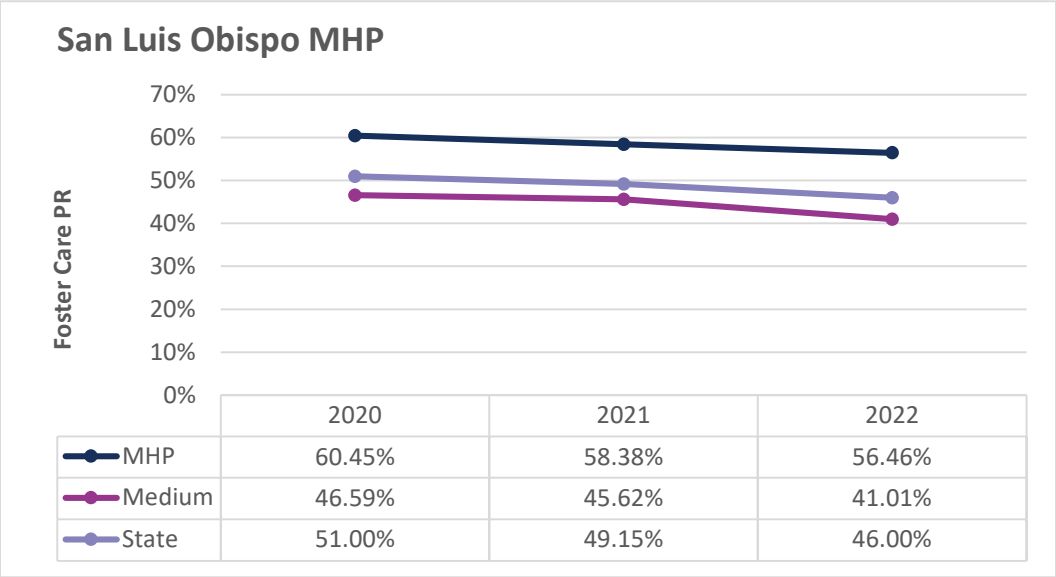
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$9,754	$5,080	$3,994
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM declined markedly from CY 2020 to CY 2022. However, it should be noted that in CY 2022, the Asian/Pacific Islander group was 1 percent of those served, and small numbers can cause dramatic shifts in year over year data.

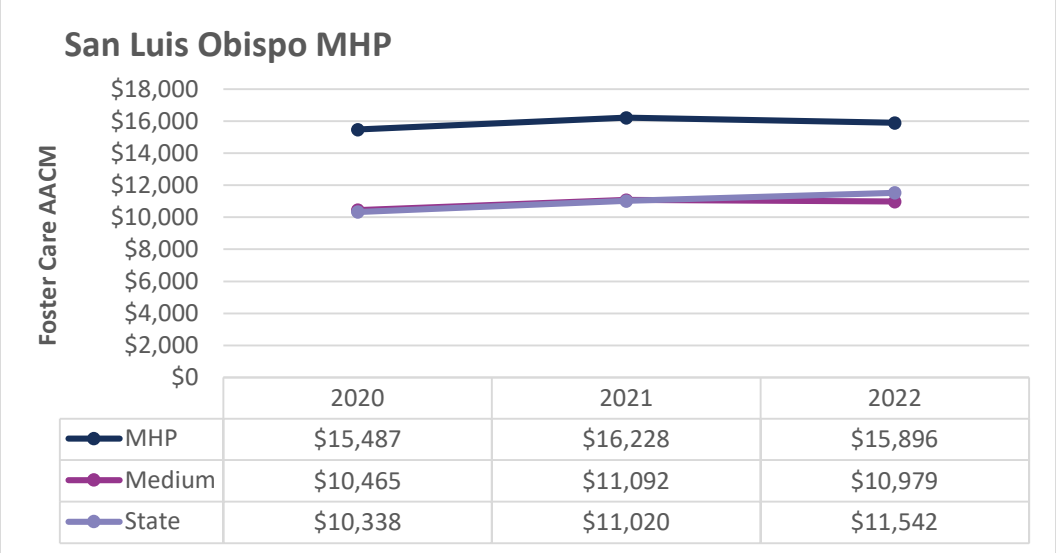
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	60.45%	58.38%	56.46%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%

- The MHP's FC PR was greater than that of medium county and statewide rates from CY 2020 to CY 2022. In CY 2022, the MHP's PR is 38 percent greater than the medium county rate and 23 percent higher than the statewide rate, indicating greater access to care at the MHP compared to that seen in medium counties and statewide.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$15,487	$16,228	$15,896
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, whereas the MHP's FC AACM was relatively stable during this time and remained much higher than both medium county and statewide averages.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the San Luis Obispo MHP to Adults, CY 2022

Service Category	MHP N = 2,497				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	25	1.0%	6	4	10.3%	14	8
Inpatient Admin	<11	-	10	9	0.4%	26	10
Psychiatric Health Facility	221	8.9%	5	3	1.2%	16	8
Residential	16	0.6%	107	104	0.3%	114	84
Crisis Residential	<11	-	6	5	1.9%	23	15
Per Minute Services							
Crisis Stabilization	167	6.7%	1,048	1,080	13.4%	1,449	1,200
Crisis Intervention	295	11.8%	261	180	12.2%	236	144
Medication Support	1,375	55.1%	219	142	59.7%	298	190
MH Services	1,512	60.6%	725	240	62.7%	832	329
Targeted Case Management	1,645	65.9%	241	77	36.9%	445	135

- The MHP's combined inpatient and PHF utilization rate of 9.9 percent was lower than the combined statewide rate of 11.5 percent. Preliminary data reportedly indicate these numbers are increasing since the PHF became contract operated.
- The member count is suppressed due to a small number, as it appears that the MHP does not offer a local crisis residential program.
- The MHP's crisis stabilization rate, as well as average and median units for this service, were lower than the statewide rates and units.
- The MHP's targeted case management (TCM) rate at 65.9 percent is notably higher than is seen statewide at 36.9 percent. This may be associated with bridge services provided during the long wait times reported by members to begin regular meetings with a clinician.

Table 9: Services Delivered by the MHP to San Luis Obispo MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 188				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	14	7.4%	9	9	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	420	420	3.1%	1,166	1,095
Crisis Intervention	20	10.6%	334	330	8.5%	371	182
Medication Support	61	32.4%	350	249	27.6%	364	257
TBS	<11	-	4,200	2,586	3.9%	4,077	2,457
Therapeutic FC	<11	-	503	533	0.1%	911	495
ICC	107	56.9%	989	604	40.8%	1,458	441
IHBS	81	43.1%	2,583	1,492	19.5%	2,440	1,334
Katie-A-Like	<11	-	980	596	0.2%	390	158
MH Services	177	94.1%	1,488	751	95.4%	1,846	1,053
Targeted Case Management	111	59.0%	153	75	35.8%	307	118

- The MHP's combined inpatient and PHF utilization rate at 7.4 percent was higher than the combined statewide rate at 4.7 percent.
- The MHP's ICC and IHBS utilization rates were both higher than statewide rates, and both also had higher median units compared to statewide units.
- Like adult services, the MHP's TCM utilization rate is higher than the statewide rate, 59.0 percent compared to 35.8 percent, though with fewer units of service on average.
- The MHP is one of eleven counties that implemented and claimed for therapeutic FC in CY 2022. Though the number served is too small to display, its PR ranks third among those MHPs that provided this service.

- While the number of FC youth in TBS is too small to display, the PR for FC receiving this service is above the State target for 4 percent TBS utilization.

IMPACT OF ACCESS FINDINGS

- The PRs for all age groups exceeded statewide rates, possibly indicating higher service accessibility in both the adult and youth systems of care.
- The MHP's PR for FC has been higher than that of medium county and statewide rates for the past three years, and the MHP's ICC/IHBS utilization rates for FC youth were well above statewide. The MHP assesses for and offers ICC/IHBS for all youth and notes strong coordination with schools, teachers, and social workers. This is evident for EPSDT youth, the MHP's utilization is roughly triple the statewide rates. Further, the MHP has FC youth receiving therapeutic FC which is less common.
- For adults, case management is reportedly used as a bridge, with a higher than state average rate of use, but less units per member. This could be reflecting reports that there is a need for more case managers in the county, especially for those who speak Spanish.
- As seen in the clinical PIP for members under five years of age, youth are actively provided TCM early in care especially to quickly address social determinates of health. The MHP delivers TCM to EPSDT youth at a rate approximately 50 percent higher than statewide.
- Hispanic/Latino PR remains lower than the statewide rate in CY 2022, indicating a potential need for increased outreach to this group. The MHP shared that media contact with monolingual, Spanish speakers has preliminarily increased since hiring a cultural representative for media outreach and expressed hopes that this will show in the PR next year.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful in providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Partially Met

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

- The MHP has tracked and trended follow-up after CSU, inpatient, and PHF for both youth and adults, and specifically for Spanish speakers. Also, other timeliness data sets have been tracked aggregate for Spanish-speaking

members. This is seen as a strength and will hopefully be continued with the new data tracking methods.

- These key components ratings are grossly impacted by the fact that the timeliness reporting is not yet available within SmartCare. The expected level of tracking and trending with continuous improvement is not currently possible. The MHP has a history of meeting many of these, with three timeliness key components met last review. However, the quality of the data was frequently questioned in reviews and the source of many recommendations. The MHP seems optimistic that after this transition, they will have more reliable and useful timeliness data.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. This data represents county-operated services. The MHP does not track timeliness to the first non-urgent psychiatry service delivered, and their timeliness standard for urgent services is four days, which differs from the DHCS required standard of 48 hours. Data and results for urgent services only include follow-up for CSU discharges and were submitted by the MHP in units of days which were converted to hours by CalEQRO. For first non-urgent appointment and first non-urgent psychiatric appointment offered, the MHP did not report the percent of appointments that met the DHCS timeliness standards, instead it reported what percents met a 14-calendar-day and 21-business-day standard. Fourteen calendar days is reportedly the MHP's equivalent to the DHCS standard of ten business days.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality-of-Care section.

Table 11: FY 2023-24 San Luis Obispo MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	24 Business Days	10 Business Days*	***
First Non-Urgent Service Rendered	24 Business Days	21 Business Days**	59%
First Non-Urgent Psychiatry Appointment Offered	25 Business Days	15 Business Days*	***
First Non-Urgent Psychiatry Service Rendered	****	****	****
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required*	72 Hours †	96 Hours †	90%**
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	4 Calendar Days	7 Calendar Days	91%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	4 Calendar Days	30 Calendar Days	100%
No-Show Rate – Psychiatry	15%	No Standard**	n/a
No-Show Rate – Clinicians	10%	No Standard**	n/a

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

** MHP-defined timeliness standards

*** The MHP did not report % meeting identified standard for this measure

**** Not tracked

† CalEQRO converted units of days to units of hours

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

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

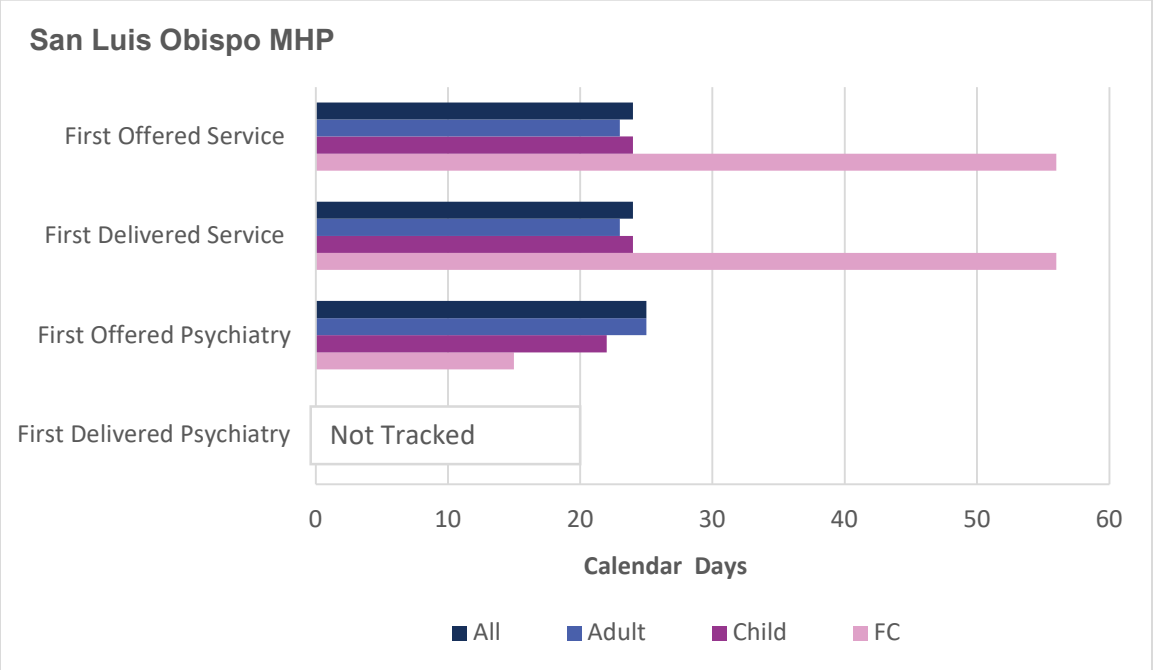


Figure 13: Wait Times for Urgent Services

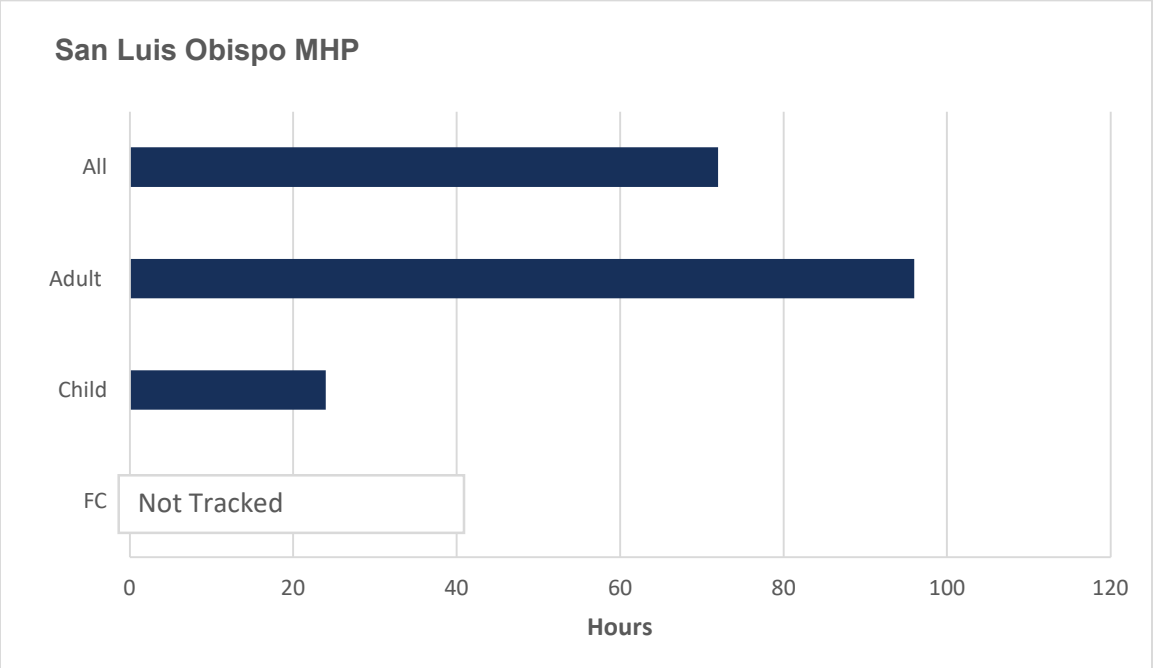
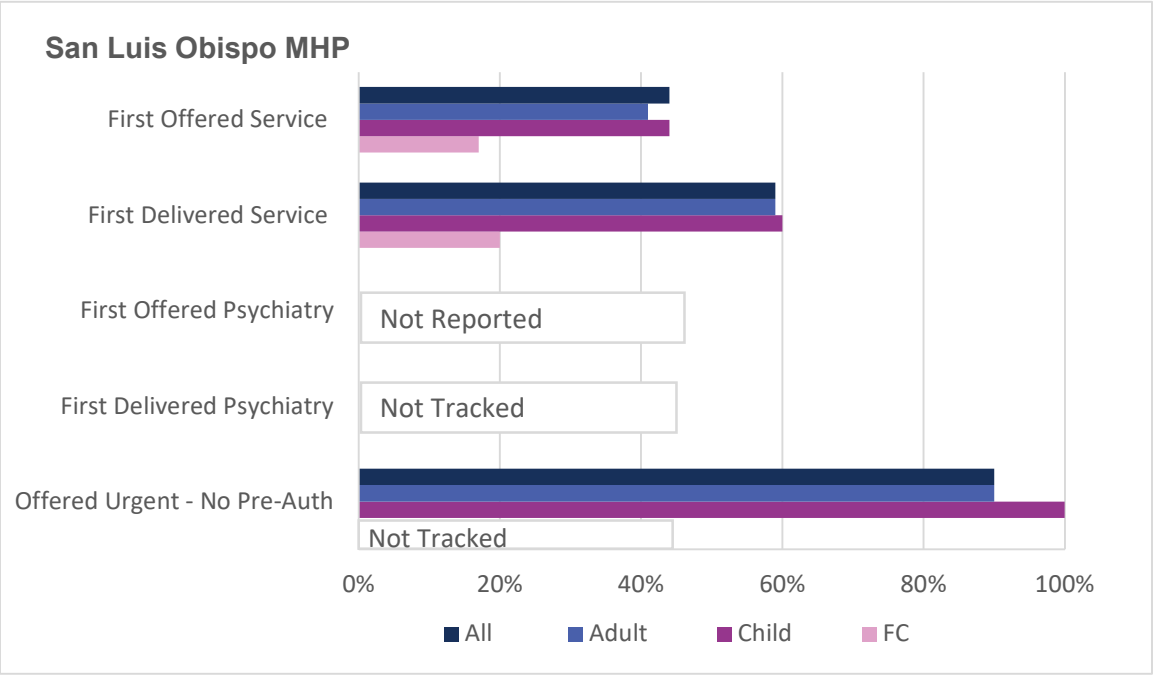


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments for county-operated services only.
- The MHP defined “urgent services” for purposes of the Assessment of Timely Access as follow-up after a member was discharged from the CSU, a subset of the MHP’s population. There were reportedly 11 urgent service requests with a reported actual wait time to services for the overall population of 72 hours. The MHP does not require pre-authorization for any urgent services.
- The MHP defines timeliness to first offered psychiatry services as from the date of first clinical determination of need for all new clients to psychiatry within the county-operated services only. The MHP does not track timeliness to the first non-urgent psychiatry service delivered/rendered due to limitations of its now legacy EHR.
- The MHP does track and monitor data for no-shows for both psychiatrists and non-psychiatry clinical staff for county-operated services only. The MHP reports an all-services no-show rate of 15 percent for psychiatry and 10 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- Contract provider timeliness data was only included in timeliness calculations for follow up after psychiatric hospitalization on the submitted ATA.

- The MHP identifies and tracks urgent services only for the sub-population of those members released from the CSU. The MHP standard for timeliness to an appointment offered for urgent services is four days, exceeding the DHCS 48-hour standard.
- The MHP reports significant errors on the ATA submitted by the MHP due to data-entry problems on manual spreadsheet tracking; it was unable to provide a corrected document to be included in this report. As mentioned earlier, the MHP is confidently expecting accurate timeliness measures with the new EHR.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to members. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement."

QUALITY IN THE MHP

In the MHP, the responsibility for QI is with the QST including responsibility for the following functions: quality support, health information, managed care, patients' rights, equity diversity inclusion, and clinical supervision and training. Compliance is separate from the QST and the BH department, falling under the larger Health Agency Assistant Director.

The MHP monitors its quality processes through the QIC, a QAPI workplan, and the annual evaluation of the QAPI workplan. The QAPI workplan is inclusive of Drug Medi-Cal Organized Delivery System (DMC-ODS) and MHP goals and objectives. The QIC is scheduled to meet quarterly and the MHP QIC met seven times since the last EQR on October 6, 2022. Every other quarter is either the Crisis Continuum QIC where inpatient and CSU data, crisis-oriented service, legislative changes, and placement resources are discussed; or the MH QIC which focuses upon all other components of the QAPI workplan including timeliness measures, clinical trainings, morbidity, and grievances, to name a few. It is comprised of members of the QST, contractor leadership and quality teams, members of the medical team, program managers, and a peer advocate. Of the eight identified FY 2022-23 QAPI workplan goals, the MHP identified only two of the associated objectives to be in progress while the rest were completed. However, the FY 2023-24 QAPI Workplan is largely unaltered from the prior year.

The MHP currently utilizes the CANS as a LOC tool for youth and does not utilize a LOC tool for adults except for the Milestones of Recovery Scale (MORS) for adults served in FSP. The MHP indicates a history of using the Adult Needs and Strengths Assessment tool (ANSA), but this reportedly did not provide useful data out of the previous EHR. A stated hope of the MHP is that a LOC tool will be put in place by CalMHSA within the SmartCare EHR so that aggregate analysis will become possible.

The MHP utilizes the following outcomes tools: CANS, the Pediatric Symptom Checklist (PSC-35), and the Ages and Stages Questionnaire (ASQ) is used for youth under five years in the Martha's Place program. The CANS is used both as a LOC and an outcomes measure for youth, and as a tool between the social services department and

the managed care plans, but it does not currently appear to be tracked or trended for QI processes. There does not appear to be an outcome measure for adults.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

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

- The QAPI plan includes the goal of sharing the Consumer Perception Survey (CPS) results and there is an interactive multi-year CPS results dashboard on the website, which is seen as a strength. The MHP does use aggregate CPS results to inform improvements to access, timeliness, and/or quality.
- Several members indicated during the review focus groups that they have benefitted from utilizing the wellness centers, a peer from a contract agency is present in the QIC, wellness centers are not limited to members already receiving care, and there is a new Service Enhancement Team that has placed

BH Navigators within one clinic lobby. These are strengths and the MHP is encouraged to expand these efforts.

- The MHP is partially met on Data is Used to Inform Decisions, as many of the data extraction processes for access, timeliness, and quality have been significantly disrupted by the new EHR transition. The MHP does have a history of meeting this key component and is expected to continue using data to influence system change.
- Members and their families indicate there is no formal channel where they can receive regular communication and the opportunity for feedback about the delivery of services. They note no involvement with peers in the system. There is a standing item for a “Consumer Family Advocate” at QIC, but nothing has been presented during the past year according to minutes. Thus, Stakeholder Input is also considered partially met.
- The MHP shared a clear continuum of care, which has been expanded with the new crisis-specific continuum. The MHP seems dedicated to closing gaps in the continuum. However, the MHP reports no LOC or outcome measures for adults beyond the MORS for FSP LOC. The CANS is utilized as both an outcome and LOC tool for youth, although aggregate data does not appear to be routinely tracked and trended. There is a need to establish a process for tracking and trending LOC transitions and outcomes aggregately. These are the reasons for the partially met rating on both Clinical Continuum of Care and Measures Clinical and/or Functional Outcomes. It is expected that this will be improved with the anticipated SmartCare tools.
- There does seem to be some disruption of processes for medication providers after the retirement of their Medical Director, although there are two identified interim directors currently. Supervisors are reportedly struggling to establish practices for psychiatric staffing in their clinics, and members in the focus groups noted no collaboration with primary health providers in their care. This is the reason for partially met on Medication Monitoring.
- While there are peers present in the MHP, they are only within contract agencies and county line staff indicate no involvement with them. Also, one member commented that “there are hardly any peers.” The MHP reported some efforts to discuss peer roles within county employment with Human Resources but there is no plan at this time. Due to the positive impact peers have on the entirety of the care system, efforts to expand peer opportunity and integration into county clinic locations are encouraged. Lastly, peers validate that there is no career ladder without additional education. For these reasons Consumer Employment in Key Roles is considered partially met this year.
- The MHP reported that it tracks and trends the four Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5, although no evidence or trends results were provided to CalEQRO. A member of the QST team pulls the data associated with foster youth and provides it to the QST Clinician who then does chart reviews to establish criteria.

QUALITY PERFORMANCE MEASURES

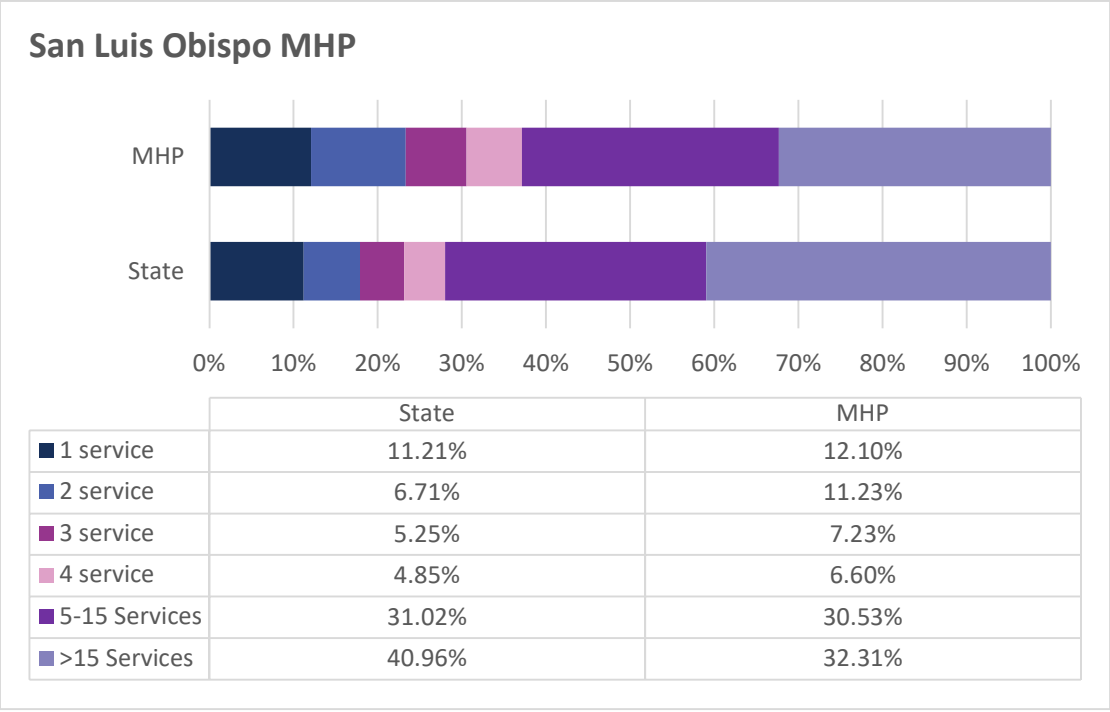
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCMs)

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



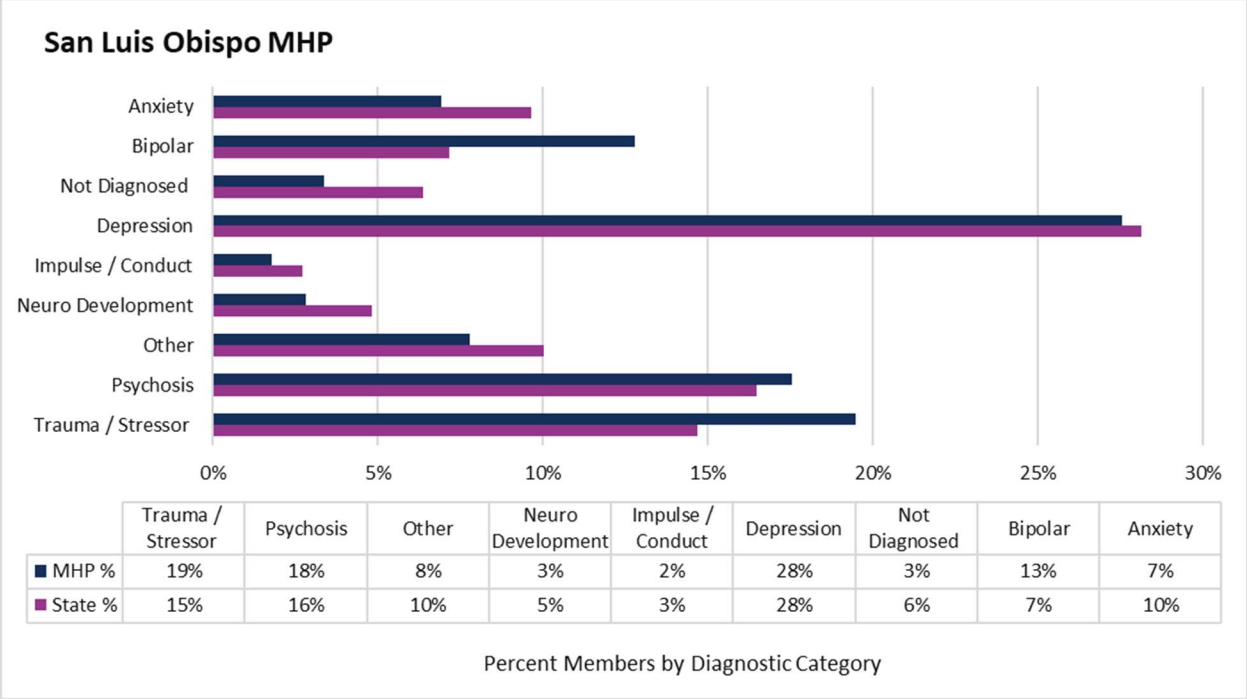
	State	MHP
1 service	11.21%	12.10%
2 service	6.71%	11.23%
3 service	5.25%	7.23%
4 service	4.85%	6.60%
5-15 Services	31.02%	30.53%
>15 Services	40.96%	32.31%

- The MHP had a greater proportion of members receiving one to four services than is seen statewide, 37.16 percent compared to 28.02 percent. This may be due to the implementation of No Wrong Door, and the operation of a CSU with follow-up services provided.
- The MHP's proportion of members receiving greater than 15 services is lower than statewide, 32.31 percent compared to 40.96 percent, which could also be associated with ongoing, although reportedly improving, shortages in clinical staff.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022

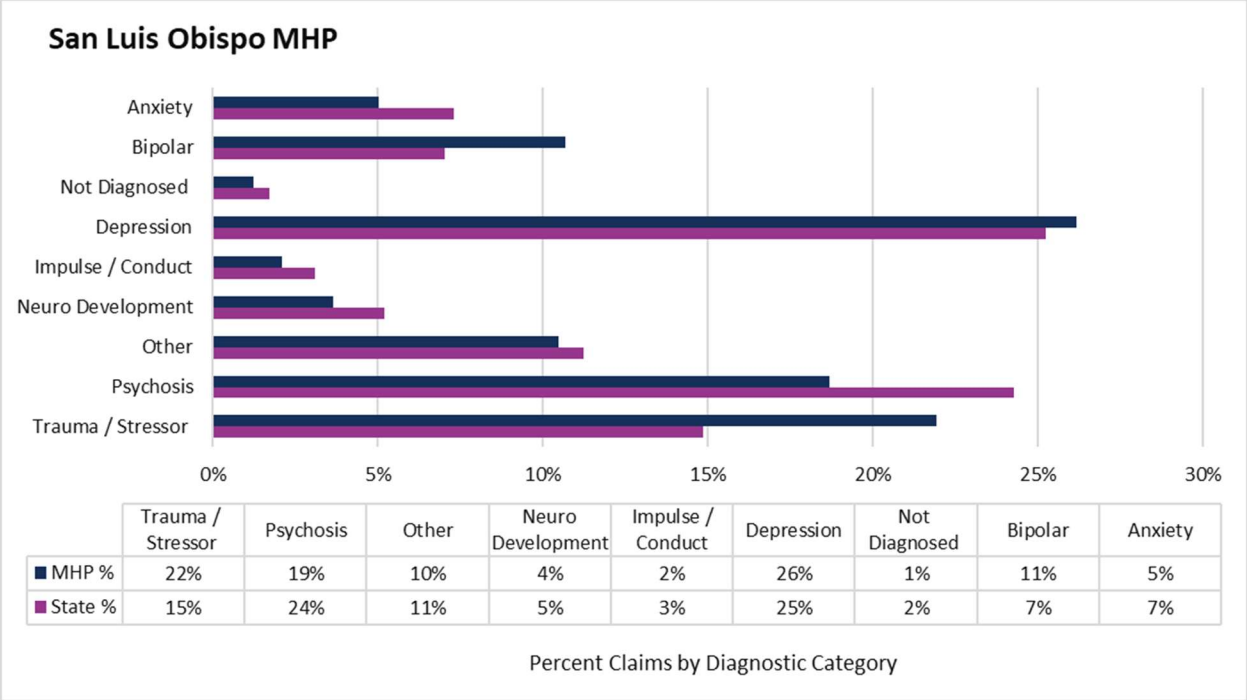


	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	18%	8%	3%	2%	28%	3%	13%	7%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Sixty-three percent of members had one of three diagnoses: Depression (28 percent), trauma/stressor (19 percent), and psychosis (18 percent).

- The MHP's diagnostic rate for bipolar is almost twice the statewide rate, 13 percent compared to 7 percent. Trauma/stressor is also higher than statewide.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	22%	19%	10%	4%	2%	26%	1%	11%	5%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The MHP's approved claims by diagnostic category generally aligned with diagnostic patterns when compared to statewide data.
- While the MHP shows slightly more members with a psychosis diagnosis, comparatively fewer dollars were claimed for this category. This suggests there may be opportunities for greater engagement of this population in services, or these members may be receiving services at lower LOCs than occur statewide (lower inpatient utilization is suggested through Tables 8 and 13).

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: San Luis Obispo MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	335	452	1.35	5.28	8.45	$8,142	$12,763	$2,727,654
CY 2021	354	508	1.44	6.25	8.86	$12,154	$12,696	$4,302,634
CY 2020	368	519	1.41	6.40	8.68	$14,270	$11,814	$5,251,336

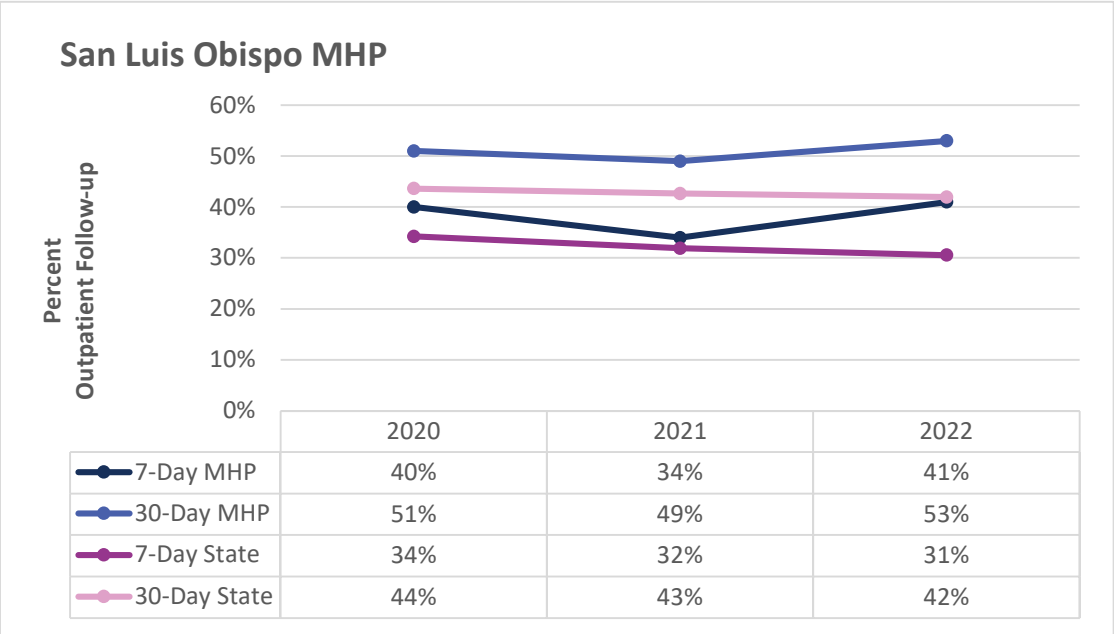
- The MHP's unique inpatient member count, total admissions, average LOS in days, and inpatient AACM declined each year from CY 2020 to CY 2022.
- The MHP's CY 2022 inpatient AACM was less than the statewide average at $8,142 compared to $12,763. Also, the MHP's LOS in days was less than statewide, 5.28 days compared to 8.45 days.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

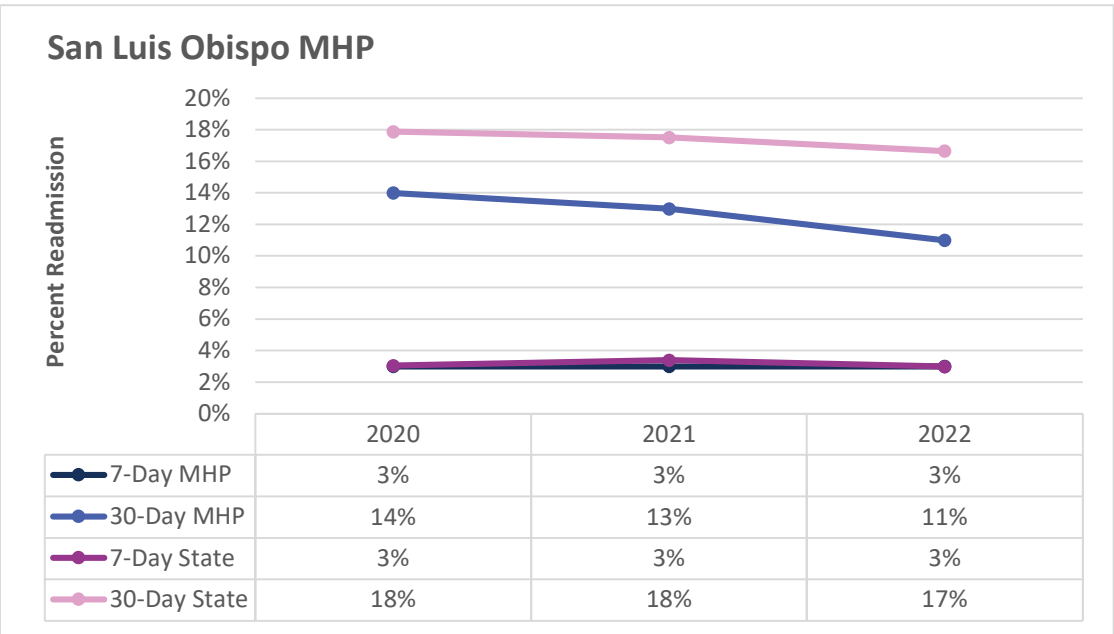
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	40%	34%	41%
30-Day MHP	51%	49%	53%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7-day and 30-day follow-up rates increased from CY 2021 to CY 2022. In CY 2022, the MHP's 7-day and 30-day follow-up rates were both higher than the statewide rates, 41 percent compared to 31 percent and 53 percent compared to 42 percent, respectively.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



	2020	2021	2022
7-Day MHP	3%	3%	3%
30-Day MHP	14%	13%	11%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7-day readmission rates have been stable over the past three years while the 30-day readmission rate showed a decline during this time period. In CY 2022, the 7-day readmission rate is the same as the statewide rate at 3 percent, while the 30-day readmission rate is lower than the statewide rate, 11 percent compared to 17 percent.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: San Luis Obispo MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	154	4.22%	30.51%	$7,238,121	$47,001	$42,283
	CY 2021	170	4.96%	32.27%	$8,399,888	$49,411	$41,801
	CY 2020	241	7.31%	38.27%	$12,380,520	$51,371	$43,817

- The number of HCMs and the percentage of HCMs decreased each year from CY 2020 to CY 2022. In CY 2022, the percentage of HCMs was below the statewide rate, 4.22 percent compared to 4.54 percent.

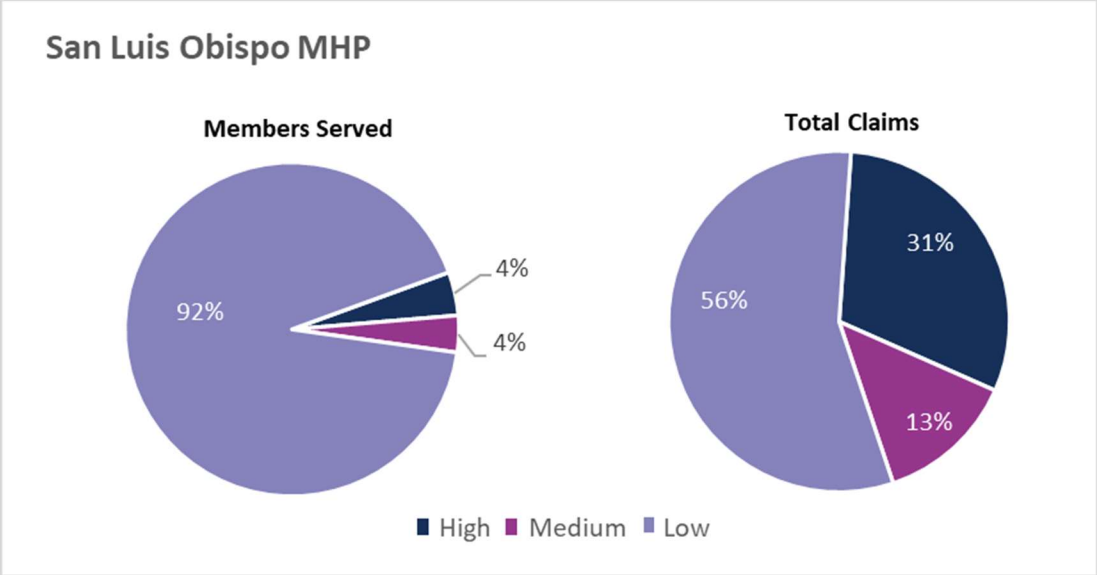
- The MHP's CY 2022 percent of HCM approved claims dollars at 30.51 percent was lower than the statewide rate of 33.86 percent. The MHP's HCM AACM was also lower than the statewide average in CY 2022, $47,001 compared to $55,518.

Table 15: San Luis Obispo MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	130	3.56%	13.24%	$3,140,446	$24,157	$23,718
Low-Cost (Less than $20K)	3,368	92.22%	56.25%	$13,342,699	$3,962	$2,140

- Low-cost members comprised 92.22 percent of those served and 56.25 percent of the approved claims dollars were attributed to this population.

Figure 20: San Luis Obispo MHP Members and Approved Claims by Claim Category, CY 2022



- The proportions of members in each cost category and the proportions of claims attributable to each group were generally comparable to the state. There is a slightly lower proportion of claims associated with HCMs, 31 percent compared to 34 percent, and a slightly higher proportion associated with low-cost members, 56 percent compared to 54 percent statewide.

IMPACT OF QUALITY FINDINGS

- At 32.31 percent, the MHP's proportion of members receiving greater than 15 services is lower than statewide at 40.96 percent. This is likely a contributing factor to the MHP's lower overall AACM.
- Psychosis spending was lower than would be expected with 18 percent of members having received a psychosis diagnosis and 19 percent of claims dollars spent on this diagnostic category. This indicates lower spending on this population than is seen statewide.
- The MHP has successfully implemented the CalAIM Screening and Transition Tools and does track the outcome of new requests for care which seems a strength.
- The QIC meets quarterly with every other being for the crisis continuum, which results in just two meetings per year to monitor general access and other QAPI goals. This seems too infrequent for continuous quality improvement or rapid cycle changes. The MHP should consider meeting more frequently once new reports are in place.
- Contractors expressed uncertainty and indicated program constriction with the implementation of CalAIM payment reform. Like in other counties at this transformative time, contractors expressed a desire to have the fiscal and contract teams in collaborative meetings or to host brainstorming sessions with all contractors to support unified navigation. Further, the impact on members could mean fewer home visits and prevention programs, particularly for those in the rural part of this county where a home visit could take most of a workday.
- Significant initiatives present a changing landscape of quality for the MHP including a new EHR with absent data and reporting tools, contracting out the PHF, and introducing mobile crisis. Regarding mobile crisis, members indicated this service as lacking during the review, so the MHP is launching a much-needed resource. Further, its new crisis continuum is aimed at improved efficiency for all crisis services.
- The MHP continues to expand integration with DMC-ODS services, co-locating integrative services, addressing the shared EHR during informed consent, and expanding medication treatment options including those addressing nicotine addiction or S-Ketamine. Especially when considering the ability to address social determinants of health and reduce barriers to care, these movements seem beneficial to the access and quality of care for members.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Martha's Place Fast Improved Access

Date Started: 03/2023

Date Completed: Ongoing

Aim Statement: "The goal of this PIP is to improve MH access to birth through 5-year-old beneficiaries within a timely manner, within the next fiscal year (23/24) by reducing wait times to beneficiaries first service provided by a clinician to ten business days or sooner."

Target Population: Medi-Cal members ages birth through five years old, who are referred, but waiting to receive an MH assessment at Martha's Place.

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

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

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

Summary

The MHP found that there were several factors influencing long wait times for the vulnerable population of members aged 0-5 in the Martha's Place clinic. Members and their families were waiting months to be assessed although some sporadic case management support was provided during that time. The referral process was moved out of the clinic, the CalAIM Youth Screening Tool implemented, a dedicated clinician for assessments who is specialty trained in this population was added, and documentation reform embraced, providing consistent case management services prior to assessment. The PIP is nonclinical in design, although there are clinical aspects. Measuring these aspects, such as the member benefit of applying case management and addressing social determinates of health earlier in care, would make this a stronger clinical PIP. The PMs could be more concise and consistent throughout the development tool, but the positive impact of the PIP is clear in that 100 percent of all referrals are now receiving timely services.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence because the interventions were applied consistently and to all members of the population, resulting in clear success, despite inconsistencies in the wording of PMs throughout the development tool. There was a well-rounded root cause exploration for these efforts and a good discussion of the new EHR impact on data collection.

The PIP was initially found to have no confidence as submitted before the review. The MHP was provided with TA during the review and accepted the opportunity to resubmit the project. The recommendations below are based on the updated PIP.

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

- Add the goal to the aim statement.
- Capture the actual counts as intended for the PMs listed, showing more concise and measurable results. Be sure planned measures match the summary table and throughout the development tool.
- Enhance the clinical aspects of this clinical PIP. Perhaps apply a measure to capture changes in enrollee satisfaction or experience of care, those who received inconsistent support and a long wait versus the experience of those after the interventions were applied.
- It seems this PIP is coming to a completion stage; include discussion of the results on Worksheet 9 and the plan moving ahead.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)

Date Started: 10/2022

Date Completed: Ongoing

Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up MH services with the MHP within 7 and 30 days by 5% by June 30, 2024."

Target Population: All Medi-Cal members who present at one of the three Dignity Hospital EDs with behavioral health concerns.

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

Summary

The MHP has created a collaborative relationship with Dignity Health, which manages three of the four EDs in the region, to receive weekly reports of Medi-Cal members who presented with MH concerns in the ED, primary or secondary to physical health conditions. The aim is to improve 30-day follow-up rates for those Medi-Cal members meeting these criteria by 5 percent by June 2024. Two measures are calculated, the percentage of those who receive an outpatient follow-up with the MHP within 30 days and the percentage of those who are not currently open to the MHP and are provided outreach interventions.

This PIP was presented as the clinical PIP at last year's review and has been in progress since October 2022. The MHP has made many positive rapid cycle improvements since that time and has fully implemented interventions and data tracking processes. However, the discussion of these changes is limited and only a brief period of data is provided. The PIP could continue with the existing measures as a relevant baseline and continue to measure efforts across time as planned in the aim statement. The MHP could also consider using the PIP Development Tool to organize a comprehensive discussion of the PIP, the baseline data, and the results over time. These suggested improvements, with more detailed explanation, could result in a higher confidence rating.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because there is no comprehensive discussion of the PIP as it exists now, with no clear measurements over time, and no data reported since August 2023. A comprehensive and updated

discussion of the PIP as it stands now and data collection moving ahead would improve the strength of this project. For example, it is difficult to tell that the population changed, the aim statement includes 7-day follow-up which is not possible with the current design, and it is unclear if the July 2023 through August 2023 data is considered baseline or if the HEDIS measures are being used as the baseline.

TA was not requested from CalEQRO since last review reportedly because the project was supported by CalMHSA. The most recent written summary, September 2023, was omitted from the review submissions, so the following recommendations were not possible until after the review's PIP session.

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

- Describe the FUM efforts in more detail to convey changes made for rapid cycle improvements and to increase feasibility of the project. For example, the aim statement should be updated since 7-day measures are not currently possible and are not included in this PIP.
- Provide data results up to the time of the review to evidence the PIP as active. Consider utilizing PIP Development Tool table 8.1 to help present the baseline and results. Routine data collection appears to have stopped late August 2023.
- Provide an organized discussion of factors that may impact the data quality or validity of the PIP as it stands now, including the EHR change, inability to measure 7-day follow-up due to weekly reporting, loss of staff who were tracking these measures, or other factors associated with data collection.
- Consider the use of the August 2023 data as the baseline and report on the remeasurement phase.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's EHR, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the CalMHSA semi-statewide EHR, SmartCare by Streamline, which has been in use for less than one year. Currently, the MHP is actively implementing this new system which requires heavy staff involvement to fully develop.

Approximately 2.41 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is an identical budget percentage to that reported by the MHP in the prior year and may not accurately represent the FY 2023-24 budget. The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 434 named users with log-on authority to the EHR, including approximately 228 county staff and 206 contractor staff. Support for the users is provided by ten full-time equivalent (FTE) IS technology positions. Currently, there are two vacant positions that are in recruitment, a Data Automation Specialist II and a Business Systems Analyst.

As of the review, most contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7. The MHP states that contract providers were encouraged to utilize the new EHR and there had been an increase in the number of contract providers who use the MHP's EHR since the last EQR.

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

Table 16: Contract Provider Transmission of Information to San Luis Obispo MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	5%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	2%
Paper documents delivered to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	3%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality is expected to be implemented within the next year.

Interoperability Support

The MHP is a member of the Orange County Partnership Regional Health Information Organization (OCPRHIO) HIE. While the MHP can download data from the HIE, they are no longer active participants and have ceased planning to upload data to OCPRHIO or become active members with bidirectional data exchange capability. Further, the MHP plans to join the CalMHSA Connex HIE. A time frame for the connection and active participation has not been established. The MHP engages in electronic exchange of information with MHP and DMC-ODS contract provider organizations.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The IS budget allocation reported by the MHP was identical to the percentage reported the prior year, 2.41 percent. A post-review update to the budget percentage was requested during the review but was not provided by the MHP. Despite the question about whether the 2.41 percent IS budget is reflective of operations over the past year, the MHP has met Investment in Information Technology Infrastructure and Resources as a Priority. Further, the MHP did add one FTE IS staff for MH and one for DMC-ODS.
- SmartCare was implemented July 1, 2023, and remains a system in development. Timeliness and productivity reporting is not yet available. Contract providers reported receiving no reports or data since the implementation of the SmartCare system. While not all contract providers utilize SmartCare for clinical documentation, the MHP reported that during early planning, contract providers were encouraged to consider utilizing the EHR. The MHP stated they have had an increase in contract provider use of the MHP's EHR for clinical documentation since the last review. Lastly, while the MHP does not currently have a database that replicates the EHR system, a read-only data warehouse is in development by CalMHSA and the MHP plans to develop an additional data warehouse that replicates the SmartCare System. For these reasons, the MHP is partially met for Integrity of Data Collection and Processing this year.
- The key component Integrity of Medi-Cal Claims is partially met again this year. The July 2023 claims were submitted in October 2023 and the MHP is working collaboratively with CalMHSA to refine denials and associated claiming functionality to resubmit the claim to DHCS.
- Key Component Security and Controls is partially met this year. The MHP does not use two-factor authentication for password updating and does not require passwords to be changed on a regular basis.
- While the MHP is a member of OCPRHIO and can download data from the HIE, they are no longer active participants and have ceased planning to upload data to OCPRHIO or become active members with bidirectional data exchange capability. The MHP plans to join the CalMHSA Connex HIE, but a time frame for the connection and active participation has not been established.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

The MHP reports that their claims are current through June 2023. The MHP is working collaboratively with CalMHSA to prepare the final submission of the July 2023 claim.

Table 18: Summary of San Luis Obispo MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,337	$1,853,206	$45,147	2.44%	$1,808,059
Feb	6,171	$1,937,850	$99,425	5.13%	$1,838,425
Mar	5,616	$1,795,344	$36,676	2.04%	$1,758,668
April	6,217	$1,965,809	$64,212	3.27%	$1,901,597
May	4,340	$1,425,899	$22,516	1.58%	$1,403,383
June	6,063	$1,993,377	$64,778	3.25%	$1,928,599
July	5,983	$1,874,747	$67,331	3.59%	$1,807,416
Aug	6,497	$2,268,974	$56,226	2.48%	$2,212,748
Sept	6,037	$2,079,769	$89,543	4.31%	$1,990,226
Oct	6,239	$2,060,006	$65,388	3.17%	$1,994,618
Nov	6,020	$2,056,134	$54,512	2.65%	$2,001,622
Dec	5,963	$2,069,402	$52,791	2.55%	$2,016,611
Total	**71,483**	**$23,380,517**	**$718,545**	**3.07%**	**$22,661,972**

- Claim volume was consistent during CY 2022.

Table 19: Summary of San Luis Obispo MHP Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	508	$297,672	41.43%
Medicare Part B must be billed before submission of claim	853	$278,305	38.73%
Beneficiary is not eligible or non-covered charges	283	$129,297	17.99%
Service line is a duplicate and repeat service modifier is not present	25	$5,686	0.79%
Place of service incomplete or invalid	2	$3,840	0.53%
Other	3	$1,572	0.22%
Deactivated NPI	5	$1,154	0.16%
Service location NPI issue	5	$1,022	0.14%
Total Denied Claims	**1,684**	**$718,548**	**100.00%**
Overall Denied Claims Rate	**3.07%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The claims denial rate for CY 2022 of 3.07 percent is notably lower than the statewide denial rate of 5.92 percent.
- Claims with denial codes: other health coverage must be billed first, Medicare Part B must be billed prior to the submission of this claim, and service location National Provider Identifier (NPI) issue are generally rebillable within state guidelines after claim denial correction.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP is commended for encouraging contract provider adoption of the same EHR as this will provide providers with more comprehensive, 24/7 access to member clinical information, including progress notes and medication lists, by availability of this data in the SmartCare system. Contract provider adoption of SmartCare will also increase data availability for reporting and analytics.
- While the system has only been in use for just over six months, it remains in a state of development regarding timeliness, productivity report, and claiming functionality. The ongoing development of these functionalities is not limited to the MHP but is true for all SmartCare counties due to the continued development and enhancement of the newly implemented system.
- While the SmartCare system will provide the benefit of new and updated functionality, the MHP reported having previously developed in-house ad hoc reports and dashboards in addition to the productivity and timeliness reports previously cited. The review of these reports and dashboards to identify

additional desired reporting and data availability in the new system will be a focus of the MHP over the next year. Further, clinical staff are reportedly continuing to adjust to the changed system and others indicate frustration with what is perceived to be disjointed and inefficient processes.

- The addition of one FTE of IS staffing is a strength of the MHP, especially during this time of SmartCare implementation, which will require increased support for staff utilizing the new EHR as well as the rebuilding of reports and data extracts available in the prior EHR that are desired but not yet available in SmartCare.
- During the review, the MHP reported no requirement for changing system passwords on a regular basis, which is a security risk to the organization and ultimately a confidentiality risk for members.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP tracks the results of the CPS through the QIC and does share the results internally, although the results for these are protracted and the MHP does not collect preliminary results. There is an interactive 2018-2022 CPS results dashboard on the website which is seen as a strength, and it is hoped that it will be updated as soon as the 2023 results are available. A goal on the FY 2023-24 QAPI plan is to utilize CPS responses to inform QI projects and treatment providers and includes objectives to share the results to the supervisor's committee, staff, and members at least annually.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included four participants; no language interpreter was needed for this focus group. All members participating receive clinical services from the MHP, but none began services in the last 12 months. All adult members participating in the focus group had been in care for at least several years.

These adult members shared a wide range of information about their experience receiving services from the MHP. Regarding appointment frequency, therapy was received one to two times per week and medication appointments varied from one to three months, depending on their condition. Although they reported that it is easier to get a telehealth appointment, the current medication provider will not be their ongoing provider, and it is problematic to work with someone who is not familiar with their unique

story. They reported ease of access to transportation supports, appointment reminders, follow-up calls if they miss an appointment, and all had successfully switched providers at some point. None had been invited to complete satisfaction surveys, attend any MH committees, or to consider peer employment. They all agreed that staff at the MHP gave them hope for a better future.

Recommendations from focus group participants included:

- Mobile crisis has not seemed mobile, although it had been in the past. Members shared that calling the crisis line was ineffective, as they had been encouraged to go to the hospital ED or call 911. Two members stated these types of troubles in the past year. They were aware of the CSU, but none had used it. One member reported having to call repeatedly to get an urgent appointment. They all agreed that better crisis services are needed.
- One member suggested doing homeless outreach in the parks, offering food and information about how to obtain services.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of English and Spanish-speaking family members of youth plan members who began services preferably within the past 12 months. The focus group was held virtually and included five participants; no language interpreter was required for this focus group. All family members participating have a youth family member who receives clinical services from the MHP. Three began services in the previous 12 months.

Those who began services in the previous 12 months noted that getting into care was difficult, that waiting two to three months for services to begin was common; and one noted that this resulted in the child member being forced to leave public school and start home schooling. Once in treatment, therapy was received weekly for all, with medication services provided weekly or monthly depending on need. They were aware of gas cards or transportation provided by MHP contractor agencies, but reported they believed Medi-Cal transit support was only for medical doctor or hospital appointments.

None had been invited to provide feedback and most expressed that the MHP would not listen to them anyway, that the system is too short-staffed and busy for their input. One said, “It would fall on deaf ears in the County, and you have to be aggressive, or you are ignored.” Most agreed, “You have to be your own advocate at the County.” Several participants noted that the contract provider, Seneca’s rapid response line, was helpful and found their services to be “rock solid” and “amazing.” No one had used mobile crisis, and several were unaware it existed; one did not know the crisis line existed.

Recommendations from focus group participants included:

- The county should replicate the teamwork at Seneca, which is reportedly efficient, effective, and evolves if it is not working.

- Several would like to have the opportunity to provide their feedback and to know more transportation options for making appointments. One parent shared about walking for an hour to and from appointments for her young child in services.
- Several mentioned reducing wait times from over three months to a couple weeks and returning calls made by members and their families.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The members and their caregivers indicate that, once in regular care, the frequency and success of treatment and linkage to services are positive and helpful. However, there is a perceived period of waiting for services to begin that is over three months. Adults seem more aware of transportation assistance than families of youth in care. None of the participants had been asked for their feedback in any form, all stated they would like to participate in the system but had never been asked, but also noted that only their therapist seemed to hear them. There seems to be a general lack of awareness about the crisis continuum of care.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. QIC reviews several data sets in aggregate for Spanish speakers. This seems particularly important considering goals around improved Latino/Hispanic PRs and to monitor equitable access for those who require translation. (Access, Quality)

2. The MHP's PRs are higher than statewide rates for all age categories and foster youth, indicating greater service accessibility. Regarding IHBS and ICC services for youth, the MHP's PRs and the approved claims per member are more than statewide and other medium-size counties. This seems indicative that those services are provided more frequently and in higher quantity per individual member. Also, the MHP has members receiving therapeutic FC and has begun tracking IHBS, ICC, and TBS as specific service data in the QIC. (Access, Quality)

3. There is a robust service for youth in Juvenile Hall and the associated Coastal Valley Academy, including dedicated therapists, one therapist dedicated to Spanish-speaking youth in detention, and medication services via telehealth. This service also helps bridge into outpatient services efficiently for youth exiting detention. (Access, Quality)

4. The MHP has counselors placed in all but one middle school, and in many elementary and high schools. In some cases, services are provided at the school during school hours to reduce transit needs or other barriers to care access. Screening, referrals into SMHS or non-SMHS, and assessment including the CANS can be provided within the schools. (Access, Timeliness)

5. There is a growing host of services co-located at the San Luis Obispo clinic location where the Genoa Pharmacy just opened, and the sobering center is planned in addition to existing outpatient services. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. As mentioned within this report, the MHP does not have a LOC nor an outcome measure for adults. Further, these tools are not yet named for integration within the new EHR. The MHP is collecting CANS data, and this aggregate reporting may be more quickly available in the new system, so it seems reasonable to

begin by monitoring LOC and/or outcomes within the youth member population. (Quality)

2. Many of the recommendations in previous reports have had to do with improved timeliness data collection, reporting, monitoring, and/or using to inform decisions and asking that this practice be expanded to contract agencies as well. Many of these difficulties have been attributed to limitations in the previous EHR. This year significant errors are seen in the ATA submission, and contract provider data was missing from all metrics except for follow up after psychiatric hospitalization. Now that the MHP and many of its outpatient contractors will use the same tools, this area can be successfully addressed. (Timeliness, Quality, IS)
3. The MHP did not address the recommendation regarding tracking, trending, and improving continuity of access between initial assessment and first follow-up. Further, despite reports that timeliness has recently improved, members reported a sense of waiting long to enter care, that this was the norm for both adult and youth programs. Members likely define this experience differently than the way data will be or have been measured. The MHP is additionally being asked to consider the experience of the member when defining access data collection and reporting. (Timeliness)
4. Last review, the MHP was recommended to maintain two PIPs, staff them adequately, and dedicate resources to these projects. At that time, both previous year PIPs had been terminated due to lack of resources. This year, two PIPs were active but one was completed with limited data analysis and stakeholder involvement, mostly managed by one member of QST who resigned shortly after the review. The lack of broad involvement from the system poses challenges for sustainability when any staff depart. (Quality)
5. The MHP reported no requirement for changing system passwords on a regular basis which is a security risk to the organization and ultimately a confidentiality risk for members. (IS)

RECOMMENDATIONS

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

1. Establish a formal LOC and/or an outcome measure for adults and plan to monitor this data aggregately. Depending on which is initially availability in SmartCare, an alternate option would be tracking and trending CANS data aggregately. (Quality)
2. Improve accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of SmartCare tools and/or other developed methods. (Timeliness)

   (This recommendation was continued from FY 2022-23.)

3. In compliance with BHIN 23-041 and No Wrong Door, create policies and workflows to address first follow-up within 10 business days of the initial appointment. Begin to track performance to support not just accurate timeliness data, but also a report of a timely access experience from members. (Access, Timeliness)

   (This recommendation was continued from FY 2022-23 with updated language.)

4. Ensure two active PIPs throughout the year, one clinical and one nonclinical, with clearly established and regular data collection and involvement of key project partners throughout the process to promote sustainability. (Quality)

   (This recommendation was continued from FY 2022-23 with updated language.)

5. Develop and implement a password update policy that strengthens the prevention of cyber threats and further protects data stored on MHP networks. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – San Luis Obispo MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Primary and Specialty Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Executive Leadership
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Heather Claibourn, LCSW, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Walter Shwe, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Adoptante	Dana	BH Information Supervisor	San Luis Obispo BH Department (SLOBHD)
Alvarez	Meghan-Boaz	Clinical Director	Transitions-MH Association (TMHA)
Archer	Michelle	BH Information Supervisor	SLOBHD
Atwell	Angela	MH Nurse	SLOBHD
Autry	Traci	Administrator	Wilshire
Barnett	Cyndi	Chief Clinical Officer	Family Care Network
Beardsley	Megan	BH Program Supervisor	SLOBHD
Bolster-White	Jill	Executive Director	TMHA
Brannen (Fraser)	Alexis	BH Program Supervisor	SLOBHD
Burns	Kellie	Department Administrator	San Luis Obispo Health Agency
Cabrera	Juan	Service Enhancement Team	TMHA
Cantu	Humberto	BH Program Supervisor	SLOBHD
Carlotti	Stephanie	Service Enhancement Team	TMHA
Castaneda	Susana	BH Specialist	SLOBHD
Crippen	John	Service Enhancement Team	TMHA
Culbert (Poe)	Mandee	BH Program Supervisor	SLOBHD
Curtis	Jeffrey	Executive Director	Pinnacle Treatment
Dabill	Jesse	Information Technology Manager	San Luis Obispo Health Agency
Drews	Nicholas	Health Agency Director	San Luis Obispo Health Agency
Elliott	Jeffrey	BH Clinician	SLOBHD
Ellis	Patrick	Service Enhancement Team	Seneca

Last Name	First Name	Position	County or Contracted Agency
Epps	Sara	Administrative Services Officer	SLOBHD
Ewen	Lynley	BH Program Supervisor	SLOBHD
Feliciano	Katrina	Administrative Services Officer	SLOBHD
Ferries	Morgan	Service Enhancement Team	TMHA
Figueroa	Alexiis	BH Clinician	SLOBHD
Forgette	Gina	BH Program Supervisor	SLOBHD
George	Tony	Service Enhancement Team	Family Care Network
Getten	Amanda	Division Manager	SLOBHD
Gifford	Melisha	BH Clinician	SLOBHD
Graber	Starlene	BH Director	SLOBHD
Grimes	Kathryn	BH Specialist	SLOBHD
Hansen	Carrie	BH Program Supervisor	SLOBHD
Hardisty	Sara	BH Clinician	SLOBHD
Harris	Andrew	Administrative Services Officer	SLOBHD
Hernandez	Alexandra	BH Clinician	SLOBHD
Hoffman	Christine	BH Program Supervisor	SLOBHD
Huffaker	Anthony	BH Program Supervisor	SLOBHD
Jensen-Best	Shannon	BH Clinician	SLOBHD
Johnson	Molly	BH Clinician	SLOBHD

Last Name	First Name	Position	County or Contracted Agency
Johnson	Barry	Division Manager	TMHA
Klever	Brooke	Service Enhancement Team	TMHA
Koenig	Rachael	Administrative Services Manager	San Luis Obispo Health Agency
Lehman	Tina	Program Director	Seneca
Levenson	Barbara	Consumer/Peer	Behavioral Health Board
Limon	Enrique	Program Manager	SLOBHD
Maxwell	Kevin	Licensed Psychiatric Technician/Nurse	SLOBHD
McGuire	Kathy	Program Manager	SLOBHD
McNamara	Gwen	Service Enhancement Team	TMHA
Mendez	Lisa	Accountant III	San Luis Obispo Health Agency
Mendoza	Gricel	BH Clinician	SLOBHD
Mendoza	CeCe	Program Director	Seneca
Mineta	Lauryn	Service Enhancement Team	TMHA
Morgan	Molly	Business Systems Analyst II	San Luis Obispo Health Agency
Munoz	Claudia	BH Clinician	SLOBHD
Myers	Sean	Licensed Psychiatric Technician/Nurse II	SLOBHD
Nibbio	Jon	Chief Operating Officer & Director of Clinical Services	Family Care Network
Olson	Carlos	BH Program Supervisor	SLOBHD

Last Name	First Name	Position	County or Contracted Agency
Paramore	Kristina	Division Manager BH	SLOBHD
Parker	Samantha	BH Program Supervisor	SLOBHD
Pemberton	Teresa	Division Manager BH	SLOBHD
Peters	Josh	Division Manager BH	SLOBHD
Puri	Siddarth	Interim Medical Director	SLOBHD
Rajlal	Christina	Division Manager	SLOBHD
Rietjens	Jill	Division Manager BH	SLOBHD
Robella	Tina	Accountant III	San Luis Obispo Health Agency
Rogers	Robert	Service Enhancement Team	Family Care Network
Salmon	Breanne	BH Program Supervisor	SLOBHD
Savage	Alexandra	BH Clinician	SLOBHD
Schmidt	Julianne	BH Program Supervisor	SLOBHD
Scott	Jean	Administrative Services Officer	SLOBHD
Selby	August	Licensed Psychiatric Technician/Nurse II	SLOBHD
Shakespeare	Bethany	Regional Manager	Sierra Mental Wellness Group
Shinglot	Jalpa	Accountant III	San Luis Obispo Health Agency
Silva-Garcia	Karina	BH Program Manager	SLOBHD
Snyder-Pennon	Matthew	BH Program Manager	SLOBHD
Soares	Traci	Administrator	Wilshire

Last Name	First Name	Position	County or Contracted Agency
Sommers	Allison	BH Program Supervisor	SLOBHD
Soul	Vivien	Service Enhancement Team	TMHA
Thomas	Gregory	Interim Medical Director	SLOBHD
Velasquez	Maria	Service Enhancement Team	TMHA
Ventresca	Kristin	Assistant Health Agency Director	San Luis Obispo Health Agency
Vierra	Allie	BH Clinician	SLOBHD
Wakefield	Cynthia	BH Clinician	SLOBHD
Wallace	Alessia	BH Program Supervisor	SLOBHD
Warren	Frank	Deputy Director	SLOBHD
Weissman	Jennifer	BH Clinician	SLOBHD
Woodbury	Joshua	BH Program Supervisor	SLOBHD
Wortley	Sandy	CSU Nursing Supervisor	Sierra Mental Wellness Group
Yarnold	Katelyn	BH Clinician	SLOBHD

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	This PIP has a wonderful intention and clear, yet understated, impact for the 0-5 years member population. It was improved from no confidence to moderate confidence after TA in the PIP review session. This PIP is planned to continue another year, which may give time to enhance the clinical aspects of the PIP and collect change in member satisfaction. PMs should be more concise and consistent, and the clinical nature should be enhanced.
General PIP Information	
MHP/DMC-ODS Name: County of San Luis Obispo Behavioral Health	
PIP Title: Martha's Place Fast Improved Access	
PIP Aim Statement: "The goal of this PIP is to improve MH access to birth through 5-year-old beneficiaries within a timely manner, within the next fiscal year (23/24) by reducing wait times to beneficiaries first service provided by a clinician to ten business days or sooner."	
Date Started: 03/2023	
Date Completed: Ongoing	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Martha's Place serves ages 0-5 years.	

General PIP Information
Target population description, such as specific diagnosis (please specify): Medi-Cal beneficiaries ages Birth through five years old, who are referred, but waiting to receive an MH assessment at Martha's Place.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Case management prior to assessment and addressing social determinates of health early in care.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Use of the CalAIM Youth Screening Tool and implementation of documentation reform.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Referral processing moved from the clinic to the access line and QST Managed Care, and dedicated assessment staff assigned.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of referrals receiving timely service. Goal: 90% of all inquiries are scheduled for a CM session within 10 business days.	Q1 Q2 2023	0% of all inquiries were receiving a session within 10 business days	Aug 2023-Jan 2024	100% Average 5 referrals per month and all received case management under 10 business days.	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical significance analysis.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number receiving screening tool.	Q1 Q2 2023	0 Martha's Place referrals were using screening tool.	Aug 2023-Jan 2024	100%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical significance analysis.

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- Add the goal to the aim statement.
- Capture the actual counts as intended for the PMs listed, showing more concise and measurable results. Be sure planned measures match the summary table and throughout the development tool.
- Enhance the clinical aspects of this clinical PIP. Perhaps apply a measure to capture changes in enrollee satisfaction or experience of care, those who received inconsistent support and a long wait versus the experience of those after the interventions were applied.
- It seems this PIP is coming to a completion stage; include discussion of the results on Worksheet 9 and the plan moving ahead.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The project itself changed significantly between the proposal and the September 2023 report and could benefit from an organized discussion of its evolution. There is no evidence of repeated measures since August 2023. The PIP could benefit from clearly outlined results perhaps using table 8.1 from the PIP Development Tool.
General PIP Information	
MHP/DMC-ODS Name: County of San Luis Obispo Behavioral Health Department	
PIP Title: Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up MH services with the MHP within 7 and 30 days by 5% by June 30, 2024."	
Date Started: 10/2022	
Date Completed: Ongoing	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All Medi-Cal members who present at one of the three Dignity Hospital EDs with behavioral health concerns.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Outreach for those Medi-Cal members who present at ED with MH concerns and are not open. Follow-up efforts improved for those who are open members of the MHP already.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Notifications to clinicians after their client has been in the ED as defined by the PIP. Collection and provision of the associated medical records.						
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Monthly meetings with Dignity Hospital, weekly reporting of members in the ED, efforts toward timely and closed-loop referrals.						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	**Baseline year**	**Baseline sample size and rate**	**Most recent remeasurement year (if applicable)**	**Most recent remeasurement sample size and rate (if applicable)**	**Demonstrated performance improvement (Yes/No)**	**Statistically significant change in performance (Yes/No) Specify P-value**
Percentage of SLO County Medi-Cal beneficiaries who present in an ED due to MH needs that receive a follow up outpatient service within 30 days.	2021	FUM 30 68%	7/9/23-8/25/23	14/29 48.3%	☐ Yes ☒ No	☐ Yes ☐ No Not Provided Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical significance analysis.
Percentage of beneficiaries referred to SLOBHD after presenting at an ED due to MH needs who receive the outreach interventions post-ED discharge.	Not Provided	Not Provided	7/9/23-8/25/23	28/29 96.6%	☒ Yes ☐ No	☐ Yes ☐ No Not Provided Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No statistical significance analysis.

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Consider utilizing the PIP Development Tool to organize the FUM efforts as a cohesive PIP and to convey changes made for rapid cycle improvements and to increase feasibility of the project. For example, the aim statement should be updated since 7-day measures are not currently possible and are not included in this PIP. • Provide data results up to the time of the review to evidence PIP as active. Consider utilizing PIP Development Tool table 8.1 to help present the baseline and results. Routine data collection appears to have stopped late August 2023. • Provide an organized discussion of factors that may impact the data quality or validity of the PIP as it stands now, including the EHR change, inability to measure 7-day follow up due to weekly reporting, loss of staff who were tracking these measures, or other factors associated with data collection. • Consider the use of the August 2023 data as your baseline and report on the remeasurement phase.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.