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FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

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

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

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the San Diego MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Southern

MHP Location — San Diego

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 37,692

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

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The Caregiver Engagement clinical PIP requires the application of an intervention that will directly impact the caregiver engagement problem to achieve active status.

Status: Met

- There were two interventions implemented for the Caregiver Engagement PIP. The first was the Motivational Enhancement for Engagement in Therapy (MEET) training, where two cohorts of a total of 59 staff from outpatient clinics came up with implementation plans based on MEET interventions.
- This PIP is scheduled to end in Spring 2020.
- The PIP has been demonstrating positive and potentially generalizable findings.

Recommendation 2: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The

non-clinical PIP requires the development and routine application of an intervention that is likely to impact beneficiary abandonment of treatment to attain active status.

Status: Met

- The intervention for the non-clinical PIP was the implementation of a contact protocol to reduce the number of clients who do not return.
- The Non-clinical PIP was almost complete at the time of the CalEQRO review.
- The PIP was promising and demonstrated progress with regard to re-engaging clients and decreasing the rate of clients who did not return to service.

Access Recommendations

Recommendation 3: When performing system redesign or adding new program elements or rebidding contract program elements, consider a process that seeks to locate all levels of care in close proximity. This will ease transitions in levels of care and provide easier access to resources. For some review informants, this takes the form of requesting one-stop locations be created for all health, mental health, SUD, and human services assistance sites. This is a long-term, strategic planning issue and not included in recommendations for this current review and coming year.

Status: Met

- The MHP has begun planning and development of Behavioral Health Services (BHS) hubs in different regions in the county. The behavioral health “hub and network” approach is identified as a model that can enable a shift from a crisis care system to a continuous and chronic care management system, through the deliberate regional distribution and coordination of resources.
- Key components of hubs include co-location and affiliation with a general acute care hospital; access to inpatient acute psychiatric care; and linkages to lower levels of care through a regional care coordination system. Networks, in turn, provide a broad array of behavioral health outpatient services and housing opportunities, also linked through a regional care coordination system, designed to remain continuously connected to service recipients.

Recommendation 4: Continue to explore innovations to the transportation issue that presents a barrier to care, particularly targeting the issue of short-notice transport needs which cannot be met by physical health plan transport services.

Status: Met

- BHS has worked to identify available and existing program contractual options to address clients’ short notice transport needs including tokens, bus passes, use of leased vehicles, ride sharing, and other means.

- The MHP is also providing additional direction on utilization of telepsychiatry and telehealth services, when appropriate.

Recommendation 5: Develop a liaison with special needs beneficiary groups, including the hearing impaired, to ensure they are aware of opportunities to participate in MHP public planning activities, and that their interpretive needs will be met.

Status: Met

- The MHP regularly engages the community in the planning process through System of Care (SOC) councils, advisory board meetings, focus groups, and by conducting a series of formal community engagement forums in each county region.
- Focused outreach efforts for the underserved are made and interpreter services are routinely provided to ensure that all stakeholders can participate.
- In addition, the MHP collaborates with Deaf Community Services to ensure the hearing-impaired community has access to translation services; individual and family therapy; crisis intervention services; co-occurring disorder treatment; and support groups.

Timeliness Recommendations

Recommendation 6: Obtain feedback from program line staff that assists in identifying how the initial timeliness data compares to the actual experience of access to care for beneficiaries.

Status: Partially Met

- The MHP has taken steps towards obtaining this feedback. The MHP's Adult and Older Adult (AOA) SOC is currently reviewing proposals to survey program staff on their experience of access to care for beneficiaries.
- Another option being considered is to include a supplemental question about timeliness and clients' access to care in the 2020 survey period for the biennial Promoting Cultural Diversity Self-Assessment (PCDSA) program staff survey.
- During the past year, efforts have also been made to remind program staff regarding the correct use of the Access to Services Journal log to ensure data entered is accurate and reflective of the beneficiary experience.

Recommendation 7: Identify remedies that would improve the access experience and alignment with beneficiary experiences, including the extent to which colocation of service levels and/or establishing separate regional walk-in services would be of help.

Status: Partially Met

- The MHP is in the process of fully addressing this recommendation. They have added a supplemental question in the Fall 2019 Consumer Perception Survey

(CPS) to gather data on barriers to accessing care. The survey was conducted in November and results will be analyzed to identify possible areas of intervention to improve access and align with the clients' experiences. Results are expected in May 2020 and will be used in conjunction with current Continuum of Care initiatives.

Recommendation 8: Study the adult rehospitalization data (22.8 percent), by hospital, outpatient region of residence, race and ethnicity, and other relevant elements, to identify interventions under the MHP's influence.

Status: Partially Met

- The MHP is in the process of fully addressing this recommendation. The MHP has developed a one-page report that breaks down readmission by hospital, region, race/ethnicity, and other relevant elements such as client disposition, living arrangement, primary diagnosis, dual diagnosis, and veteran status that could contribute to a pattern of rehospitalization. This information is to be used to determine any trends that could be addressed. The analysis is still in process.

- BHS has also been examining local inpatient rates and a potential incentive rate structure that would support improved client outcomes, such as a reduction in rehospitalizations.

Quality Recommendations

Recommendation 9: Analyze nursing staff turnover data to identify and propose solutions to address hospital staff retention. (*This recommendation is a partial carry-over from FY 2017-18.*)

Status: Met

- The study has been conducted, but the MHP did not have current turnover rates to compare to ascertain if rates have declined.

- Nursing vacancies and nurse-to-patient ratio regulatory requirements are being addressed at the San Diego County Psychiatric Hospital (SDCPH) by establishing a continuous recruitment with dual fill authority for RN and supervisor positions to assist with the timing of staff vacancies.

- In the past year salary increases were also implemented as a recruitment and retention strategy.

Recommendation 10: Investigate and analyze the Mental Health Services (MHS) category Approved Claims per Beneficiary (ACB) by age groups to assess if Adult/Older Adult (AOA) or Child, Youth and Family (CYF) are differentially impacted by this low MHS ACB phenomena. A pilot effort at one or two large sites would be an appropriate scope initially. (*This recommendation is a modified carry-over from FY 2017-18.*)

Status: Partially Met

- The MHP analyzed DHCS data to compare ACB figures for San Diego County with other large counties and the statewide average and looked at AOA and CY separately.

- As DHCS data only reflects Medi-Cal costs, the MHP is currently developing a report that containing the total costs that includes Medi-Cal, Mental Health Services Act (MHSA), and County funded dollars for San Diego County beneficiaries. This report will allow for analysis of full cost per beneficiary by client demographic groups and program level of care.

- To also aid in future analysis, the MHP is now utilizing Board Financial Management System, a cloud-based, multi-dimensional database that gets daily uploads from Oracle. It can provide actual and projected annual contract expenditures that can be leveraged when utilizing client encounter data as well.

Recommendation 11: Assess the subject matter of Responsive Integrated Health Solutions (RIHS) digital training to determine which topics would logically require a secondary, in-vivo higher level of training. A topic identified in this review is the training to support medical necessity documentation for complex care conditions, which was related to the CYF population initially.

Status: Met

- The MHP's Behavioral Health Services Training and Education Committee (BHSTEC) is involved in identifying topics that require secondary, in-vivo, higher level of training. This committee is co-chaired by the Chief of the Clinical Director's Office and the Program Manager from RIHS. Additional members include representation from AOA, CYF, Quality Improvement (QI), Prevention and Planning Unit (PPU), and the Knowledge Center.

- RIHS also has a curriculum committee that is responsible for ensuring the appropriate method and format of trainings to be provided, based on the audience, the scope of the topic, any evidence-based requirements, etc. Additionally, these committees review training participant feedback that may indicate a need for secondary, higher level training.

- During the past year, there was an identified need for enhanced in-vivo training for programs who serve justice involved clients. As a result, RIHS implemented a Justice Involved Services Training Academy, where multiple sessions were developed to guide participants through best practices when working with this population.

Recommendation 12: Pilot decentralized, regional clinical and compliance trainings to determine if effectiveness and attendance are improved when travel requirements are reduced and direct conversations are possible. The MHP may also wish to incorporate the development of examples to further improve comprehension of the changes.

Status: Met

- A pilot WebEx-based training on system of care chart documentation was conducted for a North County provider in December 2019 to determine effectiveness, technological impacts and attendance rate. To ensure comprehension of training topics, a multiple-choice posttest was developed and a score of at least 90% was required to pass and receive a certificate of attendance.

- Due to the success of this pilot, QM will be offering a documentation training via WebEx once per quarter beginning in 2020. This live documentation training allows providers to have the same experience as attending an in-person training without the required travel time based on location.

- Attendance and posttest pass rates will be monitored to determine if any potential changes are indicated.

Beneficiary Outcomes Recommendations

Recommendation 13: Continue efforts to expedite the development of a diverse process for the inclusion of individuals with lived experience in the workforce.

Status: Met

- The BHS Workforce Strategic Plan draft was developed during the past year and includes integration of individuals with lived experience in the workforce. The plan states the need to prioritize recruitment efforts towards staff vacancy needs and future network expansion, including the use of Peer Specialists. The plan also states the need to focus recruitment to improve workforce diversity.

- The BH Workforce Collaborative (formerly known as the Workforce Education and Training Collaborative) also serves as an advisory body on behavioral health workforce. The Collaborative ensures that the following five essential elements are incorporated into workforce development: community oriented; culturally responsive; person and family centered; wellness driven; recovery, resilience and whole person focused.

- In the past year this subcommittee created a stress and burnout survey to pilot in an effort to develop/tailor tools and resources to assist peer support specialist and family support partners to succeed.

Foster Care Recommendations

Recommendation 14: Track and report the FC average length of time from first request for service to first offered clinical appointment.

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

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

Status: Met

- The MHP has developed reports that include timeliness tracking capacity for FC average length of time from first request for service to first offered clinical appointment, from first request for psychiatry service to first offered appointment, and from request for urgent appointment to actual encounter.

Recommendation 15: Develop reporting for SB 1291 FC Healthcare Effectiveness Data and Information Set (HEDIS) measures and consider incorporating JV220 oversight process and direct chart review so that FC results are disaggregated from the other medication monitoring results.

Status: Met

- The MHP continues to require program medication monitoring activities each quarter, and tracks variances reported related to SB 1291 HEDIS measures to address potential concerns with individual programs.

- The MHP currently hosts the Psychotropic Medication Monitoring meeting quarterly. This meeting includes participants from Behavioral Health Services - Children Youth and Families, Child Welfare Services, Public Health Services and Medical Care Services in a collaborative effort to review and discuss JV-220 and SB1291 HEDIS outcomes data.

- Originally San Diego County Behavioral Health Services (SDCBHS) completed the quarterly report of clients receiving medications with an active JV-220. However, earlier this year, the team of nurses at Public Health Services took over reporting requirements as they now review and follow up on every case of a client receiving psychotropic medication without an active JV-220.

Recommendation 16: Study the post-hospital follow-up process for FC and determine if there are factors that have occurred that have created lower rates than other populations.

Status: Partially Met

- In an effort to better understand the unique needs of the FC population when discharging from inpatient (IP) hospitalization, the MHP is working to produce a variant of the existing Service After IP Discharge Report (CO-20) that reflects connection rates specifically for the foster care population.

- Additional foster care specific reports related to inpatient days and crisis stabilization encounters are also being developed to track and monitor foster care emergency service utilization.

Information Systems Recommendations

Recommendation 17: Identify specific Cerner Millennium (CM) workgroup members and area of responsibilities for the following roles: Overall Project Director, Technology Project Director/Manager, and Clinical Project Director/Manager.

Status: Met

- The MHP identified CM team members and area of responsibilities for the five requested positions.
- The MHP provided a summary charter of the EHR upgrade project organizational structure that identifies 50 or so positions, with staff names, and their area of responsibility currently assigned to the CM project.

Recommendation 18: Identify and assign staff, from both contract and county programs, who possess clinical operations and documentation expertise to core workgroups. Provide structure for workgroups that includes: scope of work, objectives, and workgroup end date.

Status: Met

- Since the prior year CalEQRO review, San Diego Health and Human Services Agency leadership re-prioritized the CM project. The overall CM project includes four distinct phases (roadmaps) to stand up CM for the agency. Revised roadmap implementation priorities are as follows:
    - The county psychiatric hospital roadmap plans to go-live in June 2020 with a 14-month timeline to achieve ready for use status.
    - The mental health outpatient services roadmap tentatively plans to go-live beginning Fall 2020 with an 18-month timeline to complete ready for use.
    - The roadmap for Edgemoor long-term care is still to be determined.
    - The medical records roadmap is still to be determined.

Recommendation 19: Document and publish CM project Charter Plan that identifies and outlines scope of work, objectives, communications plan, and tasks timelines.

Status: Partially Met

- No information was shared with CalEQRO to indicate the degree to which the CM project charter has been documented and shared with stakeholders to support the mental health outpatient service roadmap.
- The EHR upgrade project organizational structure summary charter identifies the Project Steering Committee members and Escalation Advisors, who, along with Project Director, who are responsible for program leadership, governance and planning, hospital leadership communications, resource scheduling, decisions affecting multiple deployments, and issue escalation.

- The summary charter also identifies subject matter expert leads for clinical, integration, and technical operations to support decision-making, communications, integration, and system interface activities.

Recommendation 20: Develop CM communications plan to inform stakeholders of CM developments and key project milestones, recognizing the variety and diversity of those who serve the various target populations may have divergent needs.

Status: Met

- The San Diego Health and Human Services Agency leadership re-prioritized the CM mental health outpatient services roadmap. See Recommendation 18 for details.
- As a result, the Mental Health Outpatient Services roadmap was delayed to accommodate the implementation of the Psychiatric Hospital roadmap. The anticipated timeframe to resume the roadmap is Fall 2020, at which time the MHP plans to address communication strategies for contract provider agencies.

Recommendation 21: Create a social media application or secure website to share information and inform stakeholders of developments and key milestones.

Status: Met

- Historically the MHP relied on the Network of Care (NOC) website to provide online information for individuals, families, and agencies concerned with health and wellness. The NOC website was hosted by a private organization, not associated with San Diego County.
- The MHP successfully migrated all content and pages from the NOC website to the MHP website. They are in the process to rolling out a replacement, GovDelivery, a content notification service. GovDelivery is an email communication management system hosted on the San Diego website that allows system providers and members of the public to directly subscribe to receive relevant and timely notification and announcements from the MHP. GovDelivery is scheduled to launch in early 2020.

Structure and Operations Recommendations

Recommendation 22: For the CM EHR implementation, recruit contractor representatives who are knowledgeable of EHR operations, from a contract organizational provider perspective, to participate in workgroups.

Status: Met

- The recommendation was never viable for CM project. In addition, there are two other similar-theme recommendations 18 and 20 already.

PERFORMANCE MEASUREMENT

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

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

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

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

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

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

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

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity San Diego MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	177,485	20.1%	11,856	31.5%
Latino/Hispanic	380,301	43.0%	11,231	29.8%
African-American	52,970	6.0%	3,436	9.1%
Asian/Pacific Islander	72,501	8.2%	1,836	4.9%
Native American	3,776	0.4%	286	0.8%
Other	196,549	22.2%	9,047	24.0%
Total	**883,580**	**100%**	**37,692**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

- During CY 2018 the MHP experienced claim submission delays that resulted in a significant number of December services not being included in the analysis below for CY 2018 results that resulted in under-reporting of penetration rates (PR) and ACB data for Figures 1-3 and Tables 2 and 3.

Penetration Rates and Approved Claims per Beneficiary

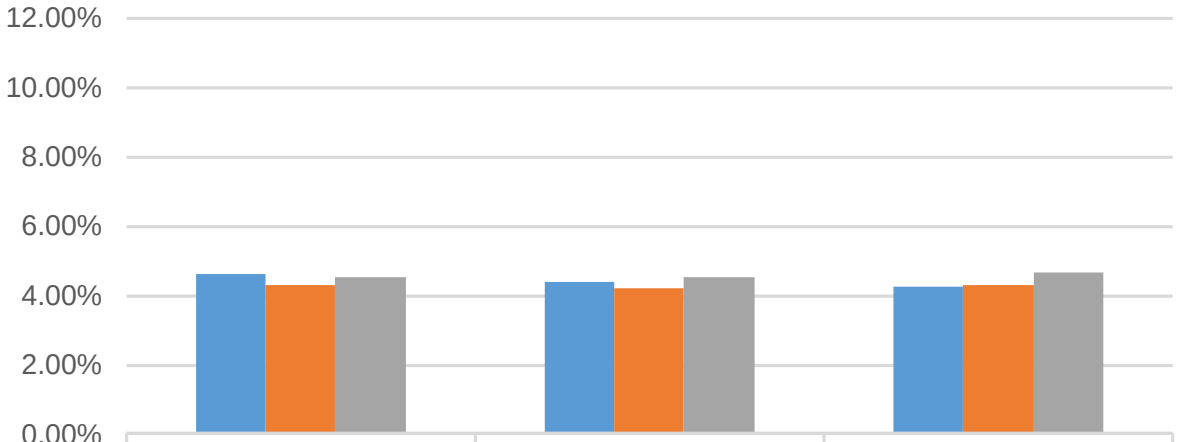
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the San Diego MHP uses a different method than that used by CalEQRO.uses a different method than that used by CalEQRO.

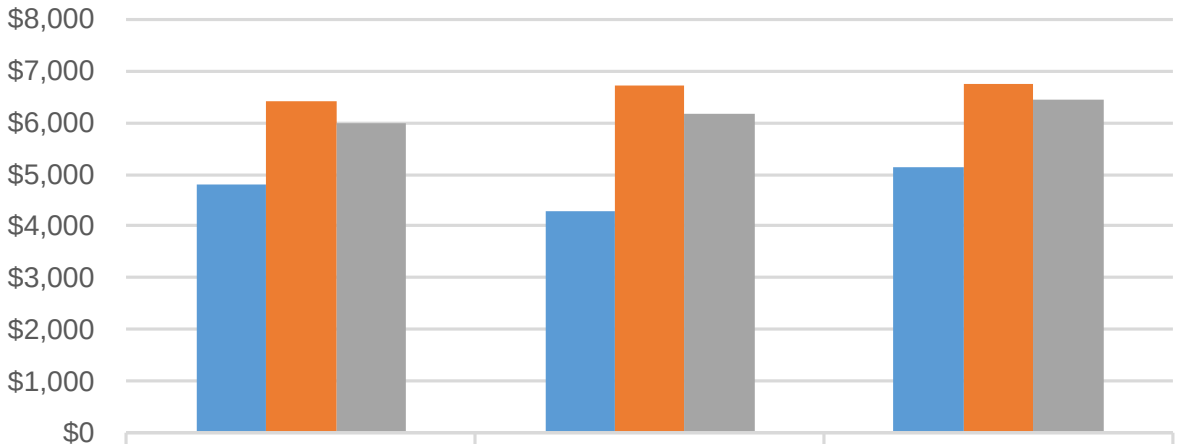
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for largelarge MHPs.

Figure 1A: Overall Penetration Rates
San Diego MHP



	CY 2016	CY 2017	CY 2018
MHP	4.63%	4.39%	4.27%
Large	4.30%	4.19%	4.31%
State	4.53%	4.52%	4.66%

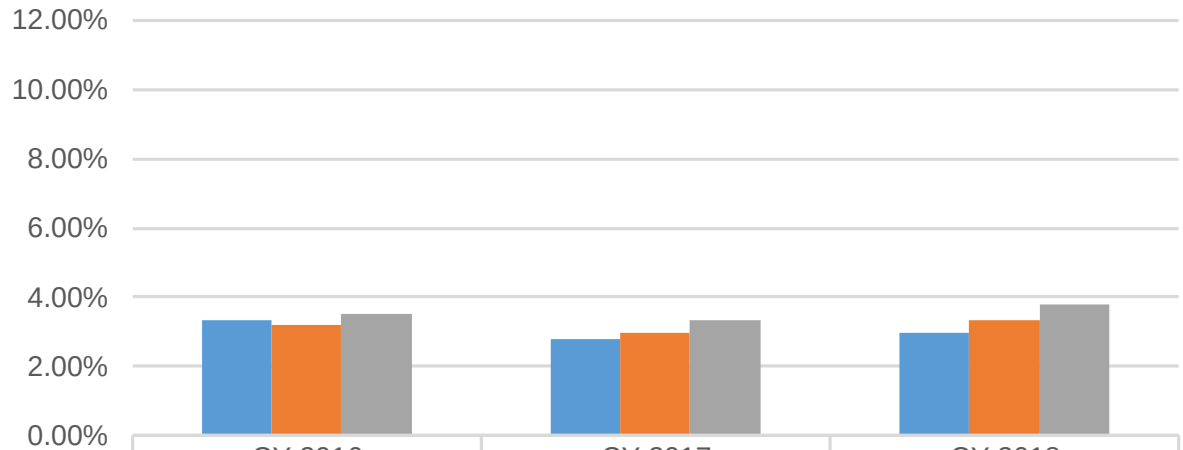
Figure 1B: Overall ACB
San Diego MHP



	CY 2016	CY 2017	CY 2018
MHP	$4,792	$4,302	$5,148
Large	$6,430	$6,723	$6,750
State	$5,978	$6,170	$6,454

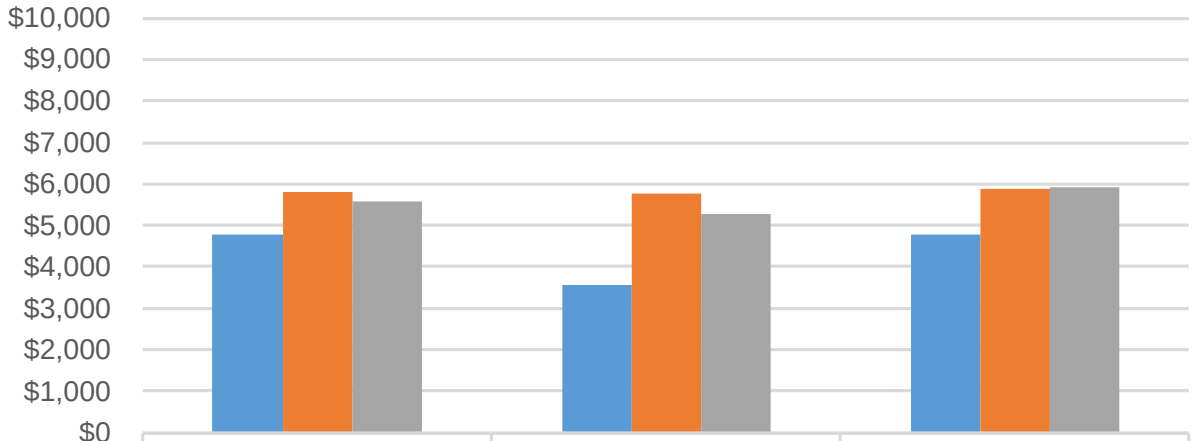
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for largelarge MHPs.

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



	CY 2016	CY 2017	CY 2018
MHP	3.31%	2.78%	2.95%
Large	3.21%	2.97%	3.33%
State	3.51%	3.35%	3.78%

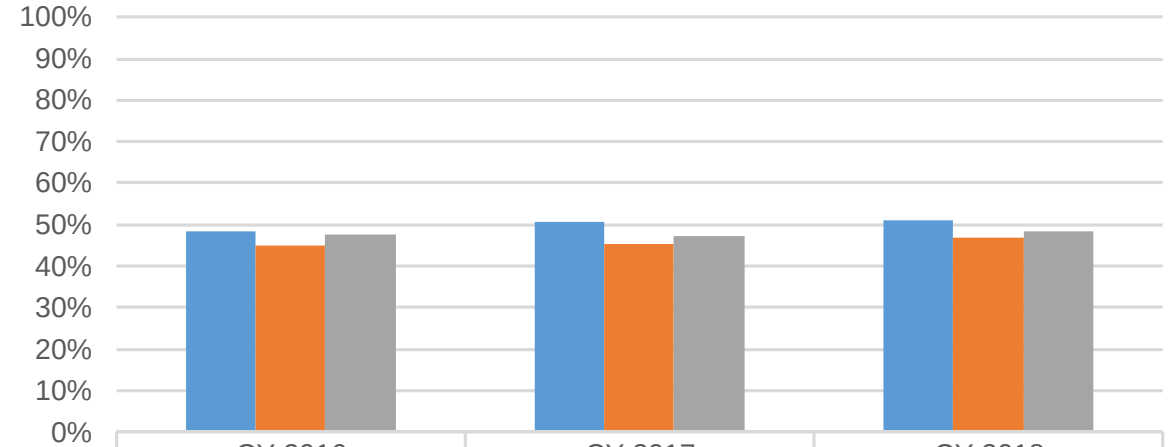
Figure 2B: Latino/Hispanic ACB
San Diego MHP



	CY 2016	CY 2017	CY 2018
MHP	$4,796	$3,547	$4,778
Large	$5,785	$5,758	$5,884
State	$5,588	$5,278	$5,904

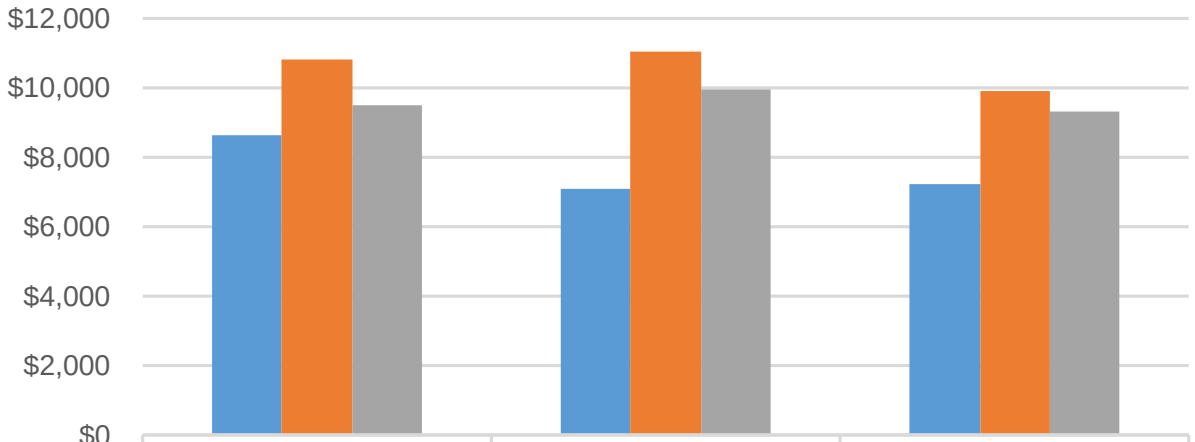
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for largelarge MHPs.

Figure 3A: FC Penetration Rates
San Diego MHP



	CY 2016	CY 2017	CY 2018
MHP	48.37%	50.83%	51.08%
Large	44.78%	45.37%	46.87%
State	47.48%	47.28%	48.41%

Figure 3B: FC ACB
San Diego MHP



	CY 2016	CY 2017	CY 2018
MHP	$8,627	$7,092	$7,235
Large	$10,805	$11,064	$9,895
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2: High-Cost Beneficiaries
San Diego MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	1,020	37,692	2.71%	$61,786	$63,022,096	32.48%
	CY 2017	746	39,759	1.88%	$48,281	$36,017,617	21.06%
	CY 2016	1,145	42,415	2.70%	$45,747	$52,380,137	25.77%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

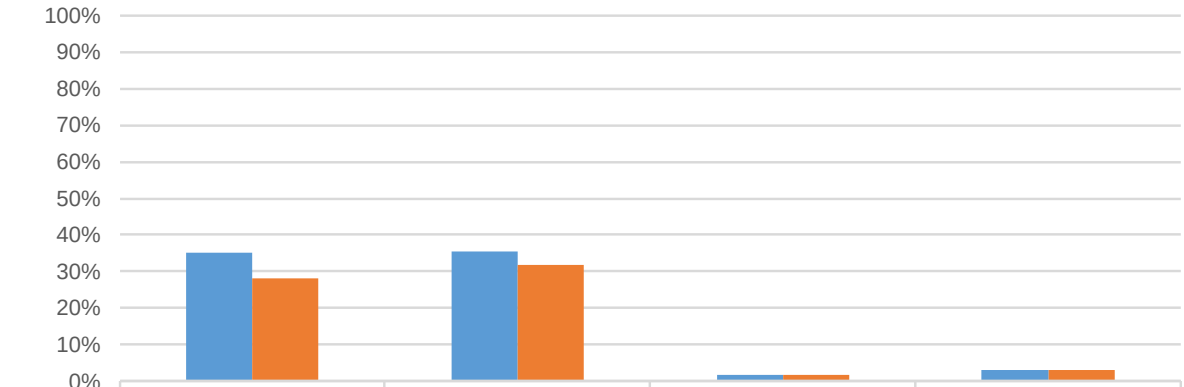
Table 3: Psychiatric Inpatient Utilization - San Diego MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	5,287	13,893	9.74	$12,801	$67,679,794
CY 2017	4,451	11,895	7.88	$8,194	$36,472,517
CY 2016	4,578	12,682	7.86	$7,534	$34,491,875

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

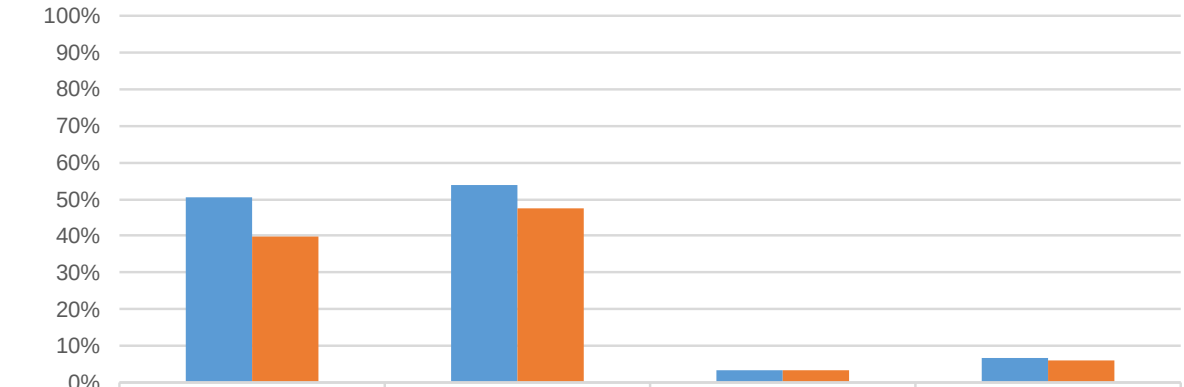
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	35%	36%	2%	3%
CY 2018	28%	32%	2%	3%

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



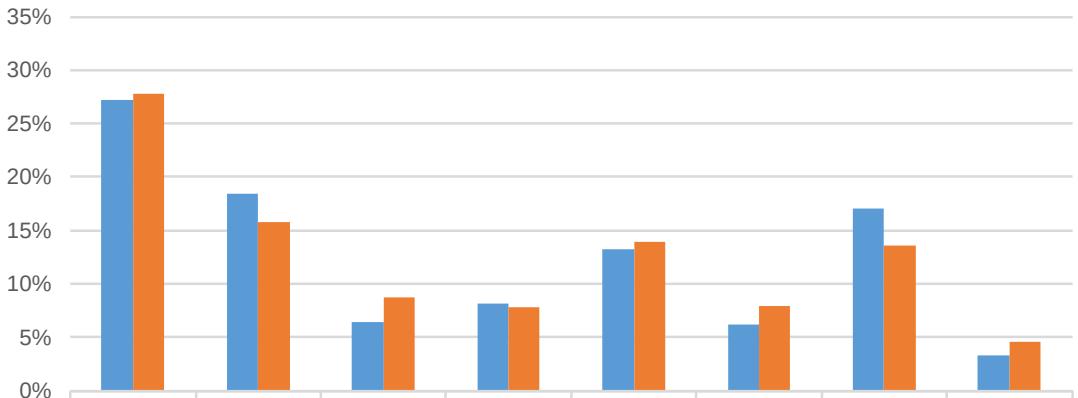
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	51%	54%	3%	7%
CY 2018	40%	48%	3%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

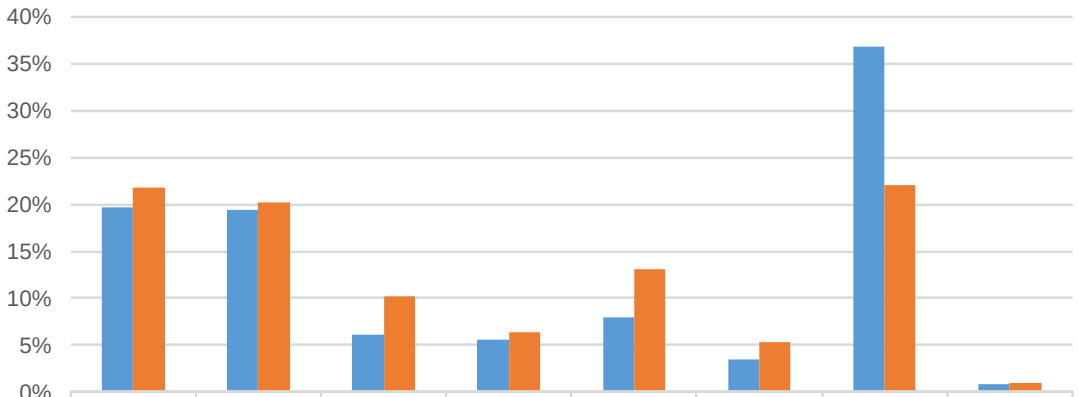
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: CYF 5.5, AOA 48.5 percent.

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	27%	18%	6%	8%	13%	6%	17%	3%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	20%	19%	6%	6%	8%	3%	37%	1%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

San Diego MHP PIPs Identified for Validation

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

Table 4 lists the PIPs that were submitted by the MHP.

Table 4: PIPs Submitted by San Diego MHP

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

Clinical PIP—Caregiver Engagement

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

“Will educating and providing strategies to the CYFBHS System on increasing caregiver participation in family therapy lead to increases in family participation and reductions in clients’ mental health symptoms?”

Date PIP began: 03/2018

Projected End date: 04/2020

Status of PIP: Active and ongoingActive and ongoing

The main goal of this PIP is to improve consumer outcomes by increasing the number of family therapy sessions for youth receiving outpatient services in the Children, Youth and Families Behavioral Health Services (CYFBHS) system. The PIP will attempt this by training CYFBHS providers on how to increase caregiver engagement in family therapy.

Suggestions to improve the PIP: The MHP designed the PIP in a manner that conformed with the CalEQRO outline. The MHP checked in with CalEQRO regularly since the last review. Feedback from CalEQRO that they had received in the prior year was taken and responded to appropriately. In particular, the MHP more clearly delineated the two training interventions as well as intentionally integrating them.

Some modifications in the study design were needed once a pilot had been completed. The MHP was aware of the limitations of the study interventions and adjusted appropriately. The fact that three programs did not have both pre and post data for all of the analyses impacts the internal validity of the outcomes. It is possible that the MEET training did not improve family therapy rates for youth with full treatment episodes or child clinical outcomes for these programs. However, these programs did have enough data for their analysis of whether the percent of family therapy sessions increased overall, and they did show improvements, so it is likely these improvements do extend to youth with full treatment episodes.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of a series for phone conversations to review progress and changes in the protocol. The MHP was responsive to suggestions throughout.

As this PIP is drawing to a close, more recent conversations with the MHP addressed future topics. It was emphasized that new PIP topics should be generated from local data that indicates a problem.

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

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

“Will a data-driven re-contact/re-engagement process result in:

1) A reduction in the number of clients who are discharged after not returning for services.

2) An increase in the number of clients who make a future appointment after successful re-contact.

3) A reduction of clients who are discharged as “did not return” who re-enter services through crisis or emergency levels of care?”

Date PIP began: 04/2018

Projected End date: 02/2020

Status of PIP: Active and ongoingActive and ongoing

The overarching goal of the PIP is to improve long term client care by investigating and addressing the discharge summary process, with a focus on reasons for outpatient clients not continuing services (discharge reason of “did not return”). Addressing these areas should decrease the proportion of outpatient clients who re-enter services through undesirable points of re-entry, such as crisis services or Psychiatric Emergency Response Team (PERT). The issues related to this problem will be explored through qualitative workgroups and a client survey. The information from these two data sources will be used to design a series of workshops that educate and inform program staff about the problem, and proposes applied solutions based on the information gathered through the activities described above.

Suggestions to improve the PIP: The MHP designed the PIP in a manner that conformed with the CalEQRO outline. The MHP checked in with CalEQRO regularly since the last review. Feedback from CalEQRO that they had received in the prior year was taken and responded to appropriately.

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

The TA provided to the MHP by CalEQRO consisted of a series for phone conversations to review progress and changes in the protocol. The MHP was responsive to suggestions throughout.

As this PIP is drawing to a close, more recent conversations with the MHP addressed future topics. It was emphasized that new PIP topics should be generated from local data that indicates a problem.

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

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M

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

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

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	22	18
Number Partially Met	3	7
Number Not Met	0	0
Unable to Determine	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**94%**	**86%**

INFORMATION SYSTEMS REVIEW

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

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

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations

	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
San Diego	8.40%	6.10%	5.80%	3.30%
Large MHP Size Group	N/A	2.70%	2.88%	2.72%
Statewide	N/A	3.40%	3.30%	3.40%

The budget determination process for information system operations is:

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

- The MHP reported 8.40 percent of annual budget is dedicated to support IT operations for FY 2019-20 (includes hardware, network, software license, and IT staff).

Table 8 shows the percentage of services provided by type of service provider.

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	6.33%
Contract providers	85.94%
Network providers	7.73%
Total	**100%***

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

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	100%	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	N/A	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	N/A	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	N/A	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	N/A	Not used
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	N/A	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of county-operated sites currently operational: 7
- Number of contract provider sub-unit sites currently operational: 108

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

☒ Hiring healthcare professional staff locally is difficult
☒ For linguistic capacity or expansion
☒ To serve outlying areas within the county
☒ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries

- Telehealth services are available with English, Spanish and Arabic speaking practitioners (not including the use of interpreters or language line).
- Approximately 109 telehealth sessions were conducted in Spanish and Arabic languages.
- To support expansion of programs that use telehealth services, the MHP provided implementation and billing guidance. Cerner Community Behavioral Health (CCBH) billing tables were updated to include necessary billing modifiers for Medi-Cal and Medicare/Medi-Cal beneficiaries who receive telehealth services.
- To monitor telehealth programs the MHP implemented an annual attestation statement to ensure appropriate levels of HIPAA compliance are in place.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	10	6	4	0
2018-19	9	4	3	2
2017-18	7	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	52.15	10.7	9.5	2.5
2018-19	53	9	6	0
2017-18	53	9	6	2

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

- Table 10 information reflects direct reports within the MHP organization chart. It does not include technology support services provided by County IT or external contractors, Cerner Corporation, or Optum San Diego staff members.
- Table 11 information includes Optum San Diego, UC San Diego – Child & Adolescent Service Research Center (CASRC), and AOA data analysis provided by UC San Diego Health Services Research Center (HSRC).
- To implement the CM project, four roadmaps were developed. San Diego Health and Human Services Agency (HHSA) designated five senior executives as the Project Steering Committee. The Behavioral Health Services Clinical Director is the one steering committee member; the remaining four members are HHSA executive level management positions responsible for other divisions.

Current Operations

- Cerner Data Center continues to host the CCBH EHR.
- The MHP is current with installation of CCBH vendor software updates. The current installed promotion is 230, which is required to proceed with transition to the Cerner Millennium product.
- The MHP continues to expand outpatient services delivered by their contract provider network. However, providers who also have local EHRs are required to do double data entry as there is no process to electronically transfer data from local EHRs to the CCBH system.
- During the past year, a data sharing process was established with four participating Health Plans (HP). Monthly, the MHP receives HP Cal Medi-Connect roster and identifies individuals who receive services by MHP system of care. A report is provided to each HP that indicates which services were provided to shared beneficiaries in order to ensure timely care coordination activities.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner Community Behavioral Health (CCBH)	Client Data and Managed Care	Cerner	11	CoSD
CCBH	Appointment Scheduling	Cerner	10	CoSD
CCBH	Clinical ATP – Assessments	Cerner	9	CoSD
CCBH	Clinical ATP - Client Plans and Progress Notes	Cerner	8	CoSD
CCBH	Doctor's Homepage e-Prescribing and Meds Management	Cerner	7	CoSD
Cerner Millennium (CM)	Hospital Inpatient	Cerner	8	CoSD
CM – CareTracker	Care Documentation	Cerner	7	CoSD
OnBase	Imaged Records	Hyland	5	CoSD

The MHP's Priorities for the Coming Year

- Implement San Diego County Psychiatric Hospital Millennium roadmap.
- Implement CCBH Millennium roadmap.
- Incorporate Cerner Millennium modules for interoperability with disparate provider systems.
- Implement, provide access, and monitor Millennium Patient Portal.
- Implement Edgemoor Hospital (post-acute care facility) Millennium roadmap.
- Special Projects (to monitor data integrity).

Major Changes since Prior Year

- Implemented San Diego Domain for Millennium roadmaps.
- Implemented Phase II Additional State CSI Requirements for Timeliness.

Other Areas for Improvement

- Two CM roadmaps will be implemented during FY 2020-21 (psychiatric hospital and outpatient mental health roadmaps) which overlap each other by almost 12 months. That will be a heavy lift as the roadmaps impact two disparate operations – hospital and outpatient mental health services which require different communication plans. The MHP has yet to share a communications strategy with outpatient mental health providers that uniquely addresses county-operated programs and contract provider agencies information sharing requirements.
- The MHP did not provide CalEQRO sufficient information regarding CM outpatient mental health services roadmap to assess the overall adequacy of dedicated resources to support the project, scheduled to start during Fall 2020. The discovery phase to determine dedicated resources had not yet begun prior to the CalEQRO visit and will be included in the 2020-21 report.
- The roll-out of the CM outpatient mental health roadmap will require training program for approximately 4,000 Millennium users who provide services at over 100 sites in the county. The MHP needs to consider strategies to minimize user-travel time as much as practical. Training strategies to consider include regional training classrooms, video training environment, web casting, and train-the-trainer model.

- San Diego Behavioral Health Services (BHS) is in the process of standing up two disparate EHR systems for outpatient mental health services and substance abuse services. To further improve data analytics and to monitor programs, BHS needs to develop a plan to implement Data Warehouse (DW) database that include clients demographic and clinical service data from both EHR systems to create a comprehensive dataset of behavioral health services. Most other large MHPs have previously implemented DW application which greatly improved the use and presentation of meaningful data.
- The Management Information Systems (MIS) Program Coordinator position currently reports to Quality Performance and Improvement Director, who reports to Assistant Director of Departmental Operations. Investigate the feasibility and benefits to reclassify MIS Program Coordinator to MIS manager level and have manager report directly to Assistant Director. For a large-size MHP to utilize a program coordinator level position to support IS operations in this ever-increasing use of data environment needs to be reassessed.
- The County of San Diego continues to work with San Diego Health Connect (SDHC) for an interface with Health Information Exchange (HIE) initiatives. The MHP needs a strong collaboration with SDHC to implement HIE projects after the CM system is live and stable.

Plans for Information Systems Change

- The MHP is migrating Cerner Community Behavioral Health into the larger Cerner Millennium application, and the implementation phase will begin in the Fall of 2020.

Current EHR Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	CCBH		X		
Assessments	CCBH	X			
Care Coordination	CCBH	X			
Document Imaging/ Storage	OnBase	X			
Electronic Signature—MHP Beneficiary	CCBH	X			

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Laboratory results (eLab)				X	
Level of Care/Level of Service	CCBH	X			
Outcomes	CCBH	X			
Prescriptions (eRx)	CCBH	X			
Progress Notes	CCBH	X			
Referral Management	CCBH	X			
Treatment Plans	CCBH	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		10	1	1	0
FY 2018-19 Summary Totals for EHR Functionality:		10	1	1	0
FY 2017-18 Summary Totals for EHR Functionality:		10	1	1	0

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

- The MHP is migrating Cerner Community Behavioral Health into the larger Cerner Millennium application. Additional builds to current state would not produce substantial gains given the migration will provide for a fully functional EHR. The timeframe to Go Live is anticipated for 2021.

Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Excel Worksheet

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Summary of CY 2018 Short Doyle/Medi-Cal Claims
San Diego MHP

Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**692,925**	**$137,252,908**	**6,135**	**$1,724,018**	**1.26%**	**$135,528,890**	**$131,645,822**
JAN18	66,639	$12,321,004	835	$211,500	1.72%	$12,109,504	$11,825,204
FEB18	61,916	$11,436,724	509	$128,054	1.12%	$11,308,670	$11,081,470
MAR18	68,202	$12,619,437	572	$195,922	1.55%	$12,423,515	$12,099,169
APR18	66,001	$11,952,933	441	$113,061	0.95%	$11,839,872	$11,644,271
MAY18	69,168	$12,772,183	542	$153,653	1.20%	$12,618,530	$12,354,955
JUN18	57,613	$10,639,618	380	$95,886	0.90%	$10,543,732	$10,367,399
JUL18	59,731	$11,719,404	596	$134,959	1.15%	$11,584,445	$11,168,658
AUG18	63,632	$13,642,776	602	$169,931	1.25%	$13,472,845	$13,002,853
SEP18	56,859	$12,549,210	560	$166,725	1.33%	$12,382,485	$11,947,412
OCT18	66,222	$14,745,405	565	$183,258	1.24%	$14,562,147	$14,028,617
NOV18	56,015	$12,520,733	492	$152,244	1.22%	$12,368,489	$11,895,131
DEC18	927	$333,482	41	$18,826	5.65%	$314,656	$230,684

Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2018 was **3.25 percent.**

- During CY 2018 the MHP experienced claim submission delays for December 2018 which resulted in a significant number of services not being included in the summary analysis results.

Table 15 summarizes the top three reasons for claim denial.

Table 15: Summary of CY 2018 Top Three Reasons for Claim Denial San Diego MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code.	2,327	$578,792	34%
Payment denied - prior processing information incorrect. Void/replacement condition.	1,805	$554,137	32%
Medicare or Other Health Coverage must be billed before submission of claim.	1,763	$488,806	28%
TOTAL	6,135	$1,724,018	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reason description “Medicare or Other Health Coverage must be billed before submission of claim” are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One: Foster Youth Caregivers

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held at Foster Family Agency Stabilization and Treatment (FFAST), 8825 Aero Drive, Suite 110, San Diego.

Number of participants: Nine

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

- Participants learned about services through FFAST. Initial services were provided within two weeks.
- Psychiatry services were provided within two months. Group members stated that delays in psychiatry were because FFAST had a psychiatrist one day per week.
- All participants felt that the process was easy, quick, enjoyable, responsive and flexible.

Participants' general comments regarding service delivery included the following:

- Services were provided once or twice weekly in the home. Transportation is available.
- Rescheduling regular appointments is perceived as easy, psychiatry appointments excepted.
- Support groups are available and were attended by most participants.

- All participants felt comfortable calling their child's therapist or caseworker after hours for crisis services.
- None were aware of the Quality Improvement Committee (QIC) or had been invited to provide feedback or participate on committees (but would like to participate if asked).
- All felt that services were enough to improve.

Participants' recommendations for improving care included the following:

- Provide a way to continue with therapist after adoption (FFAST will end).
- Provide snacks during therapy (a child's request).
- Provide an opportunity for youth to connect to other youth around similar issues (being in therapy, adoption, and general support and resources when not in crisis).

Interpreter used for focus group one: No

CFM Focus Group Two: Parent/Caregiver to Adult Beneficiaries

CalEQRO requested a culturally diverse group of parents/caregivers of adult beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. However, the participants were not consistent with that requested by CalEQRO. The location where the focus group was held at NAMI San Diego, 5095 Murphy Canyon Road, # 320, San Diego.

Number of participants: Seven

There were **no participants** who entered services within the past year. Every caregiver/parent of the adult child in question reported that their child did not receive Medi-Cal services and had not for years. All were private insurance.

Participants' recommendations for improving care included the following:

- Open services to non-Medi-Cal persons.
- Get more providers to reduce waitlists and provide information about resources.
- County mental health and schools need to be linked for services and available to non-Medi-Cal persons.
- Mandate mental health training for teachers, e.g., Mental Health First Aid, like mandated reporting and harassment training.

- Educate principals and higher up administration on mental health.
- Provide a system navigator to help someone know which steps to take to get services. Provide a comprehensive navigation tool.
- Provide information about the law enforcement PERT team.
- Improve different levels of knowledge of PERT team members.
- Improve training for clinicians who are earning hours and have limited experience with theory applicability.
- Provide a youth peer support group.

Interpreter used for focus group two: No

CFM Focus Group Three: Adults

CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held at Heartland Wellness Recovery Center, 460 North Magnolia Street, #110, El Cajon.

Number of participants: Ten

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

- Entering services was easy and straightforward. All began services within one week.
- The frequency with which participants receive therapy ranges from every few weeks to every few months. All felt that services and frequency were enough to improve.
- The MHP is viewed as helpful, inclusive, welcoming and caring. Participants reported that there were a variety of services and that services were available in non-English languages.
- All participants reported receiving psychiatry services on a regular basis, every three to six months. Psychiatry services were responsive, with reminder calls and rescheduling available if needed.

Participants' general comments regarding service delivery included the following:

- Crisis services were known to be available through the front desk, care coordinator or therapist; and all knew about the warm-line for after-hours assistance.

- Participants felt included in treatment planning and knew that Wellness and Recovery Action Plan (WRAP) groups were available.
- Some participants did not have a primary care provider, while those who did reported not knowing if their psychiatrist communicates with their primary care doctor.
- All participants utilized the wellness centers and attended groups.
- Participants learned about mental health events through the website, flyers, staff, the crisis line and access line.
- Participants provide feedback on the MHP system via surveys and the MHSA stakeholder process; however, none had been asked to take part in committees or meetings.

Participants' recommendations for improving care included the following:

- Offer a group on interacting with the larger community outside the mental health universe.
- Offer home-based services for those that cannot make it to the office.
- Offer telephonic sessions.
- Decrease the wait time by providing more therapists.

Interpreter used for focus group three: Yes Language(s): Arabic

CFM Focus Group Four: TAY

CalEQRO requested a culturally diverse group of transition age youth (TAY) who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group was held at Urban Beats, 3330 Market Street, Suite A, San Diego.

Number of participants: Ten

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

- Most were satisfied with services.
- Most saw their therapist on a regular basis.

Participants' general comments regarding service delivery included the following:

- Some expressed difficulty with transportation as the MHP stopped providing bus passes.

- Awareness of crisis services was limited. The Oasis Wellness Center is closed at 5:30 p.m. Participants reported that they did not know what to do if there was a crisis after-hours other than call or text friends.
- Some expressed concern regarding the absence of security for the building entrance; while others expressed concern for security/theft within the building, stating that shared resources go missing (e.g., Xbox).

Participants' recommendations for improving care included the following:

- Extend Oasis open hours .
- Add shower facilities to Oasis.
- Offer housing and open shelters for youth.
- Replace the electric drum set that is missing.
- Open the clinic after-hours for urgent issues.
- Add police or security presence to enhance the sense of safety.
- Offer a crisis warm-line for youth.

Interpreter used for focus group four: No

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 16: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	12

The MHP utilizes the standard methods of providing service access information to beneficiaries, e.g., pamphlets, flyers, website, email. Information is available in waiting areas in multiple languages. However, the MHP's website is available in English only.

The MHP works with providers including the transit system, to evaluate transportation options, distance, and resources.

The MHP maintains an updated provider directory.

Currently the website provider directory is available in 240-page PDF format that is searchable through the browser's basic search function. At a minimum the directory should be searchable by region; languages served; accepting new referral status; age groups served; and specialty services. The MHP is working towards this goal and is rolling out a provider directory with added searchable parameters.

The MHP maintains a "No Wrong Door" approach for beneficiary access to services. For most programs, referrals are decentralized and link to screening and assessment regardless of the referral source.

However, some beneficiaries were unaware about how to access crisis services after hours.

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1B	Capacity Management	10	9
The MHP uses mental health outcomes management systems (mHOMS) along with Cerner data to produce reports which assesses the cultural, ethnic, racial, and linguistic needs of beneficiaries. Moreover, the CCC evaluates utilization data to identify trending language needs. The MHP also utilizes data from its mHOMS program to identify capacity needs. This last year, the MHP moved clinicians from one clinic where utilization was lower than expected to another where there was higher demand. Contract providers who provide intensive outpatient services such as WRAP and TBS are required to cover the entire county. This can translate to significant travel times for these providers.			
1C	Integration and Collaboration	24	22
The MHP has many collaborative relationships including those with contractors who provide nearly 86 percent of services. The MHP continues to utilize a managed care structure for its Children, Youth and Family services. For example, in this model, sessions are limited and continued sessions beyond the initial number assigned require approval. For children's services, an initial 13 sessions are approved with further sessions approved as needed. An additional session has been added to accommodate the need to administer the Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment. Stakeholder feedback indicated that the approval process to receive additional services was easy. The MHP implemented three new Assertive community treatment (ACT) programs for specific populations. Two of the ACT programs are designed to support beneficiaries as they transition from acute care and long-term care facilities into the community. The third ACT program is designed to support individuals who are involved with the justice system. The MHP also established a family housing program. Initially, it was to be funded through Medi-Cal; however, the Medi-Cal funding stream did not work out. Alternatively, the MHP was able to fund the project through a collaboration with the Monarch School. In January 2020, the MHP partnered with Monarch School for Homeless Youth to provide 25 vouchers for supportive housing for families. The MHP is establishing an eligibility model and coordinated entry into the system for the disbursement of the 25 vouchers.			

Table 16: Access to Care Components		
Component	**Maximum Possible**	**MHP Score**
Stakeholder feedback also confirmed the presence of collaborative relationships throughout the system. There is room for improvement in collaboration with primary care. The MHP has experienced difficulties in referring clients who only need pharmacotherapy services to primary care providers (PCP) for ongoing "meds only" treatment because the PCPs are not comfortable with managing psychopharmacology regimens.		

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	16
The MHP reported that 91.7 percent of its first offered appointments met the 10 business day standard, with 95.1 percent for adults, 89.5 percent for children, and 94.8 percent for FC youth. Beneficiary participants in focus groups similarly noted that they were able to get an appointment quickly.			
2B	Assessment Follow-up and Routine Appointments	8	8
The MHP reported a very low mean length of time from first request for service to first offered appointment (in business days) The MHP reported that 91.7 percent of its first kept appointments met the 10 business day standard with 94.9 percent for adults, 89.4 percent for children, and 94.8 percent for FC youth.			
2C	First Offered Psychiatry Appointment	12	12
The MHP reported that 87.3 percent of its first offered psychiatry appointments met the 15 business day standard with 87.3 percent for adults, 91.4 percent for children, and 83.3 percent for FC youth.			
2D	Timely Appointments for Urgent Conditions	18	17

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
The MHP reported that 74.2 percent of its urgent appointments met the 48-hour standard with 79.9 percent for adults, 52.8 percent for children, and 100 percent for FC youth. The average length of time for urgent appointment that do not require prior authorization is 85.1 hours overall, with 88.8 hours for adults, 151.3 hours for children, and 24 hours for FC youth. The MHP does not require prior authorization.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	10
Of the 9,621 hospital discharges, 53.7 percent received a follow-up appointment within three days, with an average of 6.21 days overall, 6.40 days for adults, 5.19 days for children, and 4.20 days for FC youth.			
2F	Tracks and Trends Data on Rehospitalizations	6	6
Readmissions are not notably different from prior year. Of the 9,621 hospital discharges, the MHP reports a 30-day readmission rate of 23 percent overall, 23.6 percent for adults, 18.2 percent for children, and 21.8 percent for FC youth.			
2G	Tracks and Trends No-Shows	10	10
The standard for psychiatrists is 20% and actual is 17% overall, 19.7 percent for adults, 7.7 percent for children, and 3.5 percent for FC. The standard for other clinicians is 15% and actual is 5.7% overall, with 8.3 percent for adults, 3.4 percent for children, and 1.8 percent for children.			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Beneficiary Needs are Matched to the Continuum of Care	12	12

Expanding the continuum of care has been a high priority for the MHP this past year. The MHP maintains a “No Wrong Door” approach for beneficiary access to services. For most programs, referrals are decentralized and link to screening and assessment regardless of the referral source. This process makes linkages to the appropriate level of care more complicated. The MHP is actively working to mitigate and simplify this process.

The MHP offers varying levels of care. For adults, the menu of services includes medication management only, outpatient services including strength-based case management and ACT, assisted outpatient treatment, crisis stabilization, crisis residential, long term care, and acute care hospitalizations. Children’s services contain an array of similar services and include TBS, wraparound, Day Treatment, and Short-Term Residential Therapeutic Program (STRTP) (instead of crisis residential).

The MHP has a process to facilitate beneficiary transitions between levels of care. Step-down to mild-to-moderate requires partnerships with primary care. They use Evidence-based practices (EBPs) such as Level of Care Utilization System (LOCUS), Milestones of Recovery Scale (MORS) for adults, CANS-50 and Pediatric Symptom Checklist (35 items) (PSC-35) for children.

The MHP provides assessments at regular intervals (frequency varies depending on program type) to reassess progress towards goals and assesses needed transitions. The care coordinator develops the plan to a different level of care. For AOA, Outpatient programs conduct assessment quarterly based on MORS scores. ACT, FSP, and CM programs conduct assessments quarterly for clients that have been enrolled in services for 2 years or more.

For CYF, frequency of assessments also depends on program type. These can be completed every 6 months (a time-based model), or every 14/19 sessions to follow the brief treatment model (session based). They review Client Plans at this time as well.

The MHP evaluates its strategies for care transitions and they do track and trend transitions within the system. The MHP experiences challenges in track and trending transitions to resources outside of its system.

For children, one of the most vulnerable transition is to either inpatient or back into the community. There are three inpatient hospitals for children, only one of which is Short-Doyle. Transitions from STRTPs to home can be challenging and they try to continue aftercare and connecting youth with services.

Beneficiaries are involved in treatment and care planning and are aware of WRAP or similar. They also utilize contractors with affiliations to special groups, such as Hispanic, refugees, to provide services.			
3B	Quality Improvement Plan	10	10
The MHP has a current QI work plan with measurable QI goals and objectives, inclusive of prior year's findings and results. The MHP produces an annual evaluation of the effectiveness of QI activities in meeting QI goals and objectives detailed in the QI work plan.			
3C	Quality Management Structure	14	14
The QIC and associated staff communicate along usual lines including emails, meetings, trainings, and supervision. Peer employees are invited to the QIC; however, consumers were not aware of opportunities for QIC involvement.			
3D	QM Reports Act as a Change Agent in the System	10	10
The MHP initiated the use of a Biopsychosocial Rehabilitation Effectiveness Report (BPSR) which tracks data from 23 outpatient clinics, 3 county and 20 contracted. These reports identify the needs of homeless beneficiaries. Once the report is reviewed by the executive team, the MHP will be adding staff, lowering caseloads, and expanding mobile crisis to seven days per week. The Cultural Competency Committee tracks utilization by language. Data dashboards are used by QIC staff bi-monthly along with quarterly executive reports. These reports are shared with the administration in each system are used to develop and change programs. Data was used to identify a capacity gap in North County which led to the addition of clinicians to rectify. In schools, the MHP has contracted providers assigned to over 400 schools (out of 800 schools); however, the MHP did not have a systemic way of tracking school site services. To remedy this, the MHP now receives a report from the Performance Improvement Team which tracks services and clinicians on campuses. The MHP is using a School Link module to train providers and schools on standardized forms and service guidelines, i.e., reviewing office space, available clinicians, schedules, crisis response protocols, referral processes, and each contract site's minimum thresholds that need to be met. For CANS-50 and PSC-35, data is captured mHOMS. Direct entry is possible and there is a superuser group.			
3E	Medication Management	12	12

The MHP follows standard practices of care regarding medication management. It relies on HEDIS measures. It generates regular reports on prescribing practices and changes over time. The percent of children receiving medication services has stayed relatively consistent around 28%.The MHP is making an effort to increase the timely submission of JV-220s, both within the MHP as well as with providers outside the network.

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16

For adults, outcomes are collected in mHOMS and include: Illness Management and Recovery (IMR), Milestones of Recovery Scale (MORS), and Recovery Makers Questionnaire (RMQ).

ACT programs use LOCUS, while outpatient clinics use MORS.

The implementation of the new CYF outcomes measures has led to a number of related improvements including: Establishment of a CANS Sharing Confirmation Page on the client plan; development of outcome reports and local standards that were informed by first year data; development of CANS posters as clinician tools; revisions of the utilization management process to incorporate CANS and PSC; and updating the Utilization Management process to add a CANS Assessment session effective January 2020.

The MHP launched the Early Childhood CANS effective July 2019 (FY 2019-20 - year two of new outcome measures). Although not mandated for the MHP, it is aligned with the California Department of Social Services(CDSS) mandated measure for Child Welfare Services (CWS).

The MHP has a work group to address administration, challenges and barriers around using these tools. They asked what kinds of reports would be useful. Compliance reports are generated from mHOMS. They are trying to make it relevant to programs.

The outcomes manual has been updated to explain how these tools can be used for client and program improvement.			
4B	Beneficiary Perceptions	10	8
The MHP compares results from year to year and this appears in the Annual Report. They add supplemental information such as stigma, use of technology. They produce briefs on special topics from the results. They highlight not only those for which were more satisfied, but those most dissatisfied. The MHP shares the findings with leadership, staff, contractors and beneficiaries (through brief reports made available in the waiting rooms). They send the Annual Report to the Behavioral Health Board, but do not send the CPS results separately. The MHP also administers other beneficiary feedback surveys, as well as convening focus groups at individual programs. Consumer focus groups had no knowledge of committees, but CFM employees had been invited. Beneficiaries provided mixed responses regarding knowledge of opportunities to provide feedback on services or participate on MHP committees.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
The MHP contracts for the provision of 14 clubhouse programs throughout the county. These programs are strategically located to meet specific needs, including the Alvarado Parkway Institute (API) Discovery Clubhouse, Deaf Community Services, the needs of TAY through the Oasis Clubhouse, and numerous others. National Alliance on Mental Illness (NAMI) and RI wellness centers along with other others, are peer-run. The wellness centers are open to all persons. Wellness centers also offer WRAP groups and other supportive services. A calendar of events is available along with supportive services in other languages, including Spanish, Hmong, Cambodian and Vietnamese.			

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	29
The MHP offers a comprehensive array of specialty mental health services either directly or through contract providers.			
5B	Network Adequacy	18	16
The MHP uses a wide range of tools to expand service delivery options throughout the county including co-location, wellness centers, whole person care, behavioral health homes, mobile crisis response, services in threshold languages, and field-based services. As an example of this expansion, during 2019, regular meetings had been held between HHSA, Public Safety Group, the Sheriff's Department and the District Attorney's Office to support the behavioral health continuum of care redesign efforts that include the identification of services in Regions of the County to include community-based CSUs, Non-Law Enforcement Mobile Crisis Response Teams, and enhanced school-based response for threats or crisis situations that involve school youth. The Roaming Outpatient Access Mobile (ROAM) project for Native Americans residing on tribal reservations in rural San Diego project goal is to provide a comprehensive mobile health clinic with wrap-around services to Native American children and youth with serious emotional disturbances, adults with serious mental illness, and those identified as having co-occurring disorders. To support the expansion of programs utilizing telehealth services, BHS provided implementation, compliance and billing guidance to the Systems of Care during the past year. The North region is considerably underserved compared to coastal regions While the MHP has made efforts to expand services to rural and remote regions compared to urban/metro regions, there is still room for improvement. While a mobile unit was brought online recently, this may not be not sufficient to provide timely access to this remote area.			
5C	Subcontracts/Contract Providers	16	16
The MHP includes contract providers in the overall program development, planning, and performance improvement activities.			

The MHP's reports and data analyses include data from contract providers, network providers, and directly operated programs. Contract providers are involved in PIPs.			
5D	Stakeholder Engagement	12	9
BHS is consistently striving to gather stakeholder input and engage the community through its BHS MHSA Community Engagement Forums. As part of this ongoing initiative, BHS contracted with the Institute for Public Health (IPH) at San Diego State University to coordinate and facilitate the community dialog. The objective was to determine the community's perspective on the value of BHS programs and the impact to community members receiving services. IPH conducted nine community forums, two focus groups, and an online and paper-and-pencil community survey between September and December 2018. The nine forums included six general forums that focused on: 1) services for people experiencing a mental health crisis; 2) substance use among youth and young adults; and 3) school violence. Consumer focus groups had no knowledge of committees, but CFM employees had been invited.			
5E	Peer Employment	8	5
The MHP has designated positions for peer workers. NAMI has management positions designated for peers. Multiple contract providers have employment programs. RI has peers in management. Almost all staff at RI are peers. Stakeholder feedback indicated that pay for peer employees was lower than the national average. Advancement opportunities are limited. The MHP does have employment supports; however, it relies on vocational counselors and job leads rather than training and skill development.			
5F	Peer-Run Programs	10	10
NAMI and RI wellness centers along with other others, are peer-run. This year developed ClubHOMS for tracking utilization of clubhouses.			
5G	Cultural Competency	12	12
The MHP uses mental health outcomes management systems (mHOMS) along with Cerner data to produce reports which assesses the cultural, ethnic, racial, and linguistic needs of beneficiaries. Moreover, the CCC evaluates utilization data to identify trending language needs.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of San Diego MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The MHP has begun planning and development of Behavioral Health Services (BHS) hubs in different regions in the county. The behavioral health "hub and network" approach is identified as a model that can enable a shift from a crisis care system to a continuous and chronic care management system, through the deliberate regional distribution and coordination of resources.
- The behavioral health hubs in the North Inland and Central regions of San Diego County are designed to accelerate transition from behavioral health crisis to sustainable continuous chronic care management.
- The MHP has also received authority from the Board of Supervisors to explore the development of behavioral health hubs in other geographic areas of San Diego County, including South Region and East Region, as well as examining the development of community-based crisis stabilization units.
- The MHP is exploring the creation of networks of services in North Coastal and North Inland Regions. These are broad arrays of outpatient services and housing opportunities linked through a regional care coordination system designed to remain continuously connected to service recipients and to reduce episodes of crisis; these networks will further support the more intensive services of the behavioral health hubs.
- The MHP is exploring the expansion of Palomar Hospital Crisis Stabilization Unit and the addition of recliners in the emergency department to address patients with psychiatric conditions and pending transfers to appropriate level of care.
- The MHP has procured crisis stabilization services at the North Coastal Live Well Health Center located in Oceanside (North Coastal region). This will complement recently approved actions to re-establish inpatient psychiatric service capacity in partnership with Tri-City Medical Center.

- During the past year, the MHP has increased the availability of step-down and long-term care capacity including 72 Institution for Mental Disease (IMD) beds.
- In 2019 BHS implemented three new Assertive Community Treatment (ACT) programs for specific populations: Two to support beneficiaries as they transition from acute care and long-term care facilities into the community; a third to support individuals who are involved with the justice system.

Strengths:

- The MHP uses mental health outcomes management systems (mHOMS) along with Cerner data to produce reports which assesses the cultural, ethnic, racial, and linguistic needs of beneficiaries.
- This last year, the MHP moved clinicians from one clinic with lower utilization to another where there was higher demand.
- The MHP works with providers including the transit system, to evaluate transportation options, distances, and resources.
- The MHP has several new housing initiatives in process including: one to provide mental health services in addition to short-term, transitional and permanent supportive housing; another is an acute care hospital step down program through TeleCare. The MHP also established a family housing program.
- The MHP maintains a “No Wrong Door” approach for beneficiary access to services. For most programs, referrals are decentralized and link to screening and assessment regardless of the referral source.

Opportunities for Improvement:

- The MHP’s website is currently available in English only. However the MHP is working on adding language switching capabilities and is looking for a tool sophisticated enough to auto-translate appropriate medical language. In the meantime, some materials in printed format are translated and posted at provider sites, while the Optum San Diego website has all beneficiary materials in threshold languages available.
- While the online provider directory is available in a searchable 240-page PDF format, it is recommended that the MHP continue to develop its directory with an enhanced, navigable format that allows searching by region; languages served; accepting new referral status; age groups served and specialty services.
- The ACT qualification criteria makes linkages to this level of care more complicated. The MHP is actively working to mitigate and simplify this process.
- As some beneficiaries were unaware about how to access crisis services after hours, the MHP should review its communication and materials about these

services and pilot test with some beneficiaries to ensure they know how to access these services.

- While the MHP has developed integrated or collaborative programs with many partnering agencies and community-based organizations, there is room for stronger linkages with all managed care organizations in the county.
- There is room for improvement in collaboration with primary care. The MHP has experienced difficulties in referring clients who only need pharmacotherapy services to primary care providers (PCP) for ongoing “meds only” treatment because the PCPs are not comfortable with managing psychopharmacology regimens.

Timeliness of Services

Changes within the Past Year:

- From last year to this year, the MHP began tracking and reporting on length of time from initial request to first kept appointment.
- From last year to this year, the MHP has started including the tracking and reporting of time from initial request to first offered appointment for FC.

Strengths:

- On balance, the MHP meets and/or exceeds timeliness standards across the system of care.

Opportunities for Improvement:

- None noted.

Quality of Care

Changes within the Past Year:

- Expanding the continuum of care has been a high priority for the MHP this past year.
- The MHP provides assessments at regular intervals (frequency varies depending on program type) to reassess progress towards goals and assesses needed transitions.

Strengths:

- The MHP offers varying levels of care. For adults, the menu of services includes medication management only, outpatient services including strength-based case management and ACT, assisted outpatient treatment, crisis stabilization, crisis residential, long term care, and acute care hospitalizations. Children’s services

contain an array of similar services and include TBS, wraparound, and STRTPs (instead of crisis residential).

- The MHP has a robust QI Work Plan and comprehensive QI Work Plan evaluation process.
- The MHP has been actively engaged in two PIPs. Both PIPs indicate success in interventions with possibilities for expansion.
- As these two PIPs come to the close, the MHP is considering new PIP topics based on available data.

Opportunities for Improvement:

- None noted.

Beneficiary Outcomes

Changes within the Past Year:

- None noted.

Strengths:

- For adults, outcomes are collected in mHOMS and include: Illness Management and Recovery (IMR), Milestones of Recovery Scale (MORS), and Recovery Makers Questionnaire (RMQ).
- The implementation of the new CYF outcomes measures.
- Development of outcome reports and local standards that were informed by first year data.
- Revisions of the utilization management process to incorporate CANS and PSC.
- Updating the utilization management process to add a CANS Assessment session effective January 2020.
- The MHP launched the Early Childhood CANS effective July 2019 (FY 2019-20 - year two of new outcome measures). Although not mandated for the MHP, it is aligned with the CDSS mandated measure for CWS
- Launched the Early Childhood CANS effective July 2019 (FY 2019-20 - year two

Opportunities for Improvement:

- Beneficiaries provided mixed responses regarding knowledge of opportunities to provide feedback on services or participate on MHP committees.

Foster Care

Changes within the Past Year:

- The MHP has developed reports that include timeliness tracking capacity for FC average length of time from first request for service to first offered clinical appointment, from first request for psychiatry service to first offered appointment, and from request for urgent appointment to actual encounter.
- Originally SDCBHS completed the quarterly report of clients receiving medications with an active JV-220. However, earlier this year, the team of nurses at Public Health Services took over reporting requirements as they now review and follow up on every case of a client receiving psychotropic medication without an active JV-220.
- In an effort to better understand the unique needs of the FC population when discharging from IP hospitalization, the MHP is working to produce a variant of the existing Service After IP Discharge Report (CO-20) that reflects connection rates specifically for the foster care population.

Strengths:

- The MHP meets or exceeds timeliness standards for most FC metrics.
- The MHP hosts the Psychotropic Medication Monitoring meeting quarterly that includes participants from Behavioral Health Services - Children Youth and Families, Child Welfare Services, Public Health Services and Medical Care Services. The group reviews and discusses the JV-220 and SB1291 HEDIS outcomes data.
- The MHP continues to require program medication monitoring activities each quarter, and tracks variances reported related to SB 1291 HEDIS measures to address potential concerns with individual programs.
- Additional foster care specific reports related to inpatient days and crisis stabilization encounters are being developed to track and monitor foster care emergency service utilization.

Opportunities for Improvement

- None noted.

Information Systems

Changes within the Past Year:

- As part of Cal Medi-Connect data sharing project, a process was established with four participating health plans (HP). The MHP receives a monthly roster and identifies individuals who receive services by MHP system of care. A report is provided to each HP that indicates which services provided to shared beneficiaries to ensure timely care coordination activities.

Strengths:

- For FY 2019-20 the MHP reported 8.4 percent of the annual budget is dedicated to support IT operations.

Opportunities for Improvement:

- As BHS stands up two disparate EHR systems for outpatient mental health services and substance abuse services; they need to develop a plan to implement Data Warehouse (DW) database that include clients demographic and clinical service data from both EHR systems to create a comprehensive dataset of behavioral health beneficiaries and services delivered.
- Contract providers who have local EHRs are required to use double-data entry as there is no process to electronically transfer data from their local EHRs to CCBH system. The process is error-prone and is an inefficient use of agency staff time. This opportunity is not being moved forward as a recommendation this year, as the MHP is standing-up CM roadmap during upcoming year.

Structure and Operations

Changes within the Past Year:

- The MHP administrative structure changed in the past year with the arrival of a new Director and two new Assistant Directors in the roles of Chief Operations Officer and Chief Program Officer.
- Additionally, the BHS Administrative Services Unit was re-designed to include a Strategic Planning and Operations Unit responsible for Communication and Knowledge Management, Strategic and Operational Planning and Management Reporting and Analysis, with an emphasis on executive and management reports to support departmental operations and to inform BHS strategic and operational planning.
- The MHP's Planning and Prevention Unit (PPU) was also restructured to ensure a primary focus on Prevention in Mental Health (MH) and Substance Use Disorder (SUD) services and Community Engagement needs, while the need for a newly developed Project Management Unit was identified to help coordinate the various project efforts occurring within BHS.
- There continues to be ongoing efforts to ensure the organizational structure meets the vision and needs of BHS and other potential unit changes are being reviewed.
- To monitor telehealth programs the MHP implemented an annual attestation statement that documents appropriate levels of HIPAA compliance are in place.
- The North region is considerably underserved compared to coastal regions

- While the MHP has made efforts to expand services to rural and remote regions compared to urban/metro regions, there is still room for improvement. While a mobile behavioral health unit has been deployed, this may be insufficient to effectively this remote area.

Strengths:

- The impact of the new organizational structure has the potential to expand the role of behavioral health and integration within the county.

Opportunities for Improvement:

- The MHP has yet to share communications plan for outpatient mental health services roadmap with providers that uniquely addresses both county-operated programs and contract provider agencies Cerner Millennium (CM) implementation requirements.

- CM outpatient mental health roadmap will require a comprehensive training program for more than 4,000 Millennium users who provide services at over 100 sites in the county. The MHP needs to develop strategies to minimize user-travel time as much as practical.

- The MIS Program Coordinator position currently reports to Quality Performance and Improvement Director, who reports to Assistant Director of Departmental Operations. For a large-size MHP to utilize a program coordinator level position to support IS operations in this ever-increasing data use environment needs reassessment.

- There is not parity among peer employment agencies. Within the MHP, the opportunities for advancement are unclear.

- The MHP’s supported employment program is focused on job searching, and less so on vocational training and skill development.

FY 2019-20 Recommendations

PIP Status

- None noted.

Access to Care

1. Add language translation capability to the San Diego County Behavioral Health Services website. Priority should be given to the following threshold languages: Spanish, Arabic, Vietnamese, Tagalog, and Farsi.
2. Improve website provider directory search capability to include by region; languages served; accepting new referral status; age group served; and specialty services.
3. Streamline the ACT referral process to improve timeliness of these services.
4. The MHP should review its communication and materials regarding after-hours and crisis services so that this information is available to all beneficiaries and wellness center participants. Follow-up with a pilot test of beneficiaries to determine effectiveness.
5. Examine referral processes and support with primary care providers (PCPs) to beneficiaries needing only pharmacotherapy services. Establish methods to provide ongoing training and support to PCPs to increase their capacity and confident serving psychotropic medication-only beneficiaries.
6. Evaluate the distribution of specialty contracted programs throughout the county so as to maximize access for beneficiaries while minimizing staff travel and potential service delays.

Timeliness of Services

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

Quality of Care

- None noted.

Beneficiary Outcomes

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

Foster Care

- None noted.

Information Systems

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

Structure and Operations

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

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

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

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions – San Diego MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Gale Berkowitz, DrPH, Deputy Director and Lead Reviewer
Bill Ullom, Information Systems Reviewer
Cyndi Lancaster, Quality Reviewer
Walter Shwe, Consumer Family Member Consultant
Neal Adams, MD, Consulting Medical Officer

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

Sites of MHP Review

MHP Sites

San Diego County Behavioral Health Services (SDCBHS)
3255 Camino Del Rios South
San Diego, CA 92108

Contract Provider Sites

FFAST
8825 Aero Drive. Suite 110,
San Diego, CA 92123

NAMI -
5095 Murphy Canyon Rd. #320
San Diego, CA 92123

ROAM
4058 Willows Rd.
Alpine, CA 91901

Heartland Wellness Recovery Center
460 N. Magnolia Street, Suite 110
El Cajon, CA 92020

MHS Inc. Employment Solutions
10981 San Diego Mission Road, Suite 110,
San Diego, CA 92108

Urban Beats
3330 Market Street, Suite A
San Diego, CA 92102

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Aguila	Jacqueline	Employment Specialist	San Diego Workforce Partnership
Alcorta	Miguel	Business/Data Analyst	Optum
Allen	Sally	Substance Abuse Counselor	Rady Children's Hospital
Alvarez-Ron	Ingrid	Peer Support Specialist/Trainer	NAMI - CYFL
Anglo	Leizyl	Director of Nursing	HHSA, Inpatient Health Services
Annand	Stacey	Clinical Supervisor	Vista Hill's ADAPT
Arambula	Mayra	Sr. Bilingual Case Manager	San Diego Center for Children - WrapWorks North
Arehart	Annette	Family Program Manager	NAMI - Education
Barounis	Kya	Sr. Research Consultant	CASRC
Beasley	Charles	Employment Specialist	San Diego Workforce Partnership
Bergmann	Luke	Director	BHS
Beyene	Hiwot	Customer Service Specialist	RI International - Peer Run Services
Block	Kathryn	Program Manager	Vista Hill Learning Assistance Center-North Inland
Bonaparte	Deaundra	Mental Health Rehabilitation Specialist	Telecare Corp. Gateway to Recovery
Boreliz	Caitlin	Employment Specialist	San Diego Workforce Partnership
Bourcier	Jeanine	Program Administrator	Telecare AgeWise
Boysen	Megan	Supervisor/Triage Coordinator	Neighborhood House Association Project Enable BPSR
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Bucher	John	Regional Manager	San Diego Center for Children WrapWorks
Cacho	Janet	PH Program Coordinator	BHS - CDO
Chadwick	Amy	System of Care Evaluation Coordinator	CASRC
Clark Manson	Minola	Director	RIHS
Clay	Jennifer	ROAM Mental Health Therapist	S.I.H.C
Conlow	AnnLouise	Program Coordinator	BHS - MIS
Cookson	Rene	Director	NAMI
Cooper	Fran	Assistant Medical Services Administrator	BHS - CYF
Crandal	Brent	Director, Behavioral Health Quality Improvement	Rady Children's Hospital
David	Nora	BH Program Coordinator	BHS - AOA
DeGroff	Maegen	Therapist	Alianza Wellness Center
Esposito	Nicole	Assistant Clinical Director	BHS - CDO
Evans Murray	Cara	Assistant Medical Services Administrator	BHS - AOA
Everton-Lovell	Stefanie	Behavioral Health Counselor	Deaf Community Services of San Diego
Fernandez	Francisco	QA Director	New Alternatives
Garcia	Piedad	Deputy Director, Adult & Older Adult System of Care	BHS - AOA
Garcia	Winona	Clinical Case Manager	Survivors of Torture, International
George	Alexis	Administrator	Telecare Corp. Gateway to Recovery, Pathway to Recovery, Transition Team
Green	Mike	Protective Services Program Manager	COSD CWS

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Gregg	Scott	ROAM Program Manager	S.I.H.C
Guevara	Christopher	Principal Administrative Analyst	BHS - MIS
Haddad	Shadi	Program Manager	San Ysidro Health
Hammond	Linda	President & CEO	Community Research Foundation
Hamner	Christina	Program Manager	Courage to Call
Hansen	Parker	Intensive Care Coordinator	San Diego Center for Children WrapWorks
Harp	Vivian	Business Operations Specialist	Palomar Health
Hayes	Skylar	Manager of I.T.	Optum
Hebert	Valerie	Program Manager	NAMI SD
Heineman	Fukiko	Licensed Mental Health Clinician	East County Mental Health Clinic
Hiedo	Buthaena	RDA	S.I.H.C
Hill	Rodnesha	Employment Specialist	IMPACT
Hoene	Elyce	Protective Services Program Manager	COSD CWS
Jami	Farrah	Clinical Director	Telecare Corp. Gateway to Recovery
Johnson-Taylor	Casie	QI Supervisor	BHS - QM
Kahn	Margot	Assistant PM/Therapist	UPAC - MCC
Kaufman	Mandy	Behavioral Health Program Coordinator	BHS - CYF
Kemble	Derek	Administrative Analyst III	BHS – QI – PIT
King	Noel	Behavioral Health Counselor	Deaf Community Services of San Diego
Kiviat	Aurora	Assistant Director, Departmental Operations	BHS
Knight	Betsy	BH Program Coordinator	BHS - AOA
Koenig	Yael	Deputy Director, Children, Youth &	BHS - CYF

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
		Families System of Care	
Krelstein	Michael	Clinical Director	BHS
Labelle	Robert	Peer Liaison	RI International - Peer Liaison
Lagare	Tiffany	Research Associate	CASRC
Lance-Sexton	Amanda	Assistant Medical Services Administrator	BHS - CYF
Lang	Tabatha	Assistant Medical Services Administrator	BHS - QI
Lanier	Becky	Protective Services Supervisor	COSD CWS
Lara	Helen	FSP Family Support Partner	MHS Inc. FSP
Lovell	Nancy	Clinical Case Manager	Survivors of Torture, International
Loyo-Rodriguez	Raul	Department Budget Manager	BHS
Ly	Michelle	Director	UPAC MCC & CMH CTC
Madrid-Arroyo	Dolores	Admin Analyst	BHS -MIS
Mahoney	Rachel	Associate Clinical Social Worker / Senior Mental Health Clinician	Survivors of Torture, International
Manalastas	Mandy	Licensed Care Coordinator	Neighborhood House Association Project Enable BPSR
Maramba	Wendy	Chief, Child and Adolescent Services Central/N. Central Region	BHS - CYF
Maroge	Michael	Program Specialist	BHS - MIS
Maxwell	Benjamin	Medical Director, Inpatient Psychiatry	Rady Children's Hospital
Miles	Liz	Principal Administrative Analyst	BHS - QI - PIT
Miller	Sharna	Wraparound Facilitator	MHS Inc. Families Forward Wraparound

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Miller	Michael	BH Program Coordinator	BHS - CYF
Mockus-Valenzuela	Danyte	Prevention and Planning Manager	BHS - PPU
Mohler	Edith	Administrative Analyst III	BHS - CYF
Moojedi	Bardia	Admin. Intern	BHS - QI -PIT
Mueller	Sandra	Senior Director, Behavioral Health Services	Rady Children's Hospital
Mullen	David	BH Program Coordinator	BHS - AOA
Munoz	Ariel	Mental Health Rehabilitation Addictive/Other Disorder Specialist	Telecare Pathways ACT
Muranyi Anello	Margaret	Program Coordinator	Rady Children's Outpatient Psychiatry North Inland Clinic
Myers	Don	Director of Operations, Center for Behavioral Health	Palomar Health
Navarro	Jason	Job Developer	San Diego Employment Solutions
Nicario	Cathryn	Chief Executive Officer	NAMI
Olalla	Adriana	Clinical Supervisor	San Diego Youth Services
Ordorica	Marilyn	Therapist	Rady CES
Page	Gregory	Peer Recovery Coach	Telecare PTR
Panczakiewcz	Amy	Project Manager	HSRC
Parkhurst	Laura	Acting Chief Operating Officer	S.I.H.C
Parson	Heather	BH Program Coordinator	BHS - QM
Penfold	Bill	Senior Manager of IT	Optum
Peres	Mark	Family Support Partner	San Diego Center for Children - WrapWorks
Pittsley	Rachel	Program Director, PEI	School Age PEI - South Region

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Post	Dave	Administrative Analyst II	BHS – QI – PIT
Quach	Phuong	BH Program Coordinator	BHS – AOA
Quinn-OMalley	Eileen	BH Program Coordinator	BHS - CYF
Ramirez	Ezra	Admin. Analyst II	BHS - QI - PIT
Ramos	Nilanie	Chief, Agency Operations	BHS – CDO
Raymond	Rebecca	BH Program Coordinator	BHS - CYF
Reynolds	Joshua	Peer Support Specialist	Gateway to Recovery - Telecare
Rhinesmith	Danielle	URQI Supervisor	BHS - QM -MH
Rincon	Norma	Deputy Director	COSD CWS
Rode	Cheryl	VP of Clinical Operations	San Diego Center for Children
Rodriguez	Jenny	CWS Policy Analyst	COSD CWS
Sadatrafiei	Nikoo	Program Manager	Harmonium Family Youth Partner Program
Saenez	Cessar	ROAM	S.I.H.C
Sampson	JonMichael	Employment Specialist	San Diego Workforce Partnership
Sawin	Lisa	Deputy Chief Probation Officer	Probation
Schall	Emily	Clinical Supervisor	San Diego Youth Services
Shelton	Gwendolyn	QA Supervisor	SDCC
Simpson	Jeff	Peer Specialist	Telecare Agewise
Smith	Stephanie	Program Manager	Vista Hill Dependency Drug Court and Perinatal Case Management
Smylie	Bobbi	Program Coordinator	South Bay Community Services
Solom	Angela	Administrative Analyst II	BHS – QI PIT
Solomona	Sira	Clinician	New Alternatives North County

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Outpatient School Based Services
Southfox	Suzette	Director of Education	NAMI - Education
Sperrazzo-Lepley	Christine	KFS Director	S.I.H.C
Stephenson	Oscar	Peer Support Specialist	RI International - Peer Run Services
Strows	Christopher	Principal Administrative Analyst	BHS - AOA
Sudarsan	Subashini	Research Analyst	BHS – QI PIT
Sweet	Chrystal	Division Chief	Probation
Tally	Steve	Assistant Director of Evaluation Research	HSRC
Thiel	Lisa	BH Program Coordinator	BHS – AOA
Thornton-Stearns	Cecily	Assistant Director, Departmental Operations (COO)	BHS - QI
Torres	Consuelo	Care Coordinator	Center for Child and Youth Psychiatry
Trask	Emily	Senior Mental Health Consultant	CASRC
Umanzor	Krystle	Administrative Analyst III	BHS – QI - PIT
Vance	Amy	Program Specialist	San Diego Workforce Partnership
Vaughn	Carol	Program Manager	SDRC
Velasco	Manuel	Admin Analyst	BHS -MIS
Villa	Kelly	Program Manager	Mariposa Clubhouse
Villanueva	Kristine	Program Manager	Alianza Wellness Center
Vleugels	Laura	Supervising Psychiatrist	BHS - CYF
Walsh	Alicia	Clinical Director	Deaf Community Services of San Diego
Webber	Mercedes	Peer Liaison	RI International - Peer Liaison
Wells	Steven	Protective Services Program Manager	COSD CWS

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
White-Voth	Charity	Assistant Medical Services Administrator	BHS - AOA
Williams	Seth	Behavioral Health Program Manager	BHS - CYF
Winegarden	Babbi	Psychologist	COSD CWS
Woods	Rose	Manager	RIHS

Attachment C—Approved Claims Source Data

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

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

Table C1: CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
San Diego MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Large	1,833,373	69,835	3.81%	$406,057,927	$5,815
MHP	265,349	10,747	4.05%	$52,535,471	$4,888

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

Table C2: CY 2018 Distribution of Beneficiaries by ACB Cost Band
San Diego MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	35,856	95.13%	93.16%	$111,245,039	$3,103	$3,802	57.33%	54.88%
>$20K - $30K	816	2.16%	3.10%	$19,783,560	$24,245	$24,272	10.20%	11.65%
>$30K	1,020	2.71%	3.74%	$63,022,096	$61,786	$57,725	32.48%	33.47%

Attachment D—List of Commonly Used Acronyms

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

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

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

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Diego	
PIP Title: Caregiver Engagement	
Start Date (MM/DD/YY): 03/2018 **Completion Date** (MM/DD/YY): Spring 2020 **Projected Study Period** (#of Months):24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): January 9, 2020 **Name of Reviewer**: Gale Berkowitz	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The main goal of this PIP is to improve consumer outcomes by increasing the number of family therapy sessions for youth receiving outpatient services in the Children, Youth and Families Behavioral Health Services (CYFBHS) system. The PIP will attempt this by training CYFBHS providers on how to increase caregiver engagement in family therapy.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Family Therapy PIP Workgroup consists of professionals from the County of San Diego Behavioral Health Systems of Care and Behavioral Health Programs with expertise in family engagement and/or children's mental health.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Both literature around evidence-based practices and local data were used.

Select the category for each PIP:	
Clinical: ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☐ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The focus was on increasing the provision of family therapy to children and youth receiving services.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CYF and their caregivers are the target of this activity, and indirectly their caregivers who receive training in ways to better engage families.
Totals		**4** Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will educating and providing strategies to the CYFBHS System on increasing caregiver participation in family therapy lead to increases in family participation and reductions in clients' mental health symptoms?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**1** Met Partially Met Not Met UTD

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CYF beneficiaries and their caregivers are the focus of this PIP.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: Text if checked	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All CYF beneficiaries were eligible for inclusion.
	Totals	**2** Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Average caregiver report of child's symptoms of mental health problems discharge score (Pediatric Symptoms Checklist) 2. Percent of therapy sessions that are coded as "family therapy" 3. Percent of clients that had at least one family therapy session during a full treatment episode (at least 13 sessions) 4. Percent of caregivers who respond "Not at all" to the question: To what extent has your child's therapist asked you about things that might prevent you from participating in your child's treatment? (Youth Services Survey)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☒ Member Satisfaction ☒ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1) PSC 2) Percent of sessions that are Family Therapy 3) Percent of consumers that received at least one family therapy session 4) Percent of caregivers who do not report being asked to participate in family therapy

	Totals	**2** Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling needed.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
Totals	Met Partially Met Not Met **3**NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? • The average total scores at discharge on the Pediatric Symptom Checklist (PSC) • The percentage of all therapy sessions offered in outpatient programs that are coded as family therapy • The percentage of outpatient clients with 13 or more sessions (In CYFBHS which uses a short-term treatment model, 13 or more sessions is defined as a full treatment episode), that have at least one family therapy session. • The number of caregivers who respond “not at all” to the question, “To what extent has your child’s therapist asked you about things that might prevent you from participating in your child’s treatment?” on the caregiver version of the Youth Services Survey (YSS).	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☒ Claims ☒ Provider ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1. The Pediatric Symptom Checklist (PSC) 2. The family therapy billing codes 3. Youth Services Survey (YSS) response questions

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	After administering the PSC assessment, each agency entered their own PSC data into the web-based CYFBHS mHOMS Data Entry System (DES). The second two data points come from the CYFBHS medical record system. Downloads from this system were used for data analysis. The fourth data point comes from the caregiver version of the Youth Services Survey.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PSC data and family therapy session data will be collected at six time points - before and after the November 2018 presentation to the program managers, before and after the MEET training, and before and after the PACT training. In order to measure the effectiveness of the presentation, data will be taken from the entire population of clients who have outpatient services. In order to measure the effectiveness of the MEET and PACT trainings, the MHP will identify comparison clinics serving clients who have similar demographic and diagnostic profiles to the clients served by the clinics who receive the MEET and PACT trainings. The PSC and family therapy session data for both the clients from the comparison clinics and the clients from the clinics that participate in the trainings will be compared prior to and following the trainings.
6.6 Were qualified staff and personnel used to collect the data? Project Leaders: Liz Miles, Ed.D, MPH, MSW/Kya Barounis, Ph.D., Senior Mental Health Researcher, UCSD Tiffany Lagare, M.P.H., Research Associate, UCSD Anh Tran, B.S., Research Assistant, UCSD Bill Ganger, M.A., Data Manager, SDSU Shellane Villarin, M.P.H., Research Associate, Rady Children's Hospital-San Diego Project leader:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

	Totals	**6** Met Partially Met Not Met UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* By increasing family therapy sessions, caregivers will receive more psychoeducation and instruction on how to help their children cope with their mental health problems, which will improve the children's outcomes. There are three proposed interventions: 1. PIP Presentation for Program Managers 2. MEET (Motivational Enhancement for Engagement in Therapy) Training. Update: Two cohorts of outpatient clinics were trained. 3. PACT (Parent and Caregiver Active Participation Toolkit) Training.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data analytic process did not occur exactly as planned. First, the MHP had to modify one of the data points. Specifically, they had planned to compare discharge scores on the Pediatric Symptom Checklist both before and after the trainings. However, discharge scores are less meaningful than change scores, because children enter mental health treatment with varying levels of symptomology. For example, a child with a low discharge score may have had a low score on the intake assessment. Thus, they chose to look at change scores instead. Second, they updated their baseline data on rates of family therapy so that the baseline measurements reflect the time period immediately before the trainings (September 2018- January 2019), because they felt that this would provide a better test of how successful the trainings were. Third, they were unable to look at the Pediatric Symptom Checklist outcomes and the family therapy rates for youth who had 13 sessions at six time points as originally planned. They were unable to do this because the pilot clinics did not serve a large enough number of clients with either two PSC measures or at least 13 sessions that were enrolled after the MEET trainings but before the PACT trainings. Fourth, the MHP was also unable to find a comparison group of clinics that served clients with similar demographics and diagnoses.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: Monthly Indicate the statistical analysis used: t-tests, chi-square, and Fisher's exact test Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Through the use of administrative data, the MHP was able to clearly show when measurements occurred. Monitoring did not need to occur more frequently, but would have had more outcome data if the PACT trainings occurred earlier in the PIP process.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Three programs did not have both pre and post data for all of the analyses impacts the internal validity of the outcomes. The pilot programs may have made additional changes beyond what was advised in the trainings. They were only able to separate the impact of MEET from PACT when looking at changes in the percent of family therapy offered by the pilot programs. The main threat to external validity is that the pilot programs were chosen to participate in the PIP because they had low rates of family therapy compared to the system as a whole in FY 2017-18. *Conclusions regarding the success of the interpretation:* While acknowledging that the analyses had some threats to internal and external validity, the PIP appears to have been successful at increasing the amount of family therapy offered by the pilot clinics. *Recommendations for follow-up:* The MHP is considering rolling out one or both of the trainings system wide.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**2** Met **2** Partially Met Not Met NA UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP used both administrative data and survey data for outcome measures. With the administrative data they applied the same syntax (a computer code that uses a set of rules to create and analyze a dataset) to both measurement time points. The survey used the same methodology by repeating the same question.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data analyses show an improvement in processes- percentages of family therapy increased. The analyses also show an improvement in consumer outcomes as average change on the PSC measure improved after the trainings.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The improvements appear to be the result of the PIP intervention because the clinics that did not participate in the PIP did not show similar changes during the follow-up period.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	An independent sample T test was used to examine differences in PSC change scores before and after the trainings. Among the trained clinics, the average amount of change on the PSC increased from 2.15 points before the MEET trainings to 5.80 points after the MEET trainings. This difference was statistically significant (t (208)=2.57, p=.011). Chi Square tests were used to look at the differences in the percentages of family therapy sessions before and after the MEET trainings and after both the MEET and PACT trainings. Among the trained clinics, the percent of all therapy sessions that were family therapy increased from an average of 20% (September 2018-January 2019) before the MEET trainings, to an average of 24% after the MEET trainings but before the PACT trainings (April 2019-June 2019). This difference was statistically significant (□2=12.49, p.001). Additionally, among the trained clinics, the percent of all therapy sessions that were family therapy increased from an average of 20% (September 2018-January 2019) before the MEET trainings, to an average of 24% after both the MEET and PACT trainings (September 2019-October 2019). This difference was also statistically significant (□2=9.57, p=.002). A Fisher's Exact Test was used to look at differences in the percentages of youth with full treatment episodes that got at least one session of family

		therapy before and after the MEET trainings. Among the trained clinics, the percent of clients with 13 sessions who had at least one family therapy session increased from 75% before the MEET trainings, to 94% after the MEET trainings. This difference was statistically significant (Fisher's Exact Test, p=.047).
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The only outcome that provided repeated measurements was the percentage of family therapy sessions offered by the pilot clinics, that was measured monthly. However, regardless of trainings, there were seasonal variations. In order to see if improvement is sustained, the MHP plans to continue to look at the pilot clinics rates of family therapy over the 2019-20 fiscal year
Totals	**4** Met **1** Partially Met Not Met NA UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

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

Conclusions:

On balance, this PIP was successful.

Three of four outcome measures were statistically significant. The clinics that participated in the trainings had statistically significant increases in the amount of family therapy provided to clients (p.01), and the number of clients with full treatment episodes that got at least one session of family therapy (p.05). Furthermore, the average amount of change on the Pediatric Symptom Checklist (as reported by caregivers) increased significantly as well (p.05). The only outcome that did not show statistically significant change was the percentage of caregivers who responded "Not at all" to the question, "To what extent has your child's therapist asked you about things that might prevent you from participating in your child's treatment," on the Youth Services Survey (p.05).

While acknowledging that the analyses had some threats to internal and external validity, the PIP appears to have been successful at increasing the amount of family therapy offered by the pilot clinics. The percentage of all therapy sessions that were family therapy increased from 20% before the trainings, to 24% after the trainings. Additionally, the percentage of youth with full treatment episodes served by the pilot clinics that had at least one family therapy session increased from 74% to 94%, exceeding the goal for improvement. Additional investigation is needed to determine how exactly the MEET and PACT trainings lead to these changes, but the trainings were designed to teach staff how to engage more caregivers in their children's treatment through the use of motivational interviewing techniques and alliance building techniques (see Appendix 2 for more information). A major component of both trainings is to give caregivers a chance to present their concerns and empower them to help their children.

The PIP also appears to have been successful at improving the average clinical outcomes for the pilot clinics' clients. Prior to the trainings, the average amount of improvement on the PSC from intake to discharge was 2.15 points, after the MEET training it was 5.8 points. This is a large and statistically significant change. During the same time period, the average amount of improvement among the untrained clinics decreased slightly from 4.02 points to 3.84 points, and this change was not statistically significant.

It is possible that these improvements in clinical outcomes are due to the increases in family therapy, because during family therapy sessions clinicians can address dysfunctional family dynamics that may contribute to the child's symptoms and show the caregiver how he or she can assist the child. Prior research has demonstrated that when parents participate in their children's treatment the children have better outcomes than children whose parents did not participate (Dowell & Ogles, 2010).

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

CYFBHS is considering rolling out one or both of the trainings system wide. However, before doing so, CYFBHS plans to continue follow-up interviews with the pilot clinics to learn more about how both MEET and PACT were implemented and if there are any modifications to the trainings materials or processes that might be beneficial.

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

Recommendations:

The MHP designed the PIP in a manner that conformed with the CalEQRO outline. Feedback from CalEQRO that they had received in the prior year was taken and responded to appropriately.

Some modifications in the study design were needed once a pilot had been completed.

The MHP is aware of the limitations of the study interventions:

First, the initial and repeat measures were taken on different samples of clients, so any differences between the two groups of clients many influence the comparability of the measures. However, the change on the PSC and the percentages of family therapy were averaged across all clients, so the difference should be minimal.

Second, one of the pilot programs did not have "pre" data to include in the PSC outcomes analysis or any "pre" data for the full treatment episodes analysis, and two other programs did not have any "post" data to include in the full treatment episode analysis. Thus, the results of these analyses should be viewed with caution as they do not include both time points for every pilot program.

The fact that three programs did not have both pre and post data for all of the analyses impacts the internal validity of the outcomes. It is possible that the MEET training did not improve family therapy rates for youth with full treatment episodes or child clinical outcomes for these programs. However, these programs did have enough data for our analysis of whether the percent of family therapy sessions increased overall, and they did show improvements, so it is likely these improvements do extend to youth with full treatment episodes.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Diego	
PIP Title: Improved tracking and retention for patients who are discharged after not returning.	
Start Date (MM/DD/YY): 04/2018 **Completion Date** (MM/DD/YY): **Projected Study Period** (#of Months):02/2020 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): Jaunary 7-9, 2020 **Name of Reviewer**: Gale Berkowitz	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

The overarching goal of the PIP is to improve long term client care by investigating and addressing the discharge summary process, with a focus on reasons for outpatient clients not continuing services (discharge reason of "did not return"). Addressing these areas should decrease the proportion of outpatient clients who re-enter services through undesirable points of re-entry, such as crisis services or PERT. The issues related to this problem will be explored through qualitative workgroups and a client survey. The information from these two data sources will be used to design a series of workshops that educate and inform program staff about the problem, and proposes applied solutions based on the information gathered through the activities described above.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Beneficiary input was obtained vis the Spring 2018 survey, which was a query about reasons for not returning to treatment. NAMI San Diego furnished additional beneficiary focused input. Stakeholders included program staff, clinicians, MIS and database experts, MIS user groups, and beneficiary input derived from the CPS.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Analysis of FY 2016-17 systemwide discharge summary forms Discharge reasons for outpatient services. Data from the results of next services for those who discharged categorized as "did not return" furnished other information.

Select the category for each PIP: *Non-clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP focused on the retention of beneficiaries in treatment.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is looking at all populations served for unplanned discharge events.
	Totals	**4** Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will a data-driven re-contact/re-engagement process result in: 1) A reduction in the number of clients who are discharged after not returning for services. 2) An increase in the number of clients who make a future appointment after successful re-contact. 3) A reduction of clients who are discharged as "did not return" who re-enter services through crisis or emergency levels of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Outpatient clients discharged from a SDCBHS Outpatient program during the study period with the discharge reason "did not return." Although the problem in question was identified through the analysis of systemwide data, a pilot program was chosen for the intervention. This program was found to have even higher rates of "did not return" status discharges (70%) than the system rate of ~40% and deemed to be a prime candidate for testing the intervention.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Discharge data	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Discharge data was available for the entire population. CPS data were analyzed for a subset of the population.
	Totals	**1** Met **1** Partially Met Not Met UTD
STEP 4: Review Selected Study Indicators		

4.1 Did the study use objective, clearly defined, measurable indicators?
List indicators:
• Discharged due to the reason "did not return"
• Re-Entry into system for above clients:
  ○ Future Services
  ○ Clients re-contacted and scheduled an appointment
	☒ Met
	☐ Partially Met
	☐ Not Met
	☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP focuses on the rate of those who "did not return". Indicators reflect various aspects of consumer related changes, barriers and challenges.

	Totals	**2** Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* All clients were targeted.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	All clients in targeted outpatient programs with a discharge during the analysis period will be included in the analysis. Given no seasonal effects are in play, this sample should be sufficiently representative and sizeable.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **3** NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	• Client data for analysis of discharge status: • Discharge disposition (i.e., reason for discharge) • Services utilized after discharge • Appointments • Gender • Preferred Language • Race/Ethnicity • Educational Level • Employment Status • Insurance Status • Living Situation • Diagnosis • Substance Use Diagnosis Treatment Level of Care
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☒ Claims ☐ Provider ☒ Other: Consumer Perception Survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CCBH EHR for SDCBHS clients. CPS.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The analysis will utilize client data available through the SDCBHS EHR (aka Cerner/CCBH). The data produced by this system reflects valid and reliable system usage and client disposition data. Additional information will be provided by target programs in the form of contact logs.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The re-engagement analysis will utilize CCBH system data to look at discharge summary information and pre- and post-discharge service utilization. In addition, and described above, contact logs from the participating programs will be used to analyze the disposition of the re-contact process. The system data provides consistent and accurate data at the system level and provides sample sizes for 3 months for the post-intervention endpoint analysis. It will be sufficiently large to be representative (25% of entire system data for the year). The question being used for this client-reported data is provided in Appendix A. These questions will help inform the re-engagement process by determining common reasons for a client to discontinue services, to help inform interventions

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Analysis of systemwide data for the test outpatient program(s) will include calculation of proportions with each type of discharge status. The SQL analysis code will be identical wherever possible for both analysis time-points ensuring consistency of client selection and other analysis parameters. The statistical test will be Fisher's Z-Test for the comparison of proportions and is a validated method to assess the statistical significance for changes in proportions. Analytic comparisons of demographics and other defining characteristics for clients who discharge as "did not return" compared to those with other discharge dispositions will help determine if person-level characteristics (beyond status as an existing client) may perhaps differ between those who do not return and those who are retained in services. This will help explain unexpected or low-level results. Client Survey Data: Quantitative analysis of survey data to examine client-reported trends for discontinuing services.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Steve Tally, Ph.D. Contractor, Research and Statistical Methods in Mental Health Expert. UC San Diego Health Services Research Center (HSRC) • Debbie Malcarne, BHS A/OA System of Care • Liz Miles, BHS Quality Improvement - Performance Improvement Team • Christopher Guevara, BHS Quality Improvement – Performance Improvement Team • Mark Metzger, Contractor, Database and SQL Analytical expert. UC San Diego Health Services Research Center (HSRC)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**5** Met **1** Partially Met Not Met UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Recontact/engagement process:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The intervention itself is comprised of a re-contact/re-engagement process. Although fairly straightforward at the surface level, the process was informed by analysis of system data and input from program managers, clinicians and subject matter experts. The desired effect of the intervention is to re-engage clients with services. As mentioned, clients who leave services prematurely often re-enter the system through the use of emergency, crisis, or inpatient services. These re-entry pathways are both less than optimal for recovery as well as cost intensive. Clients who remain engaged with routine outpatient services are more likely to continue in their recovery without these often traumatic and expensive setbacks.
	Totals	**1** Met Partially Met Not Met UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	At the time of the review, sufficient data was available for 2 of the 3 programs. Initial data for the 3rd program will be available for analysis in mid-December 2019. Data collection for all three programs will continue through February 2020.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The goal will be to decrease those who “did not return” by 10% to 20%. Given these endpoints, an acceptable margin of error of 5% was used. For the client survey data, a 10% margin of error was considered.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Staff turnover and other factors within the program impacted procedures. A new discharge summary form was introduced to the system during March of 2019 that may have affected the discharge process. *Conclusions regarding the success of the interpretation:* The PIP was promising and a success with regard to re-engaging clients and decreasing the rate of clients who "did not return." The intervention involved attempts at re-contact. *Recommendations for follow-up:* The MHP has plans to disseminate to OP programs systemwide are in discussion and pending final data from the combined three pilot programs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**2** Met **2** Partially Met Not Met NA UTD	

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

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	Met **5** Partially Met Not Met NA UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

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

Conclusions:

Thus far, this PIP has been successful in identifying a problem, using data and expert input to devise a feasible intervention to address the problem, implementing the intervention, and analyzing results. As noted, due to the time periods involved in assessing successful re-engagement, there was no time for a systemwide dissemination process. If the data currently being collected from the additional two programs is deemed promising, future activities will include the possibility of a systemwide roll-out.

In addition, the activities leading up to the design and implementation of the intervention provided valuable information that can be used for further system improvement and retention/engagement. For example, the client survey identified a number of factors that clients listed as reasons for discontinuing services. Although some of these were out of the reasonable scope of this PIP, they still provided information for possible future system improvement. For example, transportation issues continue to be a major reason why beneficiaries stop coming to services. This area is being explored for possible solutions.

The PIP was promising and a success with regard to re-engaging clients and decreasing the rate of clients who "did not return." The intervention involved attempts at re-contact. As is fairly well known, clients with serious mental illness are often difficult to contact by nature, and many do not have reliable contact information, or do not respond well to attempts to contact. Given these limitations, we feel the simple re-contact solution is a success. Further, given the above-noted difficulties and unreliability of client phone and address information, we are discussing with clinicians the best way to implement periodic contact information verification and quality checks as part of the final process.

There are plans to disseminate to OP programs systemwide are in discussion and pending final data from the combined three pilot programs.

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

Recommendations:

CalEQRO supports the MHPs plans to repeat the data analyses through the fiscal year to determine if the impact remains throughout a fiscal year for the pilot and additional two clinics.

CalEQRO is supportive of the in-depth analysis the MHP did to determine who were most likely to not return to services. They also demonstrated flexibility in their approach. Originally, they had expected that redesigning the discharge form would improve the rates. However, the redesigned form did not affect the discharge rates.

The MHP did a thorough analysis of reasons why clients stopped receiving services for three months or longer.

One clinic has "did not return" rate that was higher than others (around 67%). They found that there was a "cliff" that was hit at around 80 days. If someone was not reengaged with services within 80 days, the chance that they returned declined significantly.

They developed a tickler in the system to call patients who have not been reengaged at 80 days, followed by a letter, if they did not respond to call.

They analyzed reasons why people were not returning, including those that reported they no longer needed services.

They found that 26% reengaged in response to the follow-up.

For final update, they will also include no-show rates.

They are currently operating in 3 clinics. They will share results with other clinics.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time