County of Imperial

Behavioral Health Services

Quality Improvement Work Plan

FY 2022-2023

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Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

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INTRODUCTION

It is a well-established industry standard that Quality Improvement (QI) must become an integral part of every successful organization's focus and activities. The critical component of successfully implementing strategies and achieving quality and accountability in our programs is a fundamental belief in and commitment to the right of every beneficiary to quality of care.

This belief must be held by everyone, from management and supervisors to every staff involved. When this belief permeates every aspect of the agency, then resources become available for achieving a few selected key activities. Staff must truly believe that doing things right the first time saves money in the long run and cannot be afraid to take a critical look at how things get done. It has been proven that outdated and inefficient processes are the main barriers and obstacles in the way of getting a high-quality job done.

Quality management and quality improvement are not the job of just one unit or person. Every unit within the department and staff has a part to play in the total quality picture. Visualize a quality management program as an umbrella. The umbrella canopy is your Quality Management (QM) Program; the ribs holding it open are your units, staff, and QI activities; the QM Unit, its staff, and management are the handle supporting it all.

The Imperial County Behavioral Health Services (ICBHS) QM Program, the local Mental Health Plan (MHP), and the local Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan hold a shared responsibility and a continuing commitment to maintain and improve the quality of its service delivery system.

It is the function of the QM Unit to identify opportunities for improvement, make recommendations for needed QI activities, including Performance Improvement Projects (PIPs), and ensure follow-up. The QM Unit must also establish systematic processes for reviewing documentation of services provided, in order to ensure compliance with minimum standards and implement feedback mechanisms to support and ensure the establishment of processes for continuous improvement. The Quality Improvement Committee evaluates the results of QI activities, recommends policy decisions, institutes needed QI action and ensures follow up to QI processes.

The purpose of the QI Work Plan is to describe the QI activities conducted by the QI Program, including the PIPs. The Work Plan also reports the effectiveness of the QI Program in terms of the contribution of QI activities to improvement in clinical care and services to beneficiaries. The QM Unit updates the Work Plan annually so that it documents the progress of the QI Program in evaluating and monitoring all of its activities. This annual update reflects current goals, monitoring results and improvement processes. It also describes the FY 22-23 objectives that were built upon previous findings, as well as goals that represent new opportunities for improvement as identified by stakeholders (e.g. MHP and DMC-ODS staff, fee-for-service providers, consumers, and family members).

I. QUALITY IMPROVEMENT PROGRAM

The goal of the QI Program is to improve access to and delivery of both mental health and substance use disorder (SUD) services, while assuring that services are community-based, beneficiary directed, age appropriate, culturally competent, and process and outcome focused. The QI Program approach is an integrative process that links knowledge, structure, and process together in order to assess and improve quality. This approach is designed to coordinate with performance monitoring activities throughout the organization including, but not limited to, beneficiary and system outcomes, utilization management, clinical records review, monitoring of beneficiary and provider satisfaction, and resolution of beneficiary and provider grievances/appeals.

A. QI Program Description

It is the responsibility of ICBHS as a provider of both Medi-Cal Specialty Mental Health Services and DMC-ODS services to develop a written QI Program description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. The MHP's QI Program description includes the following elements:

1. The QI Program description shall be evaluated annually and updated as necessary.

2. The QI Program shall be accountable to the ICBHS Director.

3. A licensed mental health staff person shall have substantial involvement in QI Program implementation.

4. The MHP and DMC-ODS staff, fee-for-service (FFS) providers, consumers, and family members shall actively participate in the planning, design, and execution of the QI Program.

5. The role, structure, function, and frequency of meetings of the Quality Improvement Committee (QIC), and other relevant committees, shall be specified.

6. The QIC shall oversee and be involved in QI activities, including performance improvement projects.

7. The QIC shall recommend policy decisions; review and evaluate the results of QI activities including performance improvement projects; institute needed QI actions; and ensure follow up of QI processes.

8. Dated and signed minutes shall reflect all QIC decisions and actions.

9. The QI Program shall coordinate performance monitoring activities throughout ICBHS including, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances, appeals, fair hearings, providers' appeals, assessment of beneficiary and provider satisfaction, and clinical records review.

10. Contracts with hospitals and with individual, group, and organizational providers shall require cooperation with the ICBHS QI Program, and access to relevant clinical records to the extent permitted by State and Federal laws by ICBHS and other relevant parties.

B. Quality Improvement Committee

1. Membership Composition of the QIC

QIC members are stakeholders in the MHP and shall include a licensed mental health professional. Members will serve a one-year term, at a minimum. QIC members will be appointed by the MHP Director and will include the following stakeholders:

Director
Assistant Director
Deputy Director – Children Services
Deputy Director – Youth and Young Adult Services
Deputy Director – Adult Services
Deputy Director – Mental Health Triage & Engagement Services
Deputy Director – Substance Use Disorder Services
Deputy Director – Administration
Behavioral Health Manager – Managed Care
Behavioral Health Manager – Access Unit
Program Supervisor – Access Unit
Program Supervisor – Quality Management (Mental Health)
Program Supervisor – Quality Management (SUD)
Fee-for-Service Provider
Licensed Mental Health Professional
Licensed SUD Provider
Ethnic Services Representative
Beneficiaries of both mental health and SUD services
Consumer/Family Member Quality Improvement Subcommittee Chair(s)
Family members
Patients' Rights Advocate

2. QIC Meeting

The QIC meetings are held on the second Thursday of each month from 1:00 p.m. to 2:30 p.m. An exception is made for the month of August, wherein no meeting will be scheduled.

3. QIC Agenda

All departmental personnel, providers, and committee members may contribute to the agenda items. All agenda items and materials shall be submitted to the QM program clerical support prior to the first Thursday of each month by 5:00 p.m. All agenda items and materials shall be reviewed by the chairperson and the QM Unit prior to distribution. It is the goal of the QM Unit to distribute the agenda and meeting materials to all committee members one week prior to the scheduled meeting.

4. Meeting Minutes

The QM Unit is responsible for the QIC meeting minutes. The minutes are distributed to each member and to members of management. The minutes will contain, at a minimum, the following:

a. The name and location of where the meeting was held.
b. The date and time of the meeting.
c. The members present, listed by name and title.
d. The members absent, listed by name and title.
e. Issues discussed.
f. Review and evaluation of the results of QI activities, including performance improvement projects.
g. Decisions and/or recommendations made.
h. Action(s) taken.
i. Institution of needed QI activities.
j. Ensure the follow up of QI processes.
k. The date, signature, and title of the licensed committee member designated with clinical oversight of the QIC process.

5. Voting

The QIC shall follow these guidelines:

a. A quorum (presence of more than half of the appointed members) is required for any decisions and/or actions taken by the QIC.
b. The chairperson (or designee) is not a voting member, except in the event of a tie-vote in which case the chairperson (or designee) vote will prevail.

6. Officers

The Managed Care Behavioral Health Manager will be the chairperson for the QIC. The vice-chairperson for the QIC will be the QM Unit Program Supervisor.

7. Duties of Officers

The QIC chairperson shall preside at all meetings. He or she is responsible for the review of agenda items and materials with the QM Unit prior to distribution. The QIC chairperson shall sign the approved meeting minutes. In the QIC chairperson's absence, the chairperson will make arrangements with the vice-chairperson to handle his or her responsibilities.

8. QIC Role and Responsibilities

The QIC actively participates in the planning, design, and execution of the QM program. The QIC is actively involved in reviewing the annual QI Work Plan development and implementation, as appropriate.

The QIC oversees and examines the mandatory components of the QI Work Plan including the PIPs. The QIC recommends policy decisions, reviews and evaluates the

results of QI activities including performance improvement projects, institutes needed QI actions, and ensures follow up of QI processes.

The QIC coordinates performance monitoring activities by reviewing and evaluating QM Unit reports including, but not limited to, the following:

a. State Mandated Areas:
    1) Service delivery capacity;
    2) Accessibility of services;
    3) Beneficiary/family satisfaction;
    4) Service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices;
    5) Timeliness of the first dose of NTP services;
    6) NTP Utilization of Methadone and Non-Methadone MAT;
    7) Continuity and coordination of care with physical health care providers (PCP) and other human services agencies;
    8) Provider Complaints and Appeals; and,
    9) Strategies to reduce avoidable hospitalizations.
b. Additional Required Quality Improvement Activities:
    1) Utilization management program review;
    2) Underutilization and overutilization of services;
    3) Cultural and linguistic competence;
    4) Notices of adverse benefit determination; and,
    5) Requests for second opinions.
c. Performance Improvement Projects:
    1) Non-Clinical; and,
    2) Clinical

C. Consumer/Family Member Quality Improvement Subcommittee

The Consumer/Family Member Quality Improvement Subcommittee (CFQIS) consists of ICBHS consumers and family members who assist in the planning, design, and execution of the QI Program. The CFQIS was developed to improve access and delivery of services and assure that services are based on the needs of the community and are consumer-directed, age-appropriate, and culturally competent.

The CFQIS is responsible for reviewing QI activities, identifying opportunities for improvement, planning and implementing County services, and making recommendations to the QIC. The CFQIS meets on a bimonthly basis, one in El Centro and one in Brawley. The chair persons for each subcommittee are voted on by the members of each respective CFQIS and attend the QIC to address opportunities for improvement and make recommendations on behalf of the CFQIS.

D. Quality Improvement Work Plan

The Quality Improvement (QI) Program shall have a QI Work Plan that includes the required elements set forth by the Department of Health Care Services (DHCS) which include: (a) an annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement

projects; (b) monitoring of previously identified issues, including tracking of issues over time; (c) planning and initiation of activities for sustaining improvement; and (d) objectives, scope, and planned activities for the coming year, including QI activities in each of the following areas:

State Mandated Areas

1. Service Delivery Capacity
    a. ICBHS shall implement mechanisms to assure the capacity of service delivery for both mental health and DMC-ODS services.
    b. ICBHS shall describe the current number, type, and geographic distribution of mental health and DMC-ODS services within its delivery system.
    c. ICBHS shall set goals for the number, type, and geographic distribution of both mental health and SUD services.

2. Accessibility of Services
    In addition to meeting statewide standards, ICBHS will set goals for:
    a. Timeliness of routine mental health appointments.
    b. Timeliness of services for urgent conditions.
    c. Access to after-hours care.
    d. Responsiveness of the 24-hour toll-free telephone line.

    ICBHS will establish mechanisms to monitor the accessibility of mental health and SUD services, services for urgent conditions, and the 24-hour toll-free telephone line.

3. Beneficiary/Family Satisfaction
    a. ICBHS will implement mechanisms to ensure beneficiary or family satisfaction.
    b. ICBHS will assess beneficiary or family satisfaction by:
        - Surveying beneficiary/family satisfaction with ICBHS services at least annually.
        - Evaluating beneficiary grievances, appeals and fair hearings at least annually.
        - Evaluating requests to change persons providing services at least annually.

    ICBHS will inform providers of the results of beneficiary/family satisfaction activities.

4. Service Delivery System and Meaningful Clinical Issues Affecting Beneficiaries, Including the Safety and Effectiveness of Medication Practices
    a. The scope and content of the QI Program will reflect the ICBHS delivery system and meaningful clinical issues that affect its beneficiaries.
    b. Annually, ICBHS will identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.
        - These clinical issues will include a review of the safety and effectiveness of medication practices. The review shall be conducted under the supervision of a person licensed to prescribe or dispense prescription drugs.
        - In addition to medication practices, other clinical issue(s) shall be identified by ICBHS.
    c. ICBHS shall implement appropriate interventions when individual occurrences of potential poor quality are identified.

d. At a minimum, ICBHS shall adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement.
e. Providers, consumers, and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.

5. Timeliness of Services of the First Dose of NTP Services
ICBHS will monitor the timeliness of services of the first dose of NTP services to ensure beneficiaries requiring NTP services are provided timely treatment.

6. NTP Utilization of Methadone and Non-Methadone MAT
ICBHS will monitor the NTP utilization of Methadone and Non-Methadone medication treatment to ensure NTP is offering and providing when medically necessary the different medications available at the NTP setting.

7. Continuity and Coordination of Care with Physical Health Care
ICBHS shall work to ensure that services are coordinated with PCPs and other human service agencies used by its beneficiaries.
    a. When appropriate, ICBHS shall exchange information in an effective and timely manner with other agencies used by its beneficiaries.
    b. If established, ICBHS shall monitor the effectiveness of its Memorandum of Understanding (MOU) with Physical Health Care Plans.

8. Provider Complaints and Appeals
ICBHS will respond to concerns from providers on any issue, including denial of payment authorization and claims processing delays, in compliance with statewide requirements.

9. Strategies to Reduce Avoidable Hospitalizations
ICBHS will monitor beneficiary hospitalizations to identify QI actions necessary to reduce avoidable hospitalizations and reduce the overall number of beneficiaries hospitalized.

ICBHS shall follow the five steps below for each of the QI Work Plan activities numbered 1-8 above that are not conducted as PIPs, to ensure ICBHS monitoring of the implementation of the QI Program:

1. Collect and analyze data to measure against goals or prioritize areas of improvement that have been identified.
2. Identify opportunities for improvement and decide which opportunities to pursue.
3. Design and implement interventions to improve its performance.
4. Measure the effectiveness of the interventions.
5. Incorporate successful interventions in the MHP, as appropriate.

Additional QI Activities

The QIC also oversees the following QI activities:

1. Utilization Management Program Review
   The QM Unit reviews the written description of the Utilization Management (UM) Program in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The QM Unit evaluates the UM Program, as follows:
   a. The UM Program is reviewed annually by ICBHS including a review of the consistency of the authorization process.
   b. At least every two years ICBHS gathers information from beneficiaries and providers regarding their satisfaction with the UM program, and addresses identified sources of dissatisfaction.

2. Underutilization and Overutilization of Services
   ICBHS will evaluate beneficiary claim data to identify potential instances of both low and high utilization and to identify QI actions necessary to ensure beneficiaries receive the optimum quality and level of services.

3. Cultural and Linguistic Competence
   The QM Unit ensures quality management standards are consistent with the philosophy that attaining cultural and linguistic competence is an ongoing, developmental process. The QM Unit ensures that relevant cultural competence and linguistic standards are incorporated in the QI Program. The QM Unit assesses appropriateness and capacity of services delivered by ICBHS in the following areas:

   i. Continuous Quality Improvement Plan
      Incorporate relevant cultural competent and linguistic standards in the approved QI Program and in the annual QI Work Plan. This shall be measured by:
      - The incorporation of relevant cultural competence and linguistic standards in the annual QI Work Plan.
      - Progress in achieving objectives related to relevant cultural competence and linguistic standards within the annual QI Work Plan.

   ii. Capacity of Service
      Assess that both mental health and SUD services are rendered by staff that is culturally competent and linguistically proficient to meet the needs of the population(s) served. This shall be measured by an analysis of the human resources composition by location data, in contrast to population needs assessment data for each population category.

   iii. Penetration/Retention Rates and Service Retention
      Ensure that persons of diverse ethnic backgrounds access the service system in numbers consistent with their representation in the Medi-Cal beneficiary population and relevant incidence and prevalence data. This shall be measured by:

- Tracking and comparing penetration and retention rates by ethnic group to the total Medi-Cal beneficiary population.
- Analyzing these rates for each ethnic group by factors including age, gender, primary language, and diagnosis to identify potential problem areas.
- Comparing these rates across ethnic groups.
- Establishing a “percent improvement” for penetration and retention rates of ethnic groups with low penetration/retention rates.
- Taking specific actions to meet the “percent improvement” identified above.

4. Notice of Adverse Benefit Determination (NOABD):
   ICBHS is required to provide Medi-Cal beneficiaries or their representative with a Notice of Adverse Benefit Determination (NOABD) when ICBHS: 1) Denies or limits authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) Reduces, suspends, or terminates a previously authorized service;3) Denies, in whole or in part, payment for a service; 4) Fails to provide services in a timely manner; 5) Fails to act within the required timeframes for standard resolution of grievances and appeals; or 6) Denies a beneficiary’s request to dispute financial liability.

5. Requests for Second Opinion:
   Ensures that the beneficiary, at his or her request, obtains a second opinion by a licensed mental health or SUD professional, other than a psychiatric technician or a licensed vocational nurse, employed by, contracting with, or otherwise made available by ICBHS when ICBHS or its providers determine that the medical necessity criteria is not met and that the beneficiary is, therefore, not entitled to any specialty mental health or SUD services from ICBHS. ICBHS shall determine whether the second opinion requires a face-to-face encounter with the beneficiary.

6. Timeliness of Services
   ICBHS established a mechanism to monitor the timeliness of services to ensure beneficiaries have access to the service delivery system. The QM Unit ensures that beneficiaries receive a psychiatric appointment within the timeliness standards as established by ICBHS.

7. No Show Rates
   In an effort to maximize service delivery capacity and expand the service delivery to residents of Imperial County, the QM Unit monitors, tracks, and analyzes the no show rates by service type. ICBHS analyzes the ratio of client no shows to appointments to the total number of appointments to determine the no show rates.

8. Quality Improvement Review Committees
   Committees that have been established to develop practice guidelines, ensure that practice guidelines are followed appropriately and consistently throughout the Department, review the quality of services and documentation requirements, as well as to identify opportunities for improvement and training needs, as appropriate.

9. Hospital Admissions and Readmissions
   In an effort to identify any potential quality of care issues and trends in occurrences, the QM Unit tracks the admissions and readmissions of all Imperial County residents hospitalized as a result of a psychiatric or SUD condition.

Performance Improvement Projects

The QI activities in at least two of the six areas, and any additional areas required by the Centers for Medicare and Medicaid Services in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a) (2), shall meet the criteria identified in Title 42, CFR, Section 438.240(d) for performance improvement projects (PIP). At least one performance improvement project shall focus in a clinical area and one in a non-clinical area.

ICBHS will:

- Identify areas of possible concern or areas which require improvement;
- Collect baseline data;
- Identify opportunities for improvement and choose a course of action;
- Design and implement system interventions to achieve improvement in quality;
- Evaluate the effectiveness of the interventions;
- Incorporate successful interventions as appropriate; and,
- Plan and initiate activities for increasing or sustaining improvement.

In order to ensure that ICBHS is in compliance with EQRO monitoring activities, the MHP will:

- Evaluate processes used by ICBHS to obtain and analyze data pertinent to each PIP;
- Validate data used in determining the study question, the specific study focus and the findings of the study;
- Assess the degree to which the PIP responded to the study question; and,
- Assess the overall reliability and validity of the PIPs.

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a DCHS initiative to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, program, and payment reform across the Medi-Cal program. The behavioral health components of CalAIM are designed to:

- Support whole-person, integrated care;
- Move the administration of Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility; and,
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform.

CalAIM includes several initiatives focused on improving the Medi-Cal behavioral health delivery system. Policy changes will launch at different times, beginning January 1, 2022. ICBHS will monitor and oversee CalAIM implementation and incorporate updates within the QI Work Plan, as appropriate.

E. Quality Management Unit

The QM Unit oversees the coordination of QI Program activities. The Managed Care Behavioral Health Manager, under the direction of the Director, is responsible for the implementation of QI activities and provision of leadership for the QI Program. The QM Unit is responsible to the QIC for conducting, monitoring, and evaluating QI Program activities.

The QM Unit is responsible for the development of the QI Work Plan that is consistent with the DHCS contract and attachments. The QM Unit will ensure that relevant cultural competence and linguistic standards are incorporated in the QI Work Plan.

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II. QUALITY IMPROVEMENT MONITORING ACTIVITIES & GOALS

MENTAL HEALTH PLAN (MHP) SERVICES

A. State Mandated Areas

1. Service Delivery Capacity

As the MHP for the County of Imperial, ICBHS provides services in a rural area that extends 4,482 square miles. Described below are the current number, types, and geographical distribution of mental health services within the MHP's delivery system and Federal Network Adequacy Standards for FY 21-22.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

The QM Unit compiled information on the current number, type, and geographical distribution of mental health services provided by the MHP through staff providers and contract providers. The information provided includes the geographic distribution of services, the target population, the type of service, the number of contacts provided in FY 21-22. The types, number of services provided, and geographic distribution of services were retrieved from the MHP's electronic information system, AVATAR.

1) MHP Direct Service Providers

a) Geographic Location and Target Population

The MHP makes every effort to bring services to all areas of the county and to make those services easily available and accessible for Imperial County residents. The MHP currently has 34 Medi-Cal certified sites and ensures that staff is allocated according to the cultural needs of the population it serves.

The MHP provides services in the southern, central, northern, and eastern regions of the county. The geographic distribution within the regions is as follows:

i. *Children Services*
<u>Southern Services</u>
Children services in the southern region are provided at an outpatient clinic and at the Vista Sands Program located at an elementary school. All southern region services are provided in the city of Calexico. Calexico residents through 13 years of age, as well as youth diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) through the age of 18, are the target populations of these services.

<u>Central Services</u>
Children services in the central region are provided at two outpatient clinics, a MHSA Prevention and Early Intervention program, and the Vista Sands Program located at an elementary school. Services are

also provided by one of the MHP's contracted providers: CHARLEE Family Care, Inc. (CHARLEE). All central region services are provided in the city of El Centro. Residents of Holtville, Imperial, Seeley, Ocotillo, Heber, and El Centro through 13 years of age, as well as youth diagnosed with ADHD through the age of 18, are the target populations of these services.

Northern Services

Children services in the northern region are provided at an outpatient clinic and the Vista Sands Program located at an elementary school. All northern region services are provided in the city of Brawley. Residents of Brawley, Niland, Calipatria, Westmorland, and northern unincorporated areas through 13 years of age, as well as youth diagnosed with ADHD through the age of 18, are the target populations of these services.

Eastern Services

Children services in the eastern region are provided at a FRC. All eastern region services are provided in the city of Winterhaven. Residents of Winterhaven, Bard, and remote eastern desert areas through 13 years of age, as well as youth diagnosed with ADHD through the age of 18, are the target populations of these services.

ii. *Youth and Young Adults (YAYA) Services*

Southern Services

The YAYA Calexico Full Service Partnership and the YAYA Calexico Anxiety and Depression programs provide services at an outpatient clinic in the city of Calexico. The residents of the southern region of Imperial County between the ages of 14 and 25 are the target population for these services.

Central Services

The YAYA El Centro Anxiety and Depression program, YAYA El Centro Full Service Partnership program, YAYA El Centro FRC, and two of the MHP's contracted providers, CHARLEE and Center for Family Solutions, provide services at outpatient clinics in the city of El Centro. The residents of the central regions of Imperial County between the ages of 14 and 25 are the target populations for these services.

The Adolescent Habilitative Learning Program provides services at a school site in the city of El Centro. The target populations for these services are youth between the ages of 13 and 17 who reside in all regions of the county.

Northern Services

The YAYA Brawley Full Service Partnership, YAYA Brawley Anxiety and Depression program, and the YAYA Brawley FRC provide services at an outpatient clinic in the city of Brawley. The residents of the northern region of Imperial County between the ages of 14 and 25 are the target population for these services.

iii. *Adults Services*

Southern Services

The Adult Calexico Anxiety and Depression and Adult Calexico Full Service Partnership programs provide services at an outpatient clinic located in the city of Calexico that are age 26 or older, are the target populations for these services.

Central Services

The Adult El Centro Anxiety and Depression, Adult El Centro MHSA FSP, and one of the MHP's contracted providers, Center for Family Solutions, provide services at outpatient clinics located in El Centro. These outpatient clinics serve residents of El Centro, Imperial, Holtville, Ocotillo, Seeley, Bard, and Heber that are age 26 or older are the target populations for these services.

Northern Services

The Adult Brawley Anxiety and Depression and the Adult Brawley MHSA FSP programs provide services at outpatient clinics located in Brawley. These outpatient clinics serve residents of Brawley, Westmorland, Salton Sea area, Bombay Beach, Niland/Slabs, Calipatria, and Palo Verde that are age 26 or older, are the target population.

Eastern Services

Adult services for adults in the eastern region are provided at a FRC. All eastern region services are provided in the city of Winterhaven. Residents of Winterhaven, Bard, and remote eastern desert areas that are age 26 or older are the target populations of these services.

iv. *Services for Children, Youth, and Adults*

Central Services

Children, adolescent, and adult emergency services are provided through the Mental Health Triage Unit. Services are available 24 hours a day for children, adolescents/youth, and adults from all regions of Imperial County who need urgent mental health services. All services are provided in the city of El Centro. The residents of all regions of Imperial County are the target population for these services.

The Mental Health Triage and Engagement Services (MHTES) Division provides initial intake assessments, initial nursing assessments, and initial psychiatry assessments to adult clients, regardless of payor type. Additionally, the MHTES Division provides specialty mental health services to clients 14 years of age and older after they have been seen by the Mental Health Triage Unit, after being discharged from an acute psychiatric hospital or incarceration, upon termination of LPS Conservatorship, and/or upon community referral until outpatient services are assigned. Services provided are targeted to address the specific needs of each person at the time his or her personal crisis occurred. The individual is assisted by mental health rehabilitation technician who is trained to engage and link each person to community

resources. All services are provided in the city of El Centro to residents of all regions of Imperial County.

v. *Contract Network Providers*
Central Services
As part of the MHP's effort to ensure the appropriate level of care is available to Imperial County residents, the MHP has four contracted network provider organizations. These providers are available to serve beneficiaries in all geographic areas of the county.

During FY 21-22, the MHP began contracting with a provider for children and youth Short Term Residential Therapeutic Program (STRTP). These services are available in El Centro for all Imperial County residents under 18 years of age.

b) Type of Service, Number of Contacts, and Geographic Distribution

Medi-Cal specialty mental health services are provided based on an assessment of whether the beneficiary meets Medi-Cal medical necessity for services.

The MHP provides an array of services, which are targeted to address the needs of the identified population. Clinical services are organized primarily around the structure of Medi-Cal specialty mental health services as outlined in Title 9 of the California Code of Regulations. Additional services are provided based on other sources of funding and interagency collaboration.

The number of contacts is the total number of services for all geographic regions served by each division of the MHP. The number of unduplicated Medi-Cal beneficiaries served by division, contract providers, and the total MHP are included in Table 1.

Table 1. Beneficiaries Served by Division and MHP

Division	FY 19-20 Beneficiaries	FY 20-21 Beneficiaries	FY 21-22 Beneficiaries
Children Services	2,578	2,124	2,265
YAYA Services	1,675	1,601	1,674
Adults Services	2,448	2,307	2,503
MHTES	890	618	829
Contract Providers	195	242	468
MHP	**7,786**	**6,892**	**7,739**

Tables 2-6 indicate by type of service the number of contacts for FY 21-22. This information is provided for each of the MHP's four service divisions and each contracted network provider organization.

Table 2. Type of Services and Number of Contacts
Children Services

Division	Number of Contacts FY 19-20	Number of Contacts FY 20-21	Number of Contacts FY 21-22
Medication Education and Management	16,239	20,966	18,186
Mental Health Services	34,436	32,995	29,756
Targeted Case Management	220	193	154
Crisis Intervention	81	47	51
Intensive Care Coordination	49	31	41
Intensive Home Based Services	0	2,341	2,031

Children Services experienced a decrease in all service types, with the exception of Crisis Intervention and Intensive Care Coordination.

Table 3. Type of Services and Number of Contacts
YAYA Services

Division	Number of Contacts FY 19-20	Number of Contacts FY 20-21	Number of Contacts FY 21-22
Medication Education and Management	8,936	12,409	11,963
Mental Health Services	31,633	27,663	32,862
Targeted Case Management	447	297	292
Crisis Intervention	315	242	457
Intensive Care Coordination	1	8	15
Intensive Home Based Services	0	403	784

YAYA Services experienced an increase in all service types, with the exception of Medication Education Management.

Table 4. Type of Services and Number of Contacts
Adult Services

Division	Number of Contacts FY 19-20	Number of Contacts FY 20-21	Number of Contacts FY 21-22
Medication Education and Management	26,633	37,782	29,970

Mental Health Services	27,833	29,394	25,178
Targeted Case Management	1,246	1,288	1,205
Crisis Intervention	573	563	502

Adult Services experienced a decrease in all service types.

Table 5. Type of Service and Number of Contacts
Mental Health Triage and Engagement Services

Type of Service	Number of Contacts FY 19-20	Number of Contacts FY 20-21	Number of Contacts FY 21-22
Medication Education and Management	3,996	4,479	4,795
Mental Health Services	5,957	6,383	5,803
Targeted Case Management	623	906	615
Crisis Intervention	6,068	4,015	3,825

Mental Health Triage and Engagement Services experienced a decrease in all service types, with the exception of Medication Management.

Table 6. Type of Services and Number of Contacts
Contracted Network Providers

Division	Number of Contacts FY 19-20	Number of Contacts FY 20-21	Number of Contacts FY 21-22
Mental Health Services	1,339	1,635	3,021
Targeted Case Management	10	26	377
Therapeutic Behavioral Services	2,165	1,705	1,353
Crisis Intervention	--	6	12

Contracted network providers experienced an increase in all service types, with the exception of therapeutic behavioral health services.

The MHP also provides non-billable services to residents in Imperial County. These are summarized in Table 7.

Table 7. Type of Service and Geographical Distribution
Non-Billable Services – All Populations

Type of Service	Geographic Distribution
Wellness Center	Central, Northern
Homeless Services	Central, Northern, Southern
School-Based Socialization Programs – Vista Sands	Central, Northern, Southern
Family Resource Centers	Central, Southern, Eastern
Conservatorship Services	Central, Northern

2) Federal Network Adequacy Standards

Network adequacy standards were developed pursuant to Title 42 of the Code of Federal Regulations. Network adequacy standards include time, distance, and timely access requirements with which the MHP must comply, taking into consideration the urgency of the need for services and the assurance of adequate capacity of services in regard to the number and type of providers, age groups served by each provider, as well as the language capabilities of each. Standards for the MHP are as shown in Table 8.

Table 8. Timely Access/Time and Distance Standards

Service Type	Timely Access	Time and Distance
Psychiatry	Within 15 business days from request to appointment	Up to 60 miles or 90 minutes from the beneficiary's place of residence
Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support	Within 10 business days from request to appointment	Up to 60 miles or 90 minutes from the beneficiary's place of residence

Reporting requirements for the Network Adequacy Certification Tool include geographic access maps and accessibility analyses confirming compliance with the time and distance standards for both children/youth and adults. Provider data that includes provider counts by type, licensure, National Provider Identification numbers, site locations, ages served, caseload capacity, cultural competence, and language capabilities are also included in the reporting. In addition, timely access reporting, language line utilization, and grievances and appeals regarding access to services are submitted. The MHP

submitted the annual Network Adequacy Certification Tool (NACT) to DHCS on August 29, 2022, providing the required information.

The QM Unit is responsible for monitoring the MHP's network adequacy data to ensure all network adequacy standards established by DHCS are met. Additionally, the QM Unit is responsible for the monitoring timeliness of services from initial request to first appointment offered.

During FY 21-22, the monitoring process consisted of reviewing the Access Log report from MyAvatar to verify whether ICBHS met the timeliness standards for Psychiatry, Mental Health Services, Targeted Case Management, and Medication Support (requests for Crisis Intervention Services are included with reporting for Timeliness of Services for Requests for Urgent Conditions). There were no requests made by beneficiaries, or providers acting on behalf of a beneficiary, for Psychiatry Services. Table 9 reflects data for FY 22-22.

Table 9. Timeliness of Services

Review Period	Medi-Cal Requests for Psychiatry	Appointments Offered within the 15-Day Standard	Appointments Offered Over 15-Day Standard	Compliance Rate
FY 21-22	1	1	0	100%
FY 20-21	0	N/A	N/A	N/A
FY 19-20	0	N/A	N/A	N/A
Review Period	**Medi-Cal Request for MHS, TCM, & Med Support**	**Appointments Offered within the 10-Day Standard**	**Appointments Offered Over 10-Day Standard**	**Compliance Rate**
FY 21-22	12	10	2	83%
FY 20-21	20	20	0	100%
FY 19-20	2	2	0	100%

On March 22, 2019, the State Department of Health Care Services (DHCS) issues MHSUDS Information Notice 19-020, which details requirements for submitting new data elements to the BHIS-CSI System in an assessment record in order for DHCS to ensure MHP meet timely access standards. As part of Phase One, ICBHS is required to submit the following information for beneficiaries new to the treatment system:

- Date of first contact to request services
- Assessment appointment first offer date
- Assessment start date
- Assessment end date
- Treatment appointment first offer date
- Treatment start date
- Closed out date

On November 20, 2020, the State Department of Health Care Services (DHCS) issues MHSUDS Information Notice 20-062, which details Phase Two requirements for submitting new data elements to the BHIS-CSI System in an assessment record in order for DHCS to ensure MHP meet timely access standards. As part of Phase Two Implementation, ICBHS is required to submit the following information for beneficiaries new to the treatment system:

- Referral Source
- Assessment Appointment Second Offer Date
- Assessment Appointment Third Offer Date
- Assessment Appointment Accepted Date
- Treatment Appointment Second Offer Date
- Treatment Appointment Third Offer Date
- Treatment Appointment Accepted Date
- Closure Reason
- Referred To

Updates were made to the CSI record in Avatar to incorporate these required elements. IT/IS provides CSI Assessment data entry trainings upon request.

Information Systems compiles CSI data monthly and submits to DHCS as required.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the number, type, and geographic distribution of mental health services and will report to the QIC at least annually.

- The QIC will evaluate and make recommendations to members of management, when appropriate, regarding the number, type and geographic distribution of mental health services.

- The MHP will ensure service delivery capacity to meet the needs of beneficiaries.

- The MHP will monitor its network adequacy and submit the NACT and supporting information to DHCS on an annual basis as required.

- The QM Unit will continue to monitor timely access standards as required by DHCS and reports its findings to QIC at least annually.

- Information Systems will monitor CSI data and work with Information Systems to identify opportunities for improvement associated with timely access data submitted to DHCS as per MHSUDS Information Notice 19-020 and 20-062.

2. Accessibility of Services

The QM Unit monitors the accessibility of services through the timeliness of routine mental health appointments, the timeliness of services for urgent conditions, access to after-hours care, and the responsiveness of the statewide 24-hour toll-free telephone line.

a. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

1) Timeliness of Routine Mental Health Appointments

ICBHS has established a seven working day standard to offer a routine mental health appointment from the time of the initial request. The current intake process allows for clients to be offered an appointment or be seen on a walk-in basis at any of the outpatient clinics.

The QM Unit monitors the timeliness of routine mental health services monthly and reports findings to the QIC at least annually. The QIC reviewed a report on March 10, 2022, and the recommendation to update the timeliness standard to ten working days was made. Deputy Directors reported that meeting the seven day timeliness standard is not feasible due to the increase in requests for services and shortage of providers. QIC members approved the recommendation effective April 1, 2022.

During FY 21-22, the source documents utilized in the review were the Timeliness to Intake Appointment and Access Log reports, generated from AVATAR, which identify the date of initial contact with ICBHS or its providers to request a routine mental health appointment, the date of the first offered intake appointment, and the number of working days between the date of initial request and the date of the first offered intake appointment. The compliance rate is then determined by dividing the number of routine appointments that were offered within the seven-day standard (numerator) by the total number of routine appointments offered (denominator). The monitoring process was updated April 1, 2022, to reflect the new 10 day timeliness standard.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP and its providers were able to offer services within the timeliness standard of the initial request for all requests for routine mental health appointments. ICBHS has maintained a consistent compliance rate over the last three years, as indicated in Table 10.

Table 10. Timeliness of Routine Mental Health Appointments

Review Period	Requests for Routine Appointments	Appointments Offered Within Seven Day Standard	Appointments Offered Over Seven Day Standard	Compliance Rate
FY 21-22	5,905	5,751	154	97%
FY 20-21	4,428	4,428	0	100%
FY 19-20	5,288	5,283	5	99.9%

2) *Timeliness of Services for Urgent Conditions Not Requiring Prior Authorization*

ICBHS has established a one-hour standard, from the time of the initial request, to provide a service for an urgent condition. An urgent condition is a situation that without timely intervention is likely to result in an immediate emergency psychiatric condition. The QM Unit monitors the timeliness of services for urgent conditions quarterly and reports findings to the QIC at least annually. The QIC reviewed a report on March 10, 2022, and members concurred with the recommendations for Crisis After-Hours staff and Access After-Hours staff to ensure all requests for urgent conditions are logged and for After Hours Crisis Staff to ensure services are provided within the one-hour standard for all requests for services for urgent conditions, as required.

The QM Unit compared the time and date of initial requests for urgent services on the Access Log (requests made after-hours, weekends, and holidays) and the Assessment Center Log (requests made during working hours) to the time and date of initial contact for services on the Crisis Log Report and the Crisis and Referral Desk Log to determine if services were provided within one hour of initial beneficiary request**.** The compliance rate is then determined by dividing the number requests for services for urgent conditions that were offered within the one-hour standard (numerator) by the total number of requests for services for urgent conditions (denominator).
By evaluating the data gathered in FY 21-22, the QM Unit was able to verify that ICBHS provided services for urgent conditions within one hour of initial beneficiary request 88 percent of the time, which is a decrease when compared to FY 20-21. The objective of achieving a compliance rate of 96 percent was not achieved.

Table 11. Timeliness of Services for Urgent Conditions Not Requiring Prior Authorization

Review Period	Requests for Urgent Conditions	Requests Within 1 Hour Standard	Compliance Rate
FY 21-22	458	406	88%
FY 20-21	555	536	97%
FY 19-20	496	451	91%

During FY 21-22, the QM Unit captured data that measures the average length of time for which the MHP responds to a request for services for an urgent condition, as well as the region and age group. The QM Unit determined that the average time for responding to a request for an urgent condition was 5 minutes during FY 21-22. Additionally, individuals requesting a service for an urgent condition were categorized as follows:

- Region:
  47% – El Centro
  9% – Calexico

9% – Brawley
15% – No report
11% – Other cities
9% – Out-of-county

- Age Group:
  90% – Adults
  10% – Minors

- Gender:
  49% – Male
  51% – Female

During FY 21-22, the QM Unit provided findings to the Mental Health Triage Unit program supervisor on a monthly basis. During those meetings program supervisor reported shortage of staff which affected the logging of all calls. The program supervisor met with Crisis After-Hours staff monthly to discuss the importance of logging all requests and interventions for urgent conditions as required.

3) Timeliness of Services for Urgent Conditions Requiring Prior Authorization

The MHP is responsible for the monitoring of requests for urgent conditions that require prior authorization. The MHP must review and make a decision regarding a provider's expedited request no later than 96 hours from the time of the request.

The QM Unit monitors the timeliness of services for urgent conditions requiring prior authorization on a quarterly basis. The monitoring process entails the review of the Payment Authorization Unit Treatment Authorization Request Tracking Log to determine if any requests for urgent conditions were recorded and were authorized within the established timeframes, as required. There were no requests for urgent conditions requiring prior authorizations by providers, as indicated in Table 12.

Table 12. Timeliness of Services for Urgent Conditions Requiring Prior Authorization

Review Period	# of TARs Submitted	Requests for Urgent Conditions	Requests Within 72 Hour Standard	Compliance Rate
FY 21-22	297	0	N/A	N/A
FY 20-21	253	0	N/A	N/A
FY 19-20	271	0	N/A	N/A

4) Access to After-Hours Care

The QM Unit monitors access to after-hours care quarterly and reports findings to the QIC at least annually. The QIC reviewed a report on March 10,

2022, and members concurred with the recommendation for the Access After-Hours staff to ensure all calls received are logged as required.

The QM Unit compared the After-Hours Access Log, which identifies the beneficiary's request for after-hours care, to the Crisis Log Report, which identifies contacts made to the beneficiary by Crisis After-Hours staff, to determine whether all requests for after-hours care were logged as required.

During FY 21-22, the QM Unit provided findings to Access Unit program supervisor on a monthly basis. Additionally, the Access Unit program supervisor met with the Access After-Hours staff on a monthly basis to discuss the importance of logging all requests for after-hours care, as required to achieve compliance rate of 98 percent.

During FY 21-22, the Access Unit supervisor provided ongoing updates to the Access Unit staff regarding policy and procedures, updated directories, and practicing scenarios to assist with providing adequate information regarding services. The Access Unit provided staff with a "Response Reference Guide," that is readily available to Access After-Hours staff which helps ensure information provided is accurate.

By evaluating the data gathered in FY 21-22, the QM Unit was able to verify compliance for access to after-hours care 99 percent of the time, which met the FY 21-22 objective of achieving a 98 percent compliance rate. This is an increase when compared to last fiscal year, as indicated in Table 13.

Table 13. Access to After-Hours Care

Review Period	Requests	Within Standard	Compliance Rate
FY 21-22	309	307	99%
FY 20-21	488	480	98%
FY 19-20	314	303	96%

5) Responsiveness of the MHP's 24 Hour Toll-Free Telephone Line

The QM Unit monitors the responsiveness of the MHP's 24-hour toll-free telephone line quarterly and reports findings to the QIC at least annually. The QIC reviewed a report on March 10, 2022, and members concurred with the recommendation for the Access Unit to ensure all callers are provided with the requested information regarding the Beneficiary Problem Resolution Process, to ensure all requested materials are provided to callers, and to answer and log all calls as required.

The QM Unit's monitoring process entailed conducting random test calls, during business hours and after hours, in both English and Spanish, Imperial County's threshold language. During FY 21-22, the QM Unit followed the DHCS Protocol when conducting random test calls. The Access Logs were also reviewed to verify that the test calls were logged appropriately.

Test callers assessed Access Unit staff's knowledge in the following areas: 1) language capability; 2) how to access Specialty Mental Health Services; 3) information about services to treat an urgent condition; and 4) information about how to use the beneficiary problem resolution and fair hearing process. Test callers also assessed the Access Unit staff's ability to determine urgency of applicable test calls; whether or not calls were answered within the standard of five rings; and whether or not a Beneficiary Protection Process Brochure, materials in alternative format, request for TTY/TDY services, request for Interpreting Services, Provider Directory and/or Beneficiary Handbook was available upon request. The level of knowledge regarding services, helpfulness, and professionalism were also considered. The test calls, made at random times of the day and days of the week, verified that the 24-hour toll-free telephone line was in operation 24 hours a day, seven days a week.

During FY 21-22, the QM Unit conducted a total of 50 test calls, 25 during business hours and 25 after hours. The Access Unit was 100 percent compliant in all the test call criteria evaluation with the exception of the Beneficiary Resolution and State Fair Hearing Process, as indicated in Table 14.

Table 14. Statewide 24-Hour Toll-Free Telephone Line

Test Call Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Language Capability	100%	100%	100%
SMHS Access Information	100%	100%	100%
Urgent Condition Information	100%	100%	100%
Beneficiary Resolution and Fair Hearing Process	56%	100%	73%
Access Log Criteria	**Percentage of Test Calls Where Log Requirement Was Met**		
	Business Hours	**After Hours**	**All Calls**
Name of the caller	88%	95%	91%
Date of the request	88%	95%	91%
Initial disposition of the request	88%	95%	91%

Additionally, the MHP verified that Access Unit staff logged calls 91 percent, which represents a decrease when compared to FY 21-22. The MHP's ring standard, which is answering the calls within five rings for both business hours and after-hours calls, was met for 98 percent of the calls made. Test callers requested thirteen brochures from the various programs of the MHP, two Provider Directories, three Grievance Forms, and one Provider (Nurse) Practice Guidelines. All requested material were provided upon the caller's request with the exception of one Provider Directory resulting in 95 percent compliance.

During FY 21-22, the Access Unit program supervisor met with Access Unit and Access After-Hours staff on a monthly basis to remind staff of the importance of logging all calls received as well as to review the response standards for the 24-hour toll-free telephone line in order to meet the objectives set in FY 22-22; however, the objectives to log 100 percent of calls and answer 100 percent of calls within the MHP's response standard were not met.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the timeliness of requests for routine appointments, timeliness of services for urgent conditions, access to after-hour care, and the 24-hour toll-free telephone line and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Timeliness of Routine Appointments Report and the 24-Hour Toll-Free Telephone Line Report and will make recommendations to management, as appropriate.

- The QM Unit will monitor access to after hours care and provide monthly updates to the Mental Health Triage Unit and Access Unit program supervisor regarding timeliness of services for after hours requests.

- The Mental Health Triage program supervisor and manager will implement monthly staff meetings to remind staff of the standards for responding to and logging requests for services for urgent conditions in order to achieve a compliance rate of 96 percent.

- The QM Unit will provide monthly updates to the Access Unit program supervisor regarding the logging of after-hours calls in order to maintain a minimum compliance rate of 98 percent.

- The Access Unit Supervisor will meet with Access After-Hours staff on a monthly basis. During these meetings and as necessary, staff will be reminded of the importance of logging all calls received in order to improve compliance.

- The QM Unit will randomly monitor the statewide 24 hour toll-free telephone line to ensure the 1-800 number is available 24 hours a day, seven days per week; provides information in the beneficiaries primary language; provides information on how to access mental health services, including specialty mental health services required to assess medical necessity criteria; services needed to treat urgent conditions; language capability, and how to use the beneficiary problem resolution and fair hearing processes.

- The Access Unit Supervisor will meet with Access staff and Access After-Hours staff on a monthly basis. During these meetings and as necessary, staff will be reminded of the importance of logging all calls received and of the standards for responding to all incoming calls.

3. Beneficiary/Family Satisfaction

The QM Unit monitors beneficiary/family satisfaction with the MHP through the consumer/family satisfaction survey; the fee-for-service consumer/family satisfaction survey; beneficiary grievances, appeals, and fair-hearings process; and requests to change persons providing services.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) MHP Consumer/Family Satisfaction Survey

During FY 21-22, ICBHS administered the Statewide Consumer Perception Survey (CPS) during CY 2021 to consumers receiving services at all provider sites. The state-developed survey tools were administered in the threshold languages of English and Spanish. The CPS is conducted once a year and uses a point-in-time method that targets all consumers receiving face-to-face mental health services, case-management, and medication services from county-operated and contract network providers during a one-week sampling period throughout the state of California. Due to COVID-19 national emergency, services have been provided via video or telephone, therefore the MHP used both state-developed online survey tools (direct submission to DHCS) and paper submission to University of California Los Angeles (UCLA).

In an effort to promote beneficiary/family participation, the QM Unit provided a specialized “Consumer Perception Survey Data Collection Training” to Adult, Children, and YAYA Services staff, as well as contract provider staff, which included the CPS “Things to Remember” list for staff. In preparation for the online CPS in CY 2021, detailed trainings were provided via Zoom meetings to equip staff in navigating the online survey and to encourage clients/family members to participate, including providing the age appropriate survey links. In an effort to encourage beneficiaries to assist ICBHS in finding better ways to serve their treatment needs, beneficiaries were informed of the “Consumer Assurance of Confidentiality” with a bilingual “Consumer Assurance of Confidentiality” statement and those who completed a paper survey were also provided with the “Think Bubbles” instructions on how to complete the survey. Additionally, the QM Unit engaged MHP staff and contract providers’ staff in promoting participation by providing information regarding the upcoming survey, the importance of the survey, and the need to maintain a high level of consumer participation.

During FY 21-22, the QM Unit assessed beneficiary/family satisfaction through the CPS results available from DHCS and UCLA for CY 2021, which were presented to and reviewed by the QIC on March 10, 2022.
The following groups receiving specialty mental health services were surveyed during the CY 2021 CPS: 3 youth (age 13-17), 27 family members/caregivers of youth, 66 adults (age 18-59), and 16 older adults (age 60+). There were 351 participants in fall 2019 and 75 participants in spring 2020, for a total of 112 participants.

A total of 3 youth surveys were completed during the CY 2021 CPS, youth participants reported high satisfaction perception (96 to 100 percent) in the areas of, perception of social connectedness. The lowest satisfaction perception (80 to 95 percent) reported by youth was in the following areas: general satisfaction, perception of access, participation in treatment planning, outcome of services, perception of cultural sensitivity, and perception of functioning, representing an increase in beneficiary satisfaction perception in these areas when compared to FY 19-20. Survey findings for youths are summarized in Table 15.

Table 15. Satisfaction Rates - Youth MHSIP Consumer Perception Survey

Survey Areas	FY 19-20		FY 21-22
	Fall 2019 (n=36)	Spring 2020 (n=15)	CY 2021 (n=3)
General Satisfaction	78%	91%	96%
Perception of Access	79%	90%	95%
Participation in Treatment Planning	78%	93%	80%
Outcome of Services	66%	87%	90%
Social Connectedness	82%	82%	100%
Cultural Sensitivity	82%	93%	90%
Perception of Functioning	68%	86%	90%

A total of 27 youth family surveys were completed during CY 2021 CPS, youth families reported high satisfaction perception (88 to 90 percent) in the areas of general satisfaction, perception of access, participation in treatment planning, and cultural sensitivity. The lowest satisfaction perception reported by youth families (67 to 88 percent) was in the following areas: perception of outcome of services, perception of social connectedness, and perception of functioning representing a decrease in youth family satisfaction in these areas when compared to FY 19-20. Survey findings for youth families are summarized in Table 16, including a side-by-side comparison with FY 19-20 findings:

Table 16. Satisfaction Rates - Youth for Families MHSIP Consumer Perception Survey

Survey Areas	FY 19-20		FY 21-22
	Fall 2019 (n=107)	Spring 2020 (n=17)	CY 2021 (n=27)
General Satisfaction	89%	89%	88%
Perception of Access	92%	91%	89%
Participation in Treatment Planning	91%	91%	88%
Outcome of Services	71%	91%	80%
Social Connectedness	87%	83%	82%
Cultural Sensitivity	95%	86%	90%
Perception of Functioning	67%	88%	80%

A total of 66 adult consumers completed the survey during CY 2021 CPS, adult consumers reported high satisfaction perception (86 to 88 percent) in the areas of general satisfaction, access, quality and appropriateness. The lowest satisfaction perception (77 to 85 percent) reported by adults was in the following areas: perception of outcome of treatment planning, perception of outcome of services, social connectedness, and perception of functioning, representing a decrease in beneficiary perception of satisfaction in these areas when compared to FY 19-20. Survey findings for adults are summarized in Table 17, including a side-by-side comparison with FY 19-20 findings:

Table 17. Satisfaction Rates - Adult MHSIP Consumer Perception Survey

Survey Area	FY 19-20		FY 21-22
	Fall 2019 (n=178)	Spring 2020 (n=41)	CY 2021 (n=66)
General Satisfaction	89%	90%	86%
Perception of Access	84%	89%	88%
Quality and Appropriateness	88%	91%	87%
Participation in Treatment Planning	90%	93%	84%
Outcome of Services	64%	82%	83%
Social Connectedness	69%	86%	77%
Perception of Functioning	62%	82%	85%

A total of 16 older adult consumers completed the survey during CY 2021 CPS, older adult consumers reported high satisfaction perception (86 to 90 percent) in the areas of perception of access, quality and appropriateness, and outcome of services. The lowest satisfaction perception (80 to 85 percent) reported by older adults was in the following areas: general satisfaction, participation of treatment planning, social connectedness, and perception of functioning, representing a decrease in beneficiary satisfaction perception when compared to FY 19-20. Survey findings for older adults are summarized in Table 18, including a side-by-side comparison with FY 19-20 findings:

Table 18. Satisfaction Rates - Older Adult MHSIP Consumer Perception Survey

Survey Area	FY 19-20		FY 21-22
	Fall 2019 (n=30)	Spring 2020 (n=2)	CY 2021 (n=16)
General Satisfaction	95%	100%	85%
Perception of Access	91%	100%	86%
Quality and Appropriateness	94%	100%	87%
Participation in Treatment Planning	88%	100%	85%

Outcome of Services	77%	92%	90%
Social Connectedness	81%	100%	80%
Perception of Functioning	70%	98%	80%

The results of the surveys were provided to management, as appropriate, and an overview of the survey results were presented at the Adult, Children, and YAYA Services staff meetings, while report findings were sent to the MHP's contract providers.

2) Beneficiary Grievances and Appeals

The QM Unit monitors all Medi-Cal beneficiary grievances, appeals, and fair hearing data, completes quarterly reports, and reports findings to the QIC on a quarterly basis. The QIC reviewed reports on December 9, 2021, March 10, 2022, June 09, 2022, and September 08, 2022. The QIC agreed with the recommendations made for the MHP to make best efforts to ensure beneficiary satisfaction with specialty mental health services and to ensure all grievances and appeals are logged within one working day, acknowledgment letters are sent within 5 calendar days of receipt, notice of appeal resolutions are provided within the required timeframe, and NOABD Grievance and Appeal Timely Resolution are provided on the day timeframe expires, as required.

During FY 21-22, the MHP received a total of 100 grievances (representing both Medi-Cal beneficiaries and non-Medi-Cal clients), 14 standard appeals, and 9 expedited appeals, which represents a decrease in grievances and appeals when compared to FY 21-22 when there were 104 grievances, 30 standard appeals, and 11 expedited appeals.

It is the responsibility of ICBHS deputy directors/managers to investigate grievances and appeals. The Patients' Rights Advocate provides technical assistance to management and staff to assure that beneficiary protection requirements were met.

The findings indicate that the primary reasons why beneficiaries filed grievances were due to: 1) staff behavior concerns, 2) treatment issues or concerns and 3) confidentiality. Compliance with beneficiary protection processes were noted as follows:

- 99 grievances and 23 appeals were logged within one working day as required, while 1 grievance was not. The MHP's FY 21-22 goal of ensuring that all grievances are logged within one working day of receipt was not achieved.

- 69 standard grievances and 23 appeals were mailed a written acknowledgment within the required time frame, while 2 grievance acknowledgment were issued late. The MHP's FY 21-22 goal of

ensuring that grievances are acknowledged to beneficiaries in writing within five calendar days of receipt was not achieved.

- 99 grievances and 41 appeals were resolved within the required timeframe, while 1 grievance was resolve late.

- 99 beneficiaries were notified of the grievance resolution within the required 90 day timeframe as required.

- 14 beneficiaries were notified of the appeal resolution within the required 30 day timeframe and 9 were notified of the expedited appeal resolution within the required 72-hour timeframe.

- The MHP's FY 21-22 goal of ensuring that services are authorized or provided to beneficiaries no later than 72 hours from the date and time it reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending was achieved.

- Providers cited by the beneficiary or otherwise involved in the grievances and appeals were notified of the final disposition.

During FY 21-22 the QM Unit provided management and line staff with technical assistance and training regarding the Grievance and Appeal System in accordance with CFR Title 42 to ensure: a) the MHP staff are knowledgeable regarding the new grievance and appeal system requirements; b) beneficiaries are provided with a grievance resolution within the timeframe of disposition of standard grievances and appeals; c) beneficiaries are provided with all required templates and informational notices; d) beneficiaries are provided with a NOABD Grievance and Appeal Timely Resolution when ICBHS fails to act within the timeframes of disposition of standard grievances and appeals. In addition, the MHP updated the grievance and appeal logs in order to closely monitor the processes to ensure compliance with all requirements, including new established timeframes, and issuance of NOABD, as appropriate.

3) Requests to Change Persons Providing Services

During FY 21-22, the QM Unit monitored requests to change persons providing services and reported to the QIC at least annually. The QIC reviewed the report on April 14, 2022, and members concurred with the recommendations for the MHP to make its best efforts to ensure beneficiary satisfaction with specialty mental health services in accordance with best practices and that MHP make its best efforts to approve requests for change of provider when appropriate.

During FY 21-22, ICBHS received 212 requests to change persons providing services from Medi-Cal beneficiaries, which represents an increase when compared to 187 requests received in FY 20-21. In addition, ICBHS received 17 requests to change person providing services from non-Medi-Cal clients. The number of requests demonstrates that beneficiaries are well informed of

their right to request to be seen by a specific provider and are comfortable utilizing the request for change of practitioner process.

In total, ICBHS approved 200 (94 percent) and denied 5 (2 percent) of the requests, representing both Medi-Cal and non-Medi-Cal clients. Seven withdrew the request. Clinical managers at each division evaluated all requests to change persons providing services and discussed the reason for the request with the beneficiary/authorized representative, unless unable to contact. When appropriate, clinical managers encouraged the beneficiary/authorized representative to discuss concerns with the provider. 200 (94 percent) beneficiaries/authorized representatives were notified of the decision by telephone, by mail, or in person within the requisite 10 working days.

The findings indicate that the primary reasons why beneficiaries requested to change persons providing services were due to: 1) dissatisfaction with their provider; 2) disagreement with course of treatment; and 3) uncomfortable with provider. ICBHS approved 98 percent of requests due to feeling uncomfortable with the provider, 99 percent of requests due dissatisfaction with their provider; 98 percent of the requests due to disagreement with course of treatment; and 100 percent of requests due to difficulties communication with their with provider. A comparison of the primary reasons why beneficiaries requested to change persons providing services in previous years is included in Table 19.

Table 19. Reasons for Requests to Change Persons Providing Services

FY 19-20		FY 20-21		FY 21-22	
Reason	**% Approved**	**Reason**	**% Approved**	**Reason**	**% Approved**
Dissatisfaction with provider	96%	Dissatisfaction with provider	99%	Dissatisfaction with provider	99%
Disagreement with course of treatment	95%	Disagreement with course of treatment	97%	Disagreement with course of treatment	98%
Uncomfortable with provider	100%	Uncomfortable with provider	100%	Uncomfortable with provider	98%

Consistent with its objective in FY 21-22, the MHP reviewed all requests to change person providing services and approved requests, as appropriate.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor and assess beneficiary/family satisfaction, requests to change person providing services, and report its findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will monitor and assess beneficiary/family satisfaction, grievances, appeals, fair hearing requests, and report its findings, including identified trends and recommendations, to the QIC on a quarterly basis.

- ICBHS will ensure that grievances and appeals are logged within one working day of the date of receipt, as required.

- ICBHS will ensure that grievances and appeals are acknowledged to beneficiaries in writing within five calendar days of receipt, as required.

- ICBHS will ensure that services are authorized or provided to beneficiaries no later than 72 hours from the date and time it reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending.

- The QM Unit will provide training on beneficiary protection processes at least annually to ensure compliance with all grievance and appeal requirements.

- The QIC will review and evaluate the Beneficiary/Family Satisfaction Report; Grievance, Appeals, and State Fair Hearing Report; Request to Change Practitioner Report; and Consumer Satisfaction Survey Report and make recommendations to management, as appropriate.

- The QM Unit will monitor and assess beneficiary/family satisfaction by conducting a Consumer Perception Survey of the MHP's beneficiaries and report the findings, including identified trends and recommendations, to the QIC at least annually.

- ICBHS will review all requests to change person providing services and will consider approval of the requests, as appropriate.

- ICBHS will ensure beneficiaries are provided with a decision to their request for change of person providing services within the required timeframe.

4. Service Delivery System and Meaningful Clinical Issues Affective Beneficiaries, Including the Safety and Effectiveness of Medication Practices

The QM Unit monitors the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices, through the Medication Monitoring, Quality of Care, and Documentation Standards reviews.

During FY 21-22, as part of the CalAIM initiative, DHCS provided guidance regarding criteria to access Specialty Mental Health Services for adults and children; documentation reform; treatment during the assessment period prior to diagnosis; and No Wrong Door to Mental Health Services. ICBHS plans to train all current providers on these new policies by September 30, 2022. All new providers will be trained on these policies upon hire. These policy changes have been incorporated into the QM Unit's monitoring of the MHP service delivery system for FY 22-23.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Medication Monitoring

The QM Unit monitors the Medication Monitoring reviews and reports findings to the QIC at least annually. The QIC reviewed the annual Medication Monitoring Reviews Report on June 9, 2022, and members concurred with the following recommendations; 1) complete medication consents, 2) medication consents to be sign by the physician/provider, and 3) AIMS to be completed during the last 12 months as indicated.

The Medication Monitoring reviews are conducted monthly by seven MHP adult and child psychiatrists and the Medical Director. This process allows the reviews to be more thorough and ensures inter-rater reliability. Utilizing the review tool, the Medication Monitoring Committee monitors the MHP's service delivery system, including tele-psychiatry, to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries system-wide; review medication practices for children, youth and young adult, and adult individuals receiving medication support services; and address any quality of care concerns or outliers identified related to medication use. The Medical Director updates the Medication Monitoring tool at least annually.

The charts are randomly selected from a team center list compiled from AVATAR and through the QOC reviews or team centers when an identified concern warrants further review. The QM Unit compiles the data by provider, team, division, and the MHP, identifying opportunities for improvement and areas of concern. All reports are provided to the Medical Director, including a copy of all tools completed. The QM Unit also ensures that management receives a copy of reports and completed tools, as appropriate.
Report findings, including areas of concern and areas identified as opportunities for improvement, are discussed with the MHP psychiatrists by the Medical Director at each monthly meeting.

During FY 21-22, the medication monitoring committee reviewed 179 charts: 64 from Adults Services, 47 from Children Services, and 68 from Youth and Young Adults Services. Areas at 85 percent or below are identified as opportunities for improvement. The MHP was 88 to 100 percent compliant in all of the fifteen areas evaluated, with the exception of are medication consents obtain 78 percent compliance, are medication consents sign by the provider 78% compliance, and AIMS completed in the last 12 months of treatment as required 85 percent compliance.

2) Quality of Care

The QM Unit is responsible for monitoring the Quality of Care (QOC) reviews and presenting a report to the QIC at least annually. The QIC reviewed the annual Quality of Care Report for the MHP on October 13, 2022, and members concurred with the recommendations, as indicated below.

The QOC Committee is chaired by a Quality Improvement Specialist from the Quality Management Unit. Memberships includes a rotation of behavioral health managers and supervisors, licensed and registered mental health professionals, license vocational nurses, and mental health rehabilitation technicians from all divisions of the MHP. On a rotational basis the QOC Committee meets weekly and holds the responsibility to improve access, outcomes and overall quality of care, as well as to monitor the effectiveness of evidence-based practices and internal system process.

The QOC uses a review tool that evaluates the following areas: assessment/re-assessments, treatment planning and recommendations, treatment interventions, risk assessment, and care coordination. Cases are reviewed based on referrals bade from within the MHP, the Quality Management Unit, the Medication Monitoring Committee, or one of the Quality Improvement Review Committees. When there are no cases referred, the QOC Committee reviews cases selected at random by the QM Unit.

The QOC Committee has the responsibility of completing the QOC review tool, where finding and recommendations are provided to the respective team centers that were involved in the client's care. The final report and case is routed to the team program supervisor, manager, and deputy directory for review and discussion. The QOC reports are presented to the QIC at least annually. When quality of care issues are identified, a two-week timeframe is given for corrective action. The QM Unit is responsible for monitoring corrective action and ensuring timely intervention occurs.

During FY 21-22, the QOC reviewed the medical records of twenty clients served by the MHP. The QOC Committee made the following recommendations:

- Conduct thorough on-going assessment of the client's presenting problem, symptoms and behaviors to support diagnosis, update as appropriate, and barriers that might contribute to client's lack of progress with services provided.
- Provide meaningful care coordination with mental health providers, significant support and/or community agencies to support the client towards decreasing functional impairments and improve mental health condition.
- Utilize the Treatment Team process to discuss alternate treatment approaches when the client is not progressing with current treatment interventions, as appropriate.
- Conduct home visits to assess environmental stressors and/or family dynamics affecting client's mental health condition. When appropriate document barriers that prevent service providers from conducting home visits.

During FY 21-22, no corrective action plans were issued for instances of poor quality of care. The QM Unit compiled findings identifying strengths, opportunities for improvement and recommendations, as appropriate. Findings

were provided to the individual team supervisors and managers, as appropriate.

3) Documentation Standards

The QM Unit is responsible for conducting Documentation Standards chart reviews to monitor if the MHP is following documentation standards as set forth in DHCS regulations and MHP policies and procedures. This process is instrumental in identifying billing issues as well as opportunities for improvement.

The QM Unit compiles findings and presents a report to the QIC at least annually. The QIC reviewed the Annual Documentation Standards Reviews Report on September 8, 2022. Members concurred with the recommendations made for the MHP, listed below. Areas below the benchmark of 80 percent are identified as opportunities for improvement.

The documentation standards chart reviews were conducted by the QM Unit on an ongoing basis, with charts randomly selected from a team center list compiled from AVATAR. A review tool with the following seven categories was utilized: 1) Medical Necessity/Access Criteria; 2) Intake Assessment/Re-Assessment; 3) Client Plan; 4) Clinical Chart Progress Notes; 5) Case Management Progress Notes; 6) Care Coordination and Continuity of Care, 7) Other Chart Documentation, and 8) Quality of Care.

The QM Unit compiled the data by team identifying opportunities for improvement and areas of concern, as appropriate. Team reports were provided to the individual team supervisors and managers, as appropriate. Supervisors were given a two-week timeframe to respond to areas identified as opportunities for improvement. Areas that fell below the 80 percent benchmark required a corrective action plan. Each team manager had to review the potential corrective action plan and sign for approval. The QM Unit would approve the Corrective Action Plan, prior to its implementation, and followed up with each team to ensure all corrective actions were completed. In the event issues of potential poor quality of care were identified, the reviewer referred the case to the appropriate review committee for a second level review.

During FY 21-22, the QM Unit reviewed 288 clinical and case management charts for the MHP, of which 72 charts were for Children Services, 83 chart were for Youth and Young Adults Services, and 74 charts were for Adults Services and 59 charts were for Mental Health Triage and Engagement Service. Additionally, the QM Unit reviewed charts from the MHP's contracted network providers. Ten charts were reviewed for Center for Family Solutions, ten (TBS) for C.H.A.R.L.E.E. Family Care, 9 for Helping Hearts Adult Residential and ten for Jackson House Crisis Residential.

The MHP met the 80 percent benchmark in five of the eight categories reviewed, which include Medical Necessity, Assessment/Re-Assessment, Client Plan, Clinical and Case Management Progress Notes, Care

Coordination, Quality of Care, and Other Areas of Review. The following fell below the 80 percent benchmark:

Assessment

- Is the PSC – 35 completed with parent/caregiver for children and youth, at the beginning of treatment, every six months following the first administration and at the end of treatment; 75% compliance.
- Is the CANS completed for children and youth and their parents/caregivers at the beginning of treatment, every six months following the first administration and at the end of treatment; 73% compliance.
- Clients are assessed (ongoing) and offered ICC and IHBS services; 71% compliance.

Case Management Notes

- Is there a completed MHRT needs assessment included in the case management chart; 75% compliance.

Care Coordination

- Is there evidence the beneficiary/client was provided information on how to contact his or her service coordinator; 62% compliance.

This is an increase from last year when only one opportunity for improvement was identified in the area of the Assessment.

The following recommendations were made to the QIC:

- For children/youth to be assessed for ICC/IHBS criteria.
- Utilize PSC and CANS assessment tools as required.
- Complete the MHRT Needs Assessment as required.

Opportunities for improvement were also identified at the division level. The deputy directors were provided with an individual annual report by division to implement appropriate interventions to address areas identified as opportunities for improvement.

For contracted network providers, opportunities for improvement were identified in the areas of Assessment, Client Plan, and Progress Notes. Findings were presented to each provider. The QM Unit issued plans of correction to ensure that the appropriate corrections were made, as applicable, and that processes were established to ensure future compliance with documentation standards requirements.

Additionally, the Compliance Unit worked closely with clinical staff to ensure that services claimed were in accordance with the MHP's contract with DHCS as well as MHP policy and procedures. Any claims for services that were not in compliance were disallowed as required.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices, through medication monitoring and QOC chart reviews and report its findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Medication Monitoring Report, Quality of Care Report, and Documentation Standards Report and make recommendations to management, as appropriate.

- The MHP will implement appropriate interventions when individual occurrences of potentially poor quality of care are identified.

- The Medication Monitoring Review Committee will meet monthly and conduct medication monitoring chart reviews for the MHP.

- The QOC Committee will meet as scheduled and conduct Quality of Care chart reviews for the MHP.
- The QM Unit will monitor the MHP service delivery system to identify meaningful clinical issues affecting beneficiaries and present findings to management, as well as report findings, including trends and recommendations, to the QIC at least annually.

- The QM Unit will update its monitoring process to verify the MHP is in compliance with the CalAIM policy initiatives of criteria to access Specialty Mental Health Services for adults and children; documentation reform; treatment during the assessment period prior to diagnosis; and No Wrong Door to Mental Health Services.

- The MHP will implement strategies to address areas identified as opportunities for improvement through the Medication Monitoring, Quality of Care, and Documentation Standards reviews in an effort to improve compliance and meet the standards set forth in both the contract with DHCS and the MHP's policies and procedures.

5. Continuity and Coordination of Care with Physical Health Care Providers and Other Human Services Agencies

The QM Unit monitors the continuity and coordination of care with Physical Care Providers (PCPs) and other human services agencies used by its beneficiaries through a memorandum of understanding and chart reviews, and by providing information, training, and consultation to PCPs and other human services agencies.

On January 1, 2023, ICBHS will be required to comply with the DHCS policy to implement standardized screening and transition tools. These will be implemented to fully realize the CalAIM No Wrong Door to Mental Health Services policy. The QM Unit will be responsible for monitoring the implementation of these tools.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Care Coordination & Continuity of Care

In FY 21-22, the QM Unit monitored the MHP's care coordination of continuity of care through chart reviews. These reviews were conducted utilizing a review tool that took into consideration, if appropriate, coordination of services with PCPs and other human services agencies used by its beneficiaries as well as referrals to community resources. A report was presented to the QIC on September 8, 2022.

The reviews are included as part of the Documentation Standards chart review process and entail assessing access to care, coordination of services, and referrals to community resources. The QM Unit reviewed 288 charts and identified the following:

- Does the beneficiary have an ongoing source of care appropriate to his or her needs; 92% compliance.
- Does the beneficiary have a service coordinator assigned that is responsible for coordinating the services accessed by the beneficiary; 99% compliance.
- Is there evidence the beneficiary was provided information on how to contact his or her service coordinator; 62% compliance.
- Are the services coordinated for the beneficiary between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays; 100% compliance.
- Are services provided by the MHP coordinated with the services the beneficiary receives from any other organizations, including managed care organizations, community and social support providers, and other human services agencies; 95% compliance.

2) Memorandum of Understanding with Manage Care Plans

ICBHS maintains Memorandums of Understanding (MOU) with two Medi-Cal Managed Care Plans (MCPs) that enroll beneficiaries covered by the MHP. The MOUs address referral protocols between plans, the availability of clinical consultation, management of a beneficiary's care, procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP and a process for resolving disputes between the MHP and the MCP that includes a means for beneficiaries to receive medically necessary services.

During FY 21-22, quarterly meetings were held between the MHP's upper management team and MCP representatives to aid the MHP in working collaboratively with the MCPs to ensure that processes affecting client continuity of care are appropriate and effective.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor and assess the continuity and coordination with PCPs and other human service agencies through the Documentation Standards reviews and report its findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the QOC and Documentation Standards reviews and make recommendations to management, as appropriate.

- The QM Unit will continue to attend quarterly meetings with its MCPs in order to ensure continuity of care for beneficiaries receiving services through the MCPs.

- The QM Unit will update its monitoring process to verify the MHP is implementing the standardized screening and transition tools and is in compliance with the CalAIM policy initiative of No Wrong Door to Mental Health Services.

6. Provider Complaints and Appeals

The QM Unit monitors provider disputes with ICBHS concerning the processing or payment of a provider's claim for Specialty Mental Health Services. The QM Unit also monitors provider appeals through the written appeals submitted to ICBHS by providers for denial or modification of requests for payment authorization.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

The QM Unit monitors provider complaints and appeals and reports the findings to the QIC at least annually. The QIC reviewed the Provider Complaints and Appeals Report on July 14, 2022. No recommendations were made.

During FY 21-22, the QM Unit fulfilled the MHP's provider relations responsibilities, as needed. All providers are encouraged, as outlined in the Provider Handbook, to present complaints to the Provider Relations staff by telephone, in person, or in writing. Provider Relations staff makes every effort to resolve complaints quickly and at the lowest possible level. If providers are not satisfied with the outcome of the complaint process, they are provided information on the appeals process.

In FY 21-22, no complaints were reported to the QM Unit, as indicated in Table 20.

Table 20. Inpatient and Outpatient Provider Complaints

Period	Number of Complaints	Reason for Complaint	Resolved	
			Yes	No
FY 21-22	0	N/A	-	-
FY 20-21	0	N/A	-	-

FY 19-20	0	N/A	-	-

In FY 21-22, one appeal was reported to the QM Unit due to the PAU denying payment for inpatient psychiatry services; decision was upheld due to the hospitals late notification to the MHP. Table 21.

Table 21. Inpatient and Outpatient Provider Appeals

Period	Number of Appeals	Reason for Appeal	Appeals Denied	Appeals Approved
FY 21-22	1	Denial of Payment	1	0
FY 20-21	0	N/A	N/A	N/A
FY 19-20	0	N/A	N/A	N/A

During FY 21-22, Provider Relations staff was available to provide technical assistance to providers and MHP staff as needed to resolve complaints at the lowest level possible.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor provider complaints and appeals and report findings, including identified trends and recommendations, to the QIC at least annually.
- The Provider Relations staff will provide technical assistance to providers and/or MHP staff as needed to resolve complaints at the lowest possible level.

B. Additional MHP QI Areas

1. Utilization Management Program Review

The QM Unit monitors the Utilization Management Program (UMP) through a review of the authorization decision-making process. The UMP is also monitored through surveys for beneficiary and provider satisfaction for inpatient and outpatient services.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) UMP Authorization Process

The QM Unit monitored the UMP through a review of Treatment Authorization Requests (TARs) and Service Authorization Requests (SARs) to ensure compliance with the established standards for making authorization decisions and to evaluate the consistency of the authorization process. The Payment Authorization Unit (PAU) of the MHP is responsible for the authorization process. A report was presented to the QIC on April 14, 2022. No recommendations were made.

The process for conducting the reviews was to randomly select a 35 percent sample of all inpatient, inpatient ancillary, and outpatient TARs and SARs submitted. A total of 191 TARs were reviewed: 51 for outpatient services, 46 for inpatient/Fee-For Service hospital (ancillary) services, 90 for inpatient crisis

and adult residential and 4 SARs. This review period was July 1, 2021, through June 30, 2022. TARs for inpatient, inpatient ancillary services, and outpatient services are evaluated based on the following seven criteria:

1. Authorization decisions made by a licensed or "waivered/registered" mental health staff consistent with State regulations.
2. Relevant clinical information obtained and used for authorization decisions and a written description of the information that is collected to support authorization decision making.
3. The statewide medical necessity criteria was used to make authorization decisions.
4. Documentation and communication of reason for each denial.
5. Written notification (NOABD) to beneficiaries and providers of the reason for each denial.
6. Authorization decisions were made in accordance with the statewide timeliness standard for authorization of services for urgent conditions.
7. Information about the beneficiary grievance, appeals and fair hearing processes in all denial or modification notifications sent to the beneficiary.

a) *Outpatient Services*

The outpatient TAR review was completed with 100 percent compliance in four of the applicable areas. For this review period, 170 TARs were approved as requested:

Table 23. Outpatient Treatment Authorization Requests

Criteria		Y	N	N/A	% Compliance
1.	Authorization decisions are made by licensed or waivered/registered mental health professionals	51			100%
2.	Relevant clinical information was used in making authorization decisions and there is a written description of the information supporting the authorization decision?	51			100%
3.	Statewide medical necessity criteria was used to make authorization decisions	51			100%
4.	The MHP clearly documented the reason for each denial or modification.			51	N/A
5.	Written notification was sent to the beneficiary with the reason for denial or modification			51	N/A
6	Authorization decisions were made within the statewide timeliness standards.	51			100%
7.	Notices sent to beneficiaries included information about grievance and fair hearing processes.			51	N/A

The PAU was 100 percent compliant in the area of the authorization decision making process, as well as the consistency of the authorization process. All outpatient services requests were processed timely as required.

b) *Inpatient & FFS Inpatient (Ancillary) Services*

The inpatient TAR review was completed with 100 percent compliance in all seven areas. For this review period, 46 TARs were approved as requested and seven were denied:

Table 24. Inpatient Treatment Authorization Requests

Criteria		Y	N	N/A	% Compliance
1.	Authorization decisions are made by licensed or waivered/registered mental health professionals	46			100%
2.	Relevant clinical information was used in making authorization decisions and there is a written description of the information supporting the authorization decision?	46			100%
3.	Statewide medical necessity criteria was used to make authorization decisions	46			100%
4.	The MHP conducts concurrent review of treatment Authorization of Services following the first day of admission.	46			100%
5.	The authorization decision made was in accordance with statewide timeliness standards for authorization of services established in state regulations of 14 business days.	46			100%
6.	The MHP clearly documented the reason for each denial or modification.	7		39	100%
7.	Written notification was sent to the beneficiary with the reason for denial or modification	7		39	100%
8.	Notices sent to beneficiaries included information about grievance and fair hearing processes.	7		39	100%

The PAU was 100 percent compliant in the area of the authorization decision making process, as well as the consistency of the authorization process. All inpatient and FFS inpatient (ancillary) service requests were processed timely as required.

c) *Inpatient Crisis Residential and Adult Residential Concurrent Treatment Authorization Reviews*

The inpatient crisis and adult residential TAR review was completed with 100 percent compliance in all seven areas. For this review period, 90 TARs were approved as requested.

Table 25. Inpatient Crisis and Adult Residential Treatment Authorization Requests

Criteria		Y	N	N/A	% Compliance
1.	Authorization decisions are made by licensed or waivered/registered mental health professionals	90			100%
2.	Relevant clinical information was used in making authorization decisions and there is a written description of the information supporting the authorization decision?	90			100%
3.	Statewide medical necessity criteria was used to make authorization decisions	90			100%
4.	The MHP conducts concurrent review of treatment Authorization of Services following the first day of admission.	90			100%
5.	The MHP clearly documented the reason for each denial or modification.			90	N/A

6.	Written notification was sent to the beneficiary with the reason for denial or modification			90	N/A
7.	Authorization decisions were made within the statewide timeliness standards.	90			100%
8.	Notices sent to beneficiaries included information about grievance and fair hearing processes.			90	N/A

The PAU was 100 percent compliant in the area of the authorization decision making process, as well as the consistency of the authorization process. All inpatient crisis and adult residential service requests were processed timely as required.

d) Service Authorization Requests

The outpatient SAR review was completed with 100 percent compliance in all seven areas. For this review period, four SARs were approved as requested.

Table 26. Service Authorization Requests

Criteria		Y	N	N/A	% Compliance
1.	Authorization decisions are made by licensed or waivered/registered mental health professionals	4			100%
2.	Relevant clinical information was used in making authorization decisions and there is a written description of the information supporting the authorization decision?	4			100%
3.	Statewide medical necessity criteria was used to make authorization decisions	4			100%
4.	The MHP clearly documented the reason for each denial or modification.			4	N/A
5.	Written notification was sent to the beneficiary with the reason for denial or modification			4	N/A
6.	Authorization decisions were made within the statewide timeliness standards (3 business days, or within 72 hours for urgent requests).	4			100%
7.	a. SARs that required additional information were approved within 7 calendar days.			4	N/A
	b. Decisions made outside the applicable timeframe (3 working days from receipt of additional information or 14 calendar days from the receipt of the original SAR).			4	N/A
8.	Notices sent to beneficiaries included information about grievance and fair hearing processes			4	N/A

The PAU was 100 percent compliant in the area of the authorization decision making process, as well as the consistency of the authorization process. All service authorization requests were processed timely as required.

In the area of the consistency of the authorization process, the MHP was 100 percent compliant for all providers.

2) UMP Provider Satisfaction

As part of the UMP, the MHP is required to assess provider satisfaction with the UMP at least annually and present a report to the QIC. The assessment entailed conductions a provider satisfaction survey with the UMP for Inpatient Hospital, Inpatient Ancillary, and Outpatient Services during FY 21-22. The QM Unit conducted the survey via phone and fax, as appropriate.

The survey tool was revised prior to conducting the survey to ensure the questions are easy to understand by all providers. The survey tool includes questions in the following areas: overall satisfaction; notification process; authorization process; and provider appeal process.

a) *Inpatient Hospital Services*

A total of 24 hospitals provided inpatient services to MHP beneficiaries during FY 21-22. The survey was faxed to all providers, with phone surveys also conducted in efforts to increase the response rate. The QM Unit received nine responses, for a response rate of 42 percent. The survey was compared to the provider satisfaction survey of FY 18-19 which received three responses out of 19 providers, with a response rate of 16 percent.

The following information pertains to the hospital staff who answered the survey:

Position/Discipline:	100 percent Utilization Review Staff
Provider Status:	87 percent Non-Contract and 13 percent Contract Provider

Survey findings are as follows:

- Overall provider satisfaction with the UMP; 100 percent satisfaction.
- In the area of notification process; 100 percent satisfaction.
- In the area of authorization process; 100 percent satisfaction in all seven areas.
- In the area of provider appeal process; 100 percent satisfaction in both areas.

Based on these findings for the MHP, the QM Unit made no recommendations. The survey report was presented to the QIC on September 8, 2022.

b) *Inpatient Ancillary Services*

A total of 7 providers provided inpatient ancillary services to MHP beneficiaries during FY 20-21. The survey was faxed to all providers, in efforts to increase the response rate the QM unit provided the survey multiple times during the survey period. The QM Unit received no responses this is a decrease when compared to FY 18-19, in which the QM unit received eight responses out of 14 providers with a response rate of 57 percent.

c) *Outpatient Services*

A total of 3 providers provided outpatient services to MHP beneficiaries during FY 21-22. The survey was faxed to all providers, with phone surveys also conducted in efforts to increase the response rate. The QM Unit received three responses, for a response rate of 100 percent. The survey was compared to the provider satisfaction survey of FY 18-19, which received seven responses out of eight providers with a response rate of 88 percent.

The following information pertains to the provider who answered the survey:

Position/Discipline: 33 percent CHARLEE Family Care Inc.
33 percent Center for Family Solutions
33 percent JH Crisis Residential

Provider Status: 33 percent Contract Providers

Survey findings are as follows:

- Overall provider satisfaction with the UMP; 100 percent satisfaction.
- In the area of notification process; 100 percent satisfaction.
- In the area of authorization process; 100 percent satisfaction in all seven areas.

Based on these findings, the QM Unit made the recommendation to improve the payment process. The survey report was presented to the QIC on September 08, 2022, no recommendations were made.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The MHP will ensure that TARs are processed within the guidelines as established by the DHCS Contract, Attachment 1, and BHIN 22-016 and 22-017.

- The QM Unit will monitor the Utilization Management Program and report to the QIC at least annually.

- The QIC will review and evaluate Utilization Management Program reports and make recommendations to management, as appropriate.

- The QM Unit will conduct the provider satisfaction with UMP surveys via telephone or mail, when necessary, for inpatient, inpatient ancillary, and outpatient services.

2. Notices of Adverse Benefit Determination (NOABD)

The MHP and its contracted network providers are required to provide Medi-Cal beneficiaries, or their representative, with a Notice of Adverse Benefit Determination (NOABD) when the MHP or its providers take any of the following actions: 1) Denies or limits authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness

of a covered benefit; 2) Reduces, suspends, or terminates a previously authorized service; 3) Denies, in whole or in part, payment for a service; 4) Fails to provide services in a timely manner; 5) Fails to act within the required timeframes for standard resolution of grievances and appeals; or 6) Denies a beneficiary's request to dispute financial liability.

The MHP and its contracted network providers must provide beneficiaries with a written notice of the adverse benefit determination and the NOABD must explain the following:

1. The adverse benefit determination the MHP or one of its contracted network providers has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The NOABD shall explicitly state why the beneficiary's condition does not meet specialty mental health services medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations; and
4. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Decisions must be communicated to the beneficiary within the following timeframes:

- For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214;
- For denial of payment, at the time of any action denying the provider's claim; or,
- For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two business days of the decision.

Additionally, the decision must by communicated to the provider by telephone of facsimile and then in writing.

The following attachments must be included with each NOABD:

1. <u>"NOABD Your Rights"</u>
   The "NOABD Your Rights" provides beneficiaries with the following required information pertaining to the NOABD:
   a. The beneficiary's or provider's right to request an internal appeal with the MHP within 60 calendar days from the date on the NOABD;
   b. The beneficiary's right to request a State hearing only after filing an appeal with the MHP and receiving a notice that the Adverse Benefit Determination has been upheld;
   c. The beneficiary's right to request a State hearing if the MHP fails to send a resolution notice in response to the appeal within the required timeframe;

d. Procedures for exercising the beneficiary's rights to request an appeal;
e. Circumstances under which an expedited review is available and how to request it; and,
f. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420.

2. Nondiscrimination Notice
3. Language Assistance Taglines

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

During FY 20-21, ICBHS issued NOABDs when the MHP or its providers made any of the following actions: 1) denied or limited authorization of a requested service, including the type or level of service; 2) reduced, suspended, or terminated a previously authorized service; 3) denied in whole, or in part, payment for a service; 4) failed to act within the timeframes for resolution of grievances, appeals, or expedited appeals; or 5) failed to provide services in a timely manner.

1) Notice of Adverse Benefit Determination (NOABD) – Delivery System

The NOABD-Delivery System is issued to Medi-Cal beneficiaries when the MHP or its providers determine that the beneficiary does not meet the criteria to be eligible for specialty mental health services. The beneficiary will be referred to the Managed Care Plan, or other community systems of care, as appropriate. The decision must be communicated to the beneficiary or their representative within two business days of the date of the decision. Clinicians at each provider site issues the NOABD-Delivery System.

The QM Unit is responsible for monitoring the issuance of the NOABD-Delivery System and reporting quarterly findings to the MHP with the recommendations for the MHP to issue NOABDs when the beneficiary does not meet medical necessity criteria for specialty mental health services; to issue NOABDs within two days of the date the decision is made; to ensure all NOABD issued are client-centered and in the beneficiary's primary language; and to issue NOABDs to Medi-Cal beneficiaries only.

The QM Unit monitoring process entailed the review of NOABD Delivery System tracking log report from My Avatar report to ensure all recorded notices are sent to beneficiaries as required. The date of decision on the NOABD-Delivery System was compared to the date indicated on the NOABD Delivery System notice in order to determine the timeliness of issuance. Additionally, the QM Unit utilized the Initial Intake Discharge Report from MyAvatar to ensure all Medi-Cal beneficiaries not meeting access/medical necessity criteria for specialty mental health services were issued a NOABD-Delivery System as required.

In FY 21-22, the MHP and its providers screened out a total of 386 Medi-Cal beneficiaries at the time of the initial assessment. The MHP issued a total of 384 NOABDs as required. Two NOABDs were issued outside of the two-day timeliness requirement and 17 NOABDs were not issued, as required. There

were 254 NOABDs issued in English and 132 NOABDs issued in the MHP's threshold language, Spanish. Additionally, there were 38 issued to non-Medi-Cal beneficiaries during FY 21-22.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP had a compliance rate of 99 percent for issuing NOABDs to Medi-Cal beneficiaries who did not meet access/medical necessity criteria for specialty mental health services, as required. Table 27 reflects that data for the last three fiscal years.

Table 27. Issuance of NOABD Delivery System

Review Period	Screened Out Medi-Cal Beneficiaries	NOABD Issued Within 2 Day Standard		NOABD Issued Outside 2 Day Standard		NOABDs Not Issued	
FY 21-22	403	384	95%	2	<1%	17	4%
FY 21-21	393	361	92%	10	<3%	22	5%
FY -19-20	609	556	98%	12	<2%	41	<1%

The QM Unit worked with team centers to educate staff on the importance of issuing NOABD-Delivery System within the two-day standard and to Medi-Cal beneficiaries only.

2) *Notice of Adverse Benefit Determination (NOABD) – Termination of a Previously Authorized Service*

NOABDs for Termination of a Previously Authorized Service are issued to Medi-Cal beneficiaries when the MHP or its providers have made or intend to reduce, suspend, or terminate a previously authorized specialty mental health service. The decision must be communicated to the beneficiary at least 10 days before the date of the action. Service coordinators at each provider site issue the NOABD-Termination.

The QM Unit is responsible for monitoring the issuance of the NOABD-Termination and reporting quarterly findings to the MHP with the recommendations for the MHP to issue all NOABDs when services are being reduced, suspended, and/or terminated, at least 10 days prior to the date of action and to issue NOABDs to Medi-Cal Beneficiaries only.

During FY 21-22, the monitoring process entailed comparing the NOABD tracking logs to the Discharge Summary Report in MyAvatar to verify if the MHP issued and logged the NOABD prior to the action.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP had a compliance rate of 99 percent for issuing NOABDs for termination, reduction, or suspension of a previously authorized service to Medi-Cal beneficiaries for the 1,998 beneficiary review sample. Table 28 reflects that data for FY 21-22.

Table 28. Issuance of NOABD Termination

Review Period	# of NOABDs Issued	# of NOABDs Reviewed		NOABDs Issued Timely (10 days prior to action)		NOABDs Not Issued
FY 21-22	3,907	2,013	52%	1,998	99%	142
FY 20-21	3,534	1,804	51%	1,788	99%	151
FY 19-20	3,743	1,805	48%	1,795	99%	137

The QM Unit worked with team centers to educate staff on the importance of issuing NOABDs when reducing suspending or terminating a previously authorized service within the ten-day standard.

3) *Notice of Adverse Benefit Determination (NOABD) – Denial of Authorization for Services Requested*

NOABDs for Denial of Authorization for Services Requested are issued to beneficiaries when the MHP or its providers denies a request for a service, including determinations based on type or level of service requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

The QM Unit is responsible for monitoring the issuance of NOABDs for Denial of Authorization of Services Requested and reporting findings to the MHP at least annually.

The monitoring process entailed a review of NOABDs issued by comparing the names and dates on the NOABDs to the names and dates recorded on the monthly PAU Final Recap Report and the NOABD tracking logs received by the team centers to determine if the NOABDs were issued within the two-day timeliness standard and in the beneficiary's primary language.

In FY 21-22, there were 17 denial requests for authorization; 17 from the MHP and zero from the PAU. Fifteen NOABDs were issued to beneficiaries within the two-day timeliness standard and one was not. Three NOABD were not issued in the beneficiary's primary language, as required. By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP had a compliance rate of 88 percent for issuing the NOABD - Denial of Authorization for Services Requests to Medi-Cal beneficiaries. Report findings were presented to the MHP.

4) *Notice of Adverse Benefit Determination (NOABD) – Delay in Processing Authorization of Services*

NOABDs for Delay in Processing Authorization of Services are issued to Medi-Cal beneficiaries when the MHP delays the processing of a provider's request for authorization for specialty mental health services.

The QM Unit is responsible for monitoring the issuance of NOABDs for Delays in Processing Authorization of Services and reporting findings to the PAU at least annually.

The monitoring process entailed a review of all NOABDs issued by PAU and verify the names and dates on the NOABDs to the names and dates recorded on the monthly PAU Final Recap Report to determine if the NOABDs were issued within the two-day timeliness standard and in the beneficiary's primary language.

During FY 21-22, there were no delays in processing authorization of services from the PAU, therefore no NOABDs were required to be issued. Report findings were presented to the PAU.

5) Notice of Adverse Benefit Determination (NOABD) – Modification of a Requested Service

NOABDs for Modification of a Requested Service are issued to Medi-Cal beneficiaries when the MHP modifies or limits a provider's request for a service including reductions in frequency and/or duration of services, and approval of alternative treatments and services. The NOABDs are issued by the PAU.

The QM Unit is responsible for monitoring the issuance of NOABDs for Modification and reporting finding to the PUA at least annually.

The monitoring process entailed a review of all NOABDs issued by the PAU to verify the names and dates on the NOABDs to the names and dates recorded on the monthly PAU Final Recap Report and determine if NOABDs were issued within the two-day timeliness standard and issued in the beneficiary's primary language.

During FY 21-22, there were no modifications requested by the PAU, therefore no NOABDs were required to be issued. Report findings were presented to the PAU.

6) Notice of Adverse Benefit Determination (NOABD) – Payment Denial for Service Rendered

NOABDs for Payment Denial are issued to Medi-Cal beneficiaries the MHP denies in completely, or in part, payment for a specialty mental health service that has been provided. The NOABD-Payment Denial is issued by the PAU.

The QM Unit is responsible for monitoring the issuance of the NOABD-Payment Denial and reporting findings at least annually to the PAU. The monitoring process entailed a review of all NOABDs issued to verify the names and dates on the NOABDs to the names and dates recorded on the monthly PAU Final Recap Report to determine if the NOABDs issued within the two-day timeliness standard. The QM Unit also verifies if NOABDs were issued in the beneficiary's primary language.

In FY 21-22, there were 7 payment denials by the PAU. There were 7 NOABDs issued as required. All NOABDs issued were issued to beneficiaries within the two-day timeliness standard and in the beneficiary's primary language, as required. By evaluating the data gathered in FY 21-22, the QM Unit verified that the PAU had a compliance rate of 100 percent for issuing the NOABD-Payment Denial to Medi-Cal beneficiaries. Report findings were presented to the PAU.

7) Notice of Adverse Benefit Determination (NOABD) – Delays in Grievance/Appeal Processing

NOABDs for Grievance & Appeal Timely Resolution are issued to Medi-Cal beneficiaries when the MHP fails to act within the timeframes for resolution of grievances (90 calendar days), standard appeals (30 calendar days), or expedited appeals (72 hours from receipt). The MHP's deputy directors/managers are responsible for issuing the NOABD-Grievance/Appeal Delay as appropriate.

During FY 21-22, there was one NOABD-Grievance/Appeal Delay issued by the MHP. NOABD was not issued within the required timeliness standard, as required. The QM Unit met its objective to monitor the issuance of NOABDs and report findings and make recommendations to the MHP.

8) Notice of Adverse Benefit Determination (NOABD) – Failure to Provide Timely Access

NOABDs for Timely Access are issued to Medi-Cal beneficiaries or their representatives when the MHP, or its providers, fail to provide services in a timely manner. Providers are required to comply with the timely access standards as established by DHCS and the MHP, taking into account the urgency of the need for services. Timely access standards refers to the number of business days in which the MHP and its providers must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service. The MHP and its providers must comply with the following timely access standards:

- For requests for initial routine mental health services, within seven business days from request to appointment from July 2021 to March 2022 and within 10 business days from April 2022 to June 2022, as established by the MHP;
- For requests for psychiatry, within 15 business days from request to appointment; and,
- For requests for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services, within 10 business days from request to appointment.

The QM Unit is responsible for monitoring the issuance of the NOABD-Timely Access and reporting quarterly findings to the MHP.

During FY 21-22, the source documents utilized in the reviews were the MH Timeliness to Initial Intake Appointment Report in Avatar to verify whether ICBHS met the timeliness standard for routine mental health services, and the Access Log to verify whether ICBHS met the timeliness standards for psychiatry, Mental Health Services, Targeted Case Management, and Medication Support Services. Appointments scheduled outside timeliness standards were noted as being outside the timeliness standard, therefore requiring the issuance of a NOABD to Medi-Cal beneficiaries.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP had a compliance rate of 100 percent for issuing the NOABD-Timely Access to Medi-Cal Beneficiaries, as required. Table 29 reflects the data for the last three fiscal years.

Table 29. Issuance of NOABDs – Timely Access

Review Period	Medi-Cal Requests for Routine Appointments	Appointments Offered Over Timeliness Standard	NOABDs Issued	NOABDs Not Issued as Required	Compliance Rate
FY 21-22	4,688	97	97	0	100%
FY 20-21	3,453	0	N/A	N/A	N/A
FY 19-20	4,078	5	0	5	0%
Review Period	**Medi-Cal Requests for Psychiatry**	**Appointments Offered Over 15-Day Standard**	**NOABDs Issued**	**NOABDs Not Issued as Required**	**Compliance Rate**
FY 21-22	1	0	N/A	N/A	N/A
FY 20-21	0	N/A	N/A	N/A	N/A
FY 19-20	0	N/A	N/A	N/A	N/A
Review Period	**Medi-Cal Requests for MHS, TCM, & Med Support**	**Appointments Offered Over 10-Day Standard**	**NOABDs Issued**	**NOABDs Not Issued as Required**	**Compliance Rate**
FY 21-22	12	2	0	2	0%
FY 20-21	20	0	N/A	N/A	N/A
FY 19-20	2	0	N/A	N/A	N/A

9) *Notices of Adverse Benefit Determination (NOABD) – Dispute of Financial Liability*

NOABDs for Dispute of Financial Liability are issued to Medi-Cal beneficiaries or their representatives when the MHP or its providers denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
During FY 21-22, there were no disputes of financial liability submitted by Medi-Cal beneficiaries, therefore no NOABDs were required to be issued.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the issuance of NOABDs when the MHP makes or intends to make an adverse benefit determination and report findings, as appropriate.

- The QM will review and evaluate NOABD reports and make recommendations to management, as appropriate.

3. Request for a Second Opinion

The QM Unit monitors requests for a second opinion in an effort to ensure beneficiary satisfaction. The MHP provides for a second opinion by a licensed mental health professional when the MHP or its providers determine that the beneficiary is not entitled to specialty mental health services based on the lack of medical necessity.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

The QM Unit monitors all Medi-Cal beneficiary requests for a second opinion, completes a report biannually, and reports findings to the QIC at least annually. The QIC reviewed the report on April 14, 2022. No recommendations were made.

During FY 21-22, the MHP provided beneficiaries with a second opinion upon request. The MHP received a total of four requests for a second opinion from Medi-Cal beneficiaries, which represents a decrease when compared to FY 2-21 when there were nine requests for a second opinion. The MHP scheduled face-to-face appointments for all second opinion requests. The clinical managers for Children and Mental Health Triage and Engagement Services ensured that beneficiaries were notified of the decision in person or by mail. Four (100 percent) decisions were provided within the required 15 working days, the MHP's goal to ensure that second opinion decisions are provided within the 15 working day timeframe was achieved. The MHP provided beneficiaries with the reasons why they did not meet medical necessity and their right to file a grievance or appeal if they were not satisfied with the MHP's decision.

The findings reflect that out of the four second opinion decisions, five (56 percent) met medical necessity and three (75 percent) met medical necessity and on (25 percent did not. Four (100 percent) of the decisions were provided through a face-to-face review.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor requests for a second opinion and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Request for Second Opinion Report and make recommendations to management, as appropriate.

4. Timeliness of Services

The QM Unit monitors the timeliness to first psychiatric appointment after a hospitalization. The MHP has established a seven working day timeliness standard to provide a psychiatric appointment upon discharge from hospitalization for both active and inactive clients.

In addition, the QM Unit monitors the timeliness to initial nursing assessment and timeliness to initial psychiatric appointment. The MHP has established a 30 working day timeliness standard to provide an initial psychiatric appointment when an evaluation for Medication Support Services is recommended.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Timeliness of First Psychiatric Appointment after a Hospitalization

The QM Unit monitors the timeliness to the first psychiatric appointment after a hospitalization on a quarterly basis and reports findings to the QIC at least annually. The QIC reviewed a report on March 10, 2022. Members agreed with the recommendation for Adults Services and Mental Health Triage and Engagement Services to ensure all clients are provided with a follow-up psychiatric appointment within the MHP's standard of seven working days from the date of discharge from a hospitalization.

The monitoring process entailed collecting data on a quarterly basis for all clients who were discharged from a psychiatric hospital during FY 21-22. The source documents utilized are the Hospitalization Recap Log, which identifies the clients who were hospitalized, the date of admission, and the date of discharge; the MHP's client ledger; and treatment history from AVATAR, which identifies the dates of the first scheduled psychiatric appointment, as well as claims and other appointments scheduled. The number of days between the hospital discharge date and the date of the first scheduled psychiatric appointment were calculated to determine if the MHP met the established timeliness standards. If an appointment is outside the timeliness standard, the QM Unit reviews the client's records to ensure that there were no follow-up services provided during the timeframe identified prior to determining that the timeliness standard was not met. The compliance rate is then determined by dividing the number of required follow-up appointments that met the seven-day standard (numerator) by the total number of required follow-up appointments (denominator).

During FY 21-22, there were a total of 130 hospitalizations. Of those, 51 clients did not receive a follow-up psychiatric appointment with the MHP due to the clients receiving care from other providers or returning to placement (8 percent); residing out of county (70 percent); being unable to contact (20 percent); or refusing service (2 percent).
Of the 79 clients that received follow-up psychiatric appointments, 56 were active and 23 were inactive. In FY 21-22, the average wait time to receive an appointment was 3 days for active clients. For inactive clients, the average wait time was 5 days.

During FY 21-22, the MHP was 91 percent compliant in meeting the standard for scheduling a follow-up psychiatric appointment within seven working days after a hospitalization for active clients, which is an increase from the previous year. For inactive clients, the MHP was able to schedule follow-up psychiatric appointments within the seven working days after a hospitalization 87 percent of the time, which is a decrease from the previous year.

Additionally, the QM Unit began tracking the percentage of clients who received a follow up psychiatric appointment within 30 days of discharge. Of the 79 clients that received a follow-up psychiatric appointment, 8 received an appointment within 8 to 30 days after hospitalization.

A comparison to prior years is included in Table 30.

Table 30. Timeliness of First Psychiatric Appointment After a Hospitalization

Active Clients						
Review Period	**Clients Hospitalized**	**Met The Timeliness Standard**	**Did Not Meet The Timeliness Standard**	**Received F/U Appt. in 8-30 Days**	**Average Wait Time For Appt.**	**Compliance Rate**
FY 21-22	56	51	5	5	3 days	91%
FY 20-21	49	42	7	6	5 days	86%
FY 19-20	72	56	16	15	6 days	78%
Inactive Clients						
Review Period	**Clients Hospitalized**	**Met The Timeliness Standard**	**Did Not Meet The Timeliness Standard**	**Received F/U Appt. in 8-30 Days**	**Average Wait Time For Appt.**	**Compliance Rate**
FY 21-22	23	20	3	3	5	87%
FY 20-21	26	23	3	3	4 days	88%
FY 19-20	32	14	18	8	11 days	44%

The reports for Timeliness of First Psychiatric Appointment after a Hospitalization were provided and discussed with management, as appropriate.

2) *Timeliness of Initial Psychiatric Assessment for Medication Support Services*

The QM Unit monitors the timeliness for offering an Initial Psychiatric Assessment (IPA) whenever the MHP recommends that a beneficiary be assessed for Medication Support Services. As recommended by the EQRO during its FY 20-21 review, the QIC reviewed data and examine how timeliness to IPA can be improved. On September 9, 2021, the QIC decreased the timeliness standard from 45 working days to 30 working days to offer an IPA.

The process for receiving an IPA involves first receiving an Initial Intake Assessment, which is then followed by an Initial Nursing Assessment (INA), then the IPA, which should be offered within 30 days from the date the IPA is recommended. The QM Unit monitors compliance with the MHP's 30 day

timeliness standard and provides a report to the QIC at least annually. The QIC reviewed a report on December 9, 2021, and March 10, 2022, and agreed with the recommendation for the Adults, YAYA, and MHTES to document the first offered appointment, ensure IPAs are offered within the 30 working day timeliness standard and improve attendance rates to initial IPA.

The monitoring process consists of collecting data related to the initial intake assessment and the offered IPA appointments from AVATAR, removing entries for clients that are screened out at the time of the intake assessment as well as those that had no scheduled IPA. IPA appointments that had delayed INAs were included, but the wait time was adjusted by subtracting the delayed time from the total wait time. Delayed INAs include those that were cancelled or rescheduled by the client, or resulted in a no show. The compliance rate is then determined by dividing the number of IPAs that met the standard (numerator) by the total number of IPAs offered (denominator). Appointment wait times greater than 30 working days indicate opportunities for improvement.

A summary of the data for each division and the MHP is included in Table 31.

Table 31. Timeliness to Initial Psychiatric Assessment

Division	FY 20-21			FY 21-22		
	Scheduled IPAs	Compliance Rate	Avg. Wait Time	Scheduled IPAs	Compliance Rate	Avg. Wait Time
Children Services	305	64%	22 days	353	32%	29 days
YAYA Services	311	37%	28 days	380	47%	30 days
Adults Services	683	49%	19 days	704	39%	20 days
MHTES	329	41%	10 days	369	38%	12 days
MHP	**1,628**	**48%**	**20 days**	**1,806**	**38%**	**24 days**

The MHP met the 30 working day timeliness standard for offering an IPA with a compliance rate of 38 percent in FY 21-22. This is a decrease in compliance rate when compared to the FY 20-21. The QM Unit identified that many of the MHP's clinics were not entering the date of the offered appointment, which is largely the reason behind the low compliance rate. On March 16, 2022, the QM Unit issued a Corrective Action Plan to all divisions of the MHP to identify the corrective actions to improve the compliance rate and ensure the MHP offers and documents the first IPA offered.

The Timeliness to Initial Psychiatric Assessment reports were provided to and discussed with management, as appropriate.

e) *Timeliness of Initial Nursing Assessment for Medication Support Services*

During FY 21-22, the QM Unit monitoring the timeliness for scheduling an Initial Nursing Assessment (INA) whenever the MHP recommends that a beneficiary be assessed for Medication Support Services. An INA is scheduled whenever is a client is recommended for medication support services. There is no established timeliness standard for when the INA is to be completed. Upon completion of the INA, the client is scheduled for an IPA, which should be completed within 30 days from the date the client is referred for medication support services.

The monitoring process consists of collecting data related to the initial intake assessment and the scheduled INA appointments from AVATAR, removing entries for clients that are screened out at the time of the intake assessment as well as those that had no scheduled INA. Delayed INAs were included, but the wait time was adjusted by subtracting the delayed time from the total wait time. Delayed INAs include those that were cancelled or rescheduled by the client, or resulted in a no show. The compliance rate is then determined by dividing the number of INAs that met the standard (numerator) by the total number of INAs scheduled (denominator).

A summary of the data for each division and the MHP is included in Table 32.

Table 32. Timeliness to Initial Nursing Appointments

Division	FY 20-21			FY 21-22		
	Scheduled INAs	% of Completed INAs	Average Wait Time	Scheduled INAs	% of Completed INAs	Average Wait Time
Children Services	435	94%	13 days	456	84%	7 days
YAYA Services	479	87%	8 days	491	82%	14 days
Adults Services	471	93%	7 days	821	89%	11 days
MHTES	537	86%	2 days	418	92%	4 days
MHP	**1,922**	**90%**	**7 days**	**2,186**	**87%**	**9 days**

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the timeliness of first psychiatric appointment after a hospitalization and report findings, including identified trends and recommendations, to the QIC at least annually.

- The MHP will ensure all clients in need of a follow-up psychiatric appointment after hospitalization are offered an appointment within seven days of discharge from hospitalization.

- The QM Unit will monitor the timeliness to initial psychiatric appointments and reports its findings, including identified trends and recommendations, to the QIC at least annually.

- The MHP will ensure all initial psychiatric assessment appointments are offered within the 30-day timeliness standard whenever clients are recommended to be evaluated for Medication Support Services by the MHP.

- The QM Unit will work with the MHP's outpatient teams to ensure information regarding first offered IPAs is entered into the electronic health record.

5. No Show Rates

To maximize service delivery capacity and expand the service delivery to MHP consumers, the QM Unit monitor, track, and analyze the no show rates for psychiatrist, clinician, and nurse appointments during FY 21-22.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

The QM Unit monitors the no show rates of psychiatrist, clinician, and nurse appointments on a quarterly basis and reports findings to the QIC at least annually. The monitoring process entailed collecting data on all clients' appointments that were scheduled with psychiatrists, clinicians, and nurses during FY 21-22.

The source document utilized to collect data was the No Show to All Appointments Details Report and Mental Health Appointment Tracking Log from MyAvatar. Data collected was related to appointments by category that identified show, no show, staff canceled, staff rescheduled, client canceled, and client rescheduled. Data collected includes both Medi-Cal and non-Medi-Cal clients.

Practitioner no show rates were determined by dividing the number of no show client appointments (numerator) by the total number of appointments scheduled (denominator). Appointments that were rescheduled or canceled are not included in the calculation.

During FY 21-22, the MHP implemented strategies to decrease the no show rates to psychiatrist, clinician, and nurse appointments, including, but not limited to, the following: conducting retention calls the day before and the day of the appointment; clinical staff conducting engagement calls and meeting with clients who do not adhere to treatment to help them overcome barriers in accessing treatment and following up with clients when they do not show to their appointments. Additionally, the QM Unit conducted an in-depth analysis to evaluate what may be impacting low attendance rates. Areas reviewed included, but were not limited to, client, provider, team, and day and time of the week. Findings were included in the quarterly reports presented to the MHP's management team.

1) Psychiatric No Show Rates

The QM Unit monitors no show rates for psychiatrist IPA and medication support appointments. These no show rates are monitored and reported separately on a quarterly basis, with findings presented to the QIC at least annually. Findings are also provided to management, as appropriate.

a) No Show Rates to Initial Psychiatric Assessments (IPA)

During FY 21-22, the QM Unit monitored the no show rates to IPAs and reported findings to the QIC on February 10, 2022. Members concurred with the recommendations for the MHP to conduct retention calls to ensure client attends to scheduled appointment.

On January 21, 2021, the QIC established the following benchmarks for the no show rate to IPA:

- Children Services – 18 percent
- YAYA Services – 25 percent
- Adults Services – 23 percent
- Mental Health Triage & Engagement Services – 16 percent

Report findings reflect that the MHP no show rate to IPA was 23 percent during FY 21-22, which represents an increase when compared to FY 20-21. No trends were identified with provider, hours of operation, or days of the week. All divisions increased their no show rates in FY 21-22, with the exception of YAYA services which decreased by five percent. The results by division are summarized in Table 33.

Table 33. Psychiatrist No Show Rates Initial Psychiatric Assessment Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHTES		MHP	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rates	No Show Appts.	No Show Rate
FY 21-22	92	19%	79	16%	292	31%	65	16%	528	23%
FY 20-21	58	14%	84	21%	122	17%	48	14%	312	17%
FY 19-20	135	20%	127	27%	266	28%	43	12%	571	23%

b) No Show Rates to Medication Support Appointments

During FY 21-22, the QM Unit monitored the no show rates to psychiatrist medication support appointments and reported findings to the QIC on February 10, 2022 and no recommendations were made.

On January 21, 2021, the QIC established the following benchmarks for the no show rate to psychiatrist medication support appointments:

- Children Services – 18 percent
- YAYA Services – 22 percent
- Adults Services – 23 percent

Report findings reflect that the MHP no show rate to medication support appointments was 19 percent during FY 21-22, which represents an increase when compared to FY 20-21. No trends were identified with provider, hours of operation, or days of the week. All divisions decreased or remain the same during FY 21-22, with the exception of Adult Services which increase by 7 percent. The results by division are summarized in Table 34.

Table 34. Psychiatrist No Show Rates Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHP	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	951	14%	802	18%	2,831	21%	4,584	19%
FY 20-21	1,061	14%	972	19%	1,893	14%	3,926	15%
FY 19-20	1,111	18%	999	24%	3,177	25%	5,301	23%

2) Clinician No Show Rates

The QM Unit monitors no show rates for clinician intake assessment and psychotherapy appointments. These no show rates are monitored and reported separately on a quarterly basis, with findings presented to the QIC at least annually. Findings are also provided to management, as appropriate.

a) No Show Rates to Intake Assessments

During FY 21-22, the QM Unit monitored the no show rates to initial intake assessment appointments and reported findings to the QIC on February 10, 2022. Members concurred with the recommendations for the MHP to conduct retention calls to ensure client attends to scheduled appointment.

On January 21, 2022, the QIC established the following benchmarks for the no show rate to intake assessment appointments:

- Children Services – 20 percent
- YAYA Services – 30 percent
- Adults Services – 30 percent
- Mental Health Triage & Engagement Services – 26 percent

Report findings reflect that the MHP no show rate to initial intake assessment was 26 percent during FY 21-22, which represents an

increase when compared to FY 20-21. Mental Health Triage and Engagement Services and Youth and Young Adults decreased the no show rates during FY 21-22. Adult Services demonstrated a high no show rate for 1:00 p.m. appointments and Children Services Team 6 outpatient clinic demonstrated high no show rates in three quarters of FY 21-22. The results by division are summarized in Table 35.

Table 35. Clinician No Show Rates Intake Assessment Appointments

Review Period*	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Engagement Services		MHP	
	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	328	20%	349	27%	506	30%	188	31%	1,371	26%
FY 20-21	183	16%	257	27%	320	24%	208	34%	968	24%
FY 19-20	425	27%	351	33%	547	35%	136	27%	1,459	31%

b) *No Show Rates to Psychotherapy Appointments*

During FY 21-22, the QM Unit monitored the no show rates to psychotherapy appointments and presented a report to the QIC on February 10, 2022. Members concurred with the recommendation for the MHP to increase engagement calls and assess barriers to treatment.

On January 21, 2021, the QIC established the following benchmarks for the no show rate to psychotherapy appointments:

- Children Services – 20 percent
- YAYA Services – 25 percent
- Adults Services – 18 percent

Report findings indicate that the MHP no show rate was 20 percent during FY 21-22, which represents a decrease when compared to FY 21-22. All divisions decreased the no show rate when compared to FY 21-22 with the exception of Adult Services which increased by 2 percent. The findings by division are summarized in Table 36:

Table 36. Clinician No Show Rates Psychotherapy Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHP	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	873	17%	1,036	24%	936	21%	2,845	20%
FY 20-21	1,041	21%	1,714	29%	1,173	19%	3,928	23%
FY 19-20	813	22%	1,799	31%	1,100	20%	3,712	25%

3) *Nurse No Show Rates*

The QM Unit monitors no show rates for INAs and nurse medication support appointments. These no show rates are monitored and reported separately on a quarterly basis, with findings presented to the QIC at least annually. Findings are also provided to management, as appropriate.

a) *No Show Rates to Initial Nursing Assessments (INA)*

During FY 21-22, the QM Unit monitored the no show rates to INA and reported findings to the QIC on February 10, 2022. Members concurred with the recommendation for MHP to conduct retention calls to ensure client attends to schedule appointment.

On January 2021, the QIC established the following benchmarks for the no show rate to INA:

- Children Services – 15 percent
- YAYA Services – 22 percent
- Adults Services – 25 percent
- Mental Health Triage & Engagement Services – 17 percent

Report findings reflect that the MHP no show rate to INA was 20 percent during FY 21-22, which represents an increase when compared to FY 20-21. No trends identified with provider, hours of operation, or days of the week. All divisions increased the no show rates during FY 21-22. The results by division are summarized in Table 37.

Table 37. Nurse No Show Rates Initial Nursing Assessments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Unit		MHP	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	75	13%	153	23%	225	23%	93	19%	546	20%
FY 21-22	46	10%	108	21%	163	19%	56	14%	379	17%
FY 19-20	92	18%	152	29%	241	27%	53	15%	538	24%

b) *No Show Rates to Medication Support Appointments*

During FY 21-22, the QM Unit monitored the no show rates to nurse medication support appointments and reported findings to the QIC on February 10, 2022 and no recommendations were made.

On January 21, 2021, the QIC established the following benchmarks for the no show rate to medication support appointment:

- Children Services – 22 percent

- YAYA Services – 25 percent
- Adults Services – 25 percent

Report findings reflect that the MHP no show rate to nurse medication support appointments was 22 percent during FY 20-21. This represents an increase when compared to FY 21-22. All divisions increased the no show rates when compared to FY 21-22 with the exception of Children Services which remain the same. One trend was identified for YAYA Services in the Brawley Anxiety and Depression outpatient clinic having the highest no rate during FY 21-22 when compared to other YAYA Services outpatient clinics. The results by division are summarized in Table 38.

Table 38. Nurse No Show Rates Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHP	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	154	15%	321	34%	893	21%	1,368	22%
FY 20-21	285	15%	257	25%	1,185	20%	1,727	19%
FY 19-20	92	19%	118	26%	685	26%	895	25%

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the no show rates to initial assessments conducted by clinicians, nurses, and psychiatrists and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will monitor the no show rates to follow-up appointments conducted by clinicians, nurses, and psychiatrists and report findings, including identified trends and recommendations, to the QIC at least annually.

6. Quality Improvement Review Committees

The MHP has established two Quality Improvement Review Committees (QIRC) that review documentation requirements and the quality of services provided, identifying opportunities for improvement and training needs, as appropriate. This is done through the QIRC-Psychotherapy and the QIRC-Mental Health Rehabilitation Technician (MHRT).

Each committee is assigned a lead reviewer per week who is responsible for leading the case review for that particular week. Upon finishing the case review, the lead reviewer is responsible for completing the QIRC review tool, where findings are provided to the respective provider reviewed and their program supervisor. The program supervisor is given a two-week timeframe to meet with the staff being reviewed and complete a plan of correction. Once in agreement, the supervisor and the staff will sign an agreement to execute the plan of correction. The review tool is also provided to the program manager for approval. During FY 21-22, the completed review tool was then forwarded back to the QM Unit, where findings were

summarized, opportunities for improvement were identified, and the results were presented to each respective committee. The QM Unit is responsible for reviewing and updating each QIRC review tool at least annually.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Quality Improvement Review Committee – Psychotherapy

The QIRC-Psychotherapy is chaired by a Quality Improvement Specialist from the QM Unit. Membership includes a rotation of behavioral health managers, licensed and registered mental health professionals, program supervisors, and QM Unit staff. This committee met weekly during three scheduled rotations and reviewed cases that had been referred to psychotherapy.

The role and responsibility of the committee is to assure evidenced-based practice guidelines are being followed appropriately and consistently throughout the department for psychotherapy services; review the quality of services provided; identify opportunities for improvement and training needs; and review the implementation of learned techniques from trainings provided.

The QM Unit coordinated one rotation QIRC – Psychotherapy during FY 21-22, due to barriers the MHP faced as a result of a shortage of clinicians. In FY 21-22, there were a total of 8 cases reviewed, with opportunities for improvement identified in the following areas:

<u>Assessment</u>

- Clinicians to complete a thorough assessment and address all required elements of the psychotherapy to plan interventions that are medically necessary to address the presenting problem, as reported.

<u>Genogram</u>

- Clinicians to use the process of genogram as an intervention to assist the client in identifying trends and patterns associated with the presenting problem and mental health condition.
- Clinicians use the genogram process to be able to identify hereditary and generational patterns as well as psychological factors that affect the client's functioning.

<u>Care Coordination</u>

- Coordinate care with mental health treatment team members that will assist the client in making progress towards improving functioning.

<u>Risk Factor</u>

- Clinicians to explore in greater depth potential risk, "red flags" or other indicators that may put the client risk of not progressing towards the presenting problem as reported.

The QIRC's recommendations were reported to the QIC and to the MHP's management.

2) *Quality Improvement Review Committee – Mental Health Rehabilitation Technician*

The QIRC-MHRT is chaired by a Quality Improvement Specialist from the QM Unit and membership included a rotation of program supervisors and MHRTs from Children, Adults, YAYA and MHTE Services, as well as QM Unit staff. The QIRC-MHRT met on a weekly basis during two scheduled rotations.

The role and responsibility of this committee is to ensure that services delivered by MHRTs are provided within the boundaries of medical necessity, as well as the theoretical framework of Cognitive Behavioral techniques and other evidence-based approaches within the structure of mental health and case management services, as appropriate. This committee also reviews the quality of services, documentation requirements and outcomes, and identified opportunities for improvement and training needs, as appropriate.

In FY 21-22, there were a total of 24 cases reviewed, with opportunities for improvement identified in the following areas:

<u>Assessment</u>

- Complete a thorough MHRT Needs Assessment to assess reason for referral, presenting problem and plan medically necessary interventions to address the identified problem, as reported.

<u>Intervention Utilization</u>

- Provide medically necessary interventions to assist in decreasing the client's presenting problem, as reported.
- Collaborate and provide meaningful care coordination with other service providers and/or client's significant support in efforts to assist the client in making progress and support the client in diminishing functional impairments.

<u>Measurement Outcome Tools</u>

- Complete measurement outcome tools, as indicated in the Measurement Matrix to ensure appropriate intervention use and monitor progress with interventions being provided.

<u>Risk Factors</u>

- MHRT to evaluate and explore in greater depth potential risk, "red flags" or other indicators that may put the client risk of not progressing towards the presenting problem as reported.
- MHRT to mitigate as appropriate when triggers and/or situations may present a risk of decompensation and/or escalation of client's condition.
- MHRT to develop a safety plan when appropriate.

<u>Documentation</u>

- MHRT progress notes to describe the specific intervention provided and how interventions will reduce the identified presenting problem, including the client's response.

The QIRC's recommendations were reported to the QIC and to the MHP's management.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will conduct QIRC rotations three times a year and ensure cases are assigned for review, data is analyzed and tracked, opportunities for improvement are identified, and findings with recommendations are made to all QIRCs, the QIC, and management, as appropriate.

- The QM Unit will review and revise the QIRC tools as appropriate during FY 22-23 to accommodate changes in processes and requirements with CalAIM, as appropriate, and as recommended by the committees.

- The QM Unit will monitor and track the outcomes of the QIRC activities to ensure the MHP is following mandated state requirements and address any compliance issues that may arise.

7. Hospitalization Monitoring

In an effort to identify any potential quality of care issues and trends in occurrences, the QM Unit tracks the admissions and readmissions of all Imperial County residents hospitalized as a result of a psychiatric condition. The QM Unit also conducts chart reviews for all hospitalizations to ensure the MHP adheres to the care coordination standards established in Procedure 01-115, Hospitalization Discharge/Placement Coordination.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Hospital Admissions

The QM Unit monitored the County's psychiatric hospital admissions by conducting an assessment of all hospitalizations that occurred during FY 20-21. During FY 20-21, there were a total of 85 Medi-Cal beneficiaries and 39 non-Medi-Cal clients hospitalized, for a total of 124 clients hospitalized, which is a decrease from the previous fiscal year. For the 124 clients hospitalized, there were 106 Medi-Cal admissions and 40 non-Medi-Cal admissions for a total of 146 hospital admissions, which is a decrease from the previous fiscal year. A comparison to prior fiscal years is included in Table 39.

Table 39. Hospital Admissions

Review Period	# of Clients Hospitalized			# of Admissions		
	Medi-Cal	Non Medi-Cal	Total	Medi-Cal	Non Medi-Cal	Total
FY 20-21	85	39	124	106	40	146
FY 19-20	89	65	154	119	65	184
FY 8-19	107	36	143	137	45	182

Of the 124 client admissions during FY 20-21, 49 percent were for active clients receiving services from ICBHS at the time of the hospitalization. The status by division is included in Table 40.

Table 40. FY 20-21 Client Hospitalization Status

Status	Children Services	Youth & Young Adult Services	Adult Services	Mental Health Triage & Engagement Services	MHP
Active	5	13	29	14	61
Inactive	3	0	0	60	63
Total	8	13	29	74	124

2) Hospital Readmissions

The QM Unit monitored the County's psychiatric hospital readmissions by conducting an assessment of all readmissions that occurred during FY 20-21. Of the 146 admissions during FY 20-21, 22 were readmissions. The MHP's overall readmission rate is 15 percent. This is a decrease from FY 19-20 when the readmission rate was 16 percent. The QM Unit calculated the MHP's readmission rate for FY 20-21 by dividing the total readmissions in the fiscal year by the total number of admissions in the fiscal year.

A total of 10 readmissions occurred within 30 days of discharge, resulting in an 7 percent 30-day readmission rate. This is a decrease from FY 19-20 when the 30-day readmission rate was 11 percent. Table 41 summarizes the MHP's readmissions.

Table 41. Hospital Readmissions

Review Period	FY 18-19	FY 19-20	FY 20-21
Total Readmissions	37	30	22
Total Admissions	182	184	146
Readmission Rate	**20%**	**16%**	**15%**
Readmissions Within 30 Days	12	21	10
Total Admissions	182	184	146
30-Day Readmission Rate	**7%**	**11%**	**7%**

3) Hospital Chart Reviews

The QM Unit is responsible for conducting hospitalization chart reviews to monitor if the MHP is following established policies and procedures regarding hospitalization discharge planning and placement coordination to ensure clients receive the appropriate follow up care after a psychiatric hospitalization. This process is instrumental in identifying opportunities for improvement.

The QM Unit compiled findings and presented a report to QIC on October 13, 2022. The QIC agreed with the following recommendations:

- For the MHP's service coordinators to:
    - Contact the hospital within one working day of the hospitalization to obtain information on client's mental health status and coordinate discharge planning.
    - Present the case weekly during team meetings for updates and/or new treatment recommendations or changes during and after the hospitalization until individual regains stability.
    - Contact hospital to coordinate discharge and ensure client receives sufficient medication supply.
    - Conduct home/Zoom and/or face to face sessions within three working days of discharge to complete a thorough assessment and process referrals as appropriate.

The hospitalization chart reviews were conducted by the QM Unit on an ongoing basis, with charts selected from the PAU Hospitalization Tracking Log. A review tool with the following three categories was utilized: 1) Hospitalization Monitoring; 2) Hospitalization Discharge Planning; and 3) After Hospitalization Discharge Summary.

The QM Unit compiled the data by team identifying opportunities for improvement and areas of concern, as appropriate. Individual hospitalization reviews were provided to the team's deputy director and manager.

During FY 21-22, the QM Unit reviewed 130 hospitalizations: 42 for Adults Services, 13 for YAYA Services, 7 for Children Services, 68 for Mental Health Triage and Engagement Services.

In efforts to ensure appropriate care coordination and effective discharge planning for MHP clients transitioning to a lower level of care after inpatient psychiatric treatment, the QM Unit identified the following as areas for improvement:

<u>During Hospitalization Monitoring</u>

- Establish contact within one working day of the hospitalization to obtain information regarding the client's current mental health status and plan discharge.
- Present case during treatment team meetings to provide updates and receive treatment recommendations and/or changes after the inpatient psychiatric treatment.

<u>Hospitalization Discharge Planning</u>

- Contact the hospital staff to coordinate discharge and ensure client is discharged with sufficient medication supply.
- Complete the Hospital Discharge Summary to ensure discharge instructions and/or recommendations are being followed by other service providers to coordinate treatment.

After Hospitalization Discharge Care

- Conduct home visits within 3 working days of discharge and complete a through psychosocial assessment and review discharge recommendations.
- Discuss client's case during weekly at team meetings for status, updates/treatment recommendations until stability is regained.

Opportunities for improvement were also identified at the division level. The deputy directors were provided with an individual reports by division to implement appropriate interventions to address areas identified as opportunities for improvement.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the MHP's hospitalizations and readmissions and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will conduct hospitalization chart reviews and update tools as appropriate to adhere with CalAIM requirements and report findings, including identified trends and recommendations, to the QIC at least annually.

8. Crisis and Adult Residential and Mental Health Triage Monitoring

In efforts to identify potential quality of care concerns and trends in occurrences, the QM Unit monitors crisis residential, adult residential, and Mental Health Triage admissions, readmissions, and timeliness of follow-up upon discharge.

a. Overview of the MHP objectives, scope, and planned activities for FY 21-22:

1) Crisis Residential Admissions

During CY 2021, the QM Unit monitored and tracked the number of all crisis residential admissions. Data was gathered from the MyAvatar DMH Movement Recap. A total of 108 unduplicated individuals were admitted to crisis residential services, for a total of 138 admissions. There were a total of 30 readmissions during CY 2021. The number of individual admission by division is included in Table 42.

Table 42. Crisis Residential Admissions

Division	Total Admissions	# of Individuals	Status		Re-admissions	Average Length of Stay
			Active	Inactive		
Adults Services	82	61	59	2	21	20 days
YAYA Services	20	14	14	0	6	20 days
MHTE Services	36	33	31	2	3	20 days
MHP	**138**	**108**	**104**	**4**	**30**	**20 days**

1) *Timeliness of Services Following Crisis Residential Discharge*

The QM Unit monitors the timeliness of services to the first outpatient appointment following a crisis residential discharge. The process entails collecting data from MyAvatar DMH Movement Recap to capture the number of admission and discharges from crisis residential services. The QM Unit calculates the number of working days between the crisis residential discharge dates to the date of the first scheduled outpatient appointment with a psychiatrist or clinician.

During CY 2021, a total of 145 clients were discharged from crisis residential services. The findings related to follow-up appointments post-discharge are listed in Table 43.

Table 43. Follow-Up Appointments Post-Crisis Residential Discharge

Division	# of Discharges	Clients Scheduled for Follow-Up	Timeliness of Appointment			Average Length of Time
			0-7 Days	8-30 Days	31+ Days	
Adults Services	86	83	44	36	3	9 days
YAYA Services	19	19	12	7	0	8 days
MHTE Services	40	32	21	9	2	8 days
MHP	**145**	**134**	**77**	**52**	**5**	**9 days**

2) *Adult Residential Admissions*

During CY 2021, the QM Unit monitored and tracked the number of all crisis residential admissions. Data was gathered from the MyAvatar DMH Movement Recap. A total of 14 unduplicated individuals were admitted to crisis residential services, for a total of 14 admissions. There were no readmissions during CY 2021. The number of individual admission by division is included in Table 44:

Table 44. Adult Residential Admissions

Division	Total Admissions	# of Individuals	Status		Re-admissions	Average Length of Stay
			Active	Inactive		
Adults Services	5	5	5	0	0	N/A
YAYA Services	1	1	1	0	0	N/A
MHTE Services	8	8	2	6	0	N/A
MHP	**14**	**14**	**8**	**6**	**0**	**N/A**

There were no discharges from Adult residential during CY 2021.

4) Mental Health Triage Admissions

The QM Unit monitors Triage admissions and re-admissions (5150) to the Mental Health Triage Unit. The Mental Health Triage Unit (MHTU) is a part of the Mental Health Triage Engagement Services Division, which provides immediate crisis intervention services 24 hours a day, 7 days a week to children, adolescents, adults, and older adults.

The monitoring process consists of reviewing the crisis log, which is completed by the MHTU on a monthly basis. The data collected is as followed: demographics, status (active/inactive), type of 5150 hold, discharge dates, and outcomes of Triage admission. Additional data is tracked by the QM Unit include but not limited to the following: foster care youth, number of episodes, hospitalizations, conservatorships and care coordination services.
Report findings indicate for FY 20-21, there were a total of 573 admission to the Mental Health Triage Unit which is a decrease when compared to FY 19-20 for a total of 979 admissions. The number of individual admission by division is included in Table 45.

Table 45. Mental Health Triage Admissions

Division	Total Admissions	# of Individuals	Status		Re-admissions
			Active	Inactive	
Adults Services	140	92	91	1	48
YAYA Services	93	46	45	1	47
Children Services	27	19	19	0	8
MHTE Services	313	257	47	210	56
MHP	**573**	**414**	**202**	**212**	**159**

The majority of individuals were admitted one time during FY 20-21. There were a total of 159 readmission during this review period; 89 individuals were admitted 2-6 times, 1 individual, 7-10 times and 1 individual 11-15 times.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the MHP's crisis residential, adult residential and Mental Health Triage admissions and readmissions and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will conduct case studies to assess the quality of care the client is receiving in the various levels of care and care coordination with other service providers to evaluate the care of the beneficiary as a "whole person."

- The QM Unit will evaluate the length of time for clients to receive a follow-up outpatient appointment from the date of discharge from crisis residential services and report findings, including identified trends and recommendations, to the QIC at least annually.

C. Performance Improvement Projects:

The QIC oversees the development of the clinical and non-clinical Performance Improvement Projects (PIPs). A task force was created to develop PIPs, collect the necessary data, analyze the data, find areas for improvement, develop goals and interventions, measure outcomes, and present findings to the QIC. Membership of the task force varies depending on the focus of the project. The permanent members include: The Behavioral Health Manager for Managed Care, the program supervisor of the QM Unit, and administrative analysts from the QM Unit. The MHP also includes consumers among the stakeholders to serve on the PIP task forces.

a. Overview of MHP objectives, scope, and planned activities for FY 21-22:

1) Non-Clinical – Increase Engagement

During FY 20-21, in reviewing the MHP's No Show Summary Report it was identified that YAYA Services experienced high no show rates to individual psychotherapy appointments. YAYA Services had a no show rate to psychotherapy appointments that stayed above the established benchmark of 25 percent, reaching as high as 35 percent. Additionally, psychotherapy services had the highest no show rate within the YAYA Services Division when compared to other service modalities. Based on the information and data gathered, the MHP began this PIP in July 2020 with the objective to address high no show rates for psychotherapy services. During FY 21-22, this PIP was extended for a second year with the addition of a new intervention.

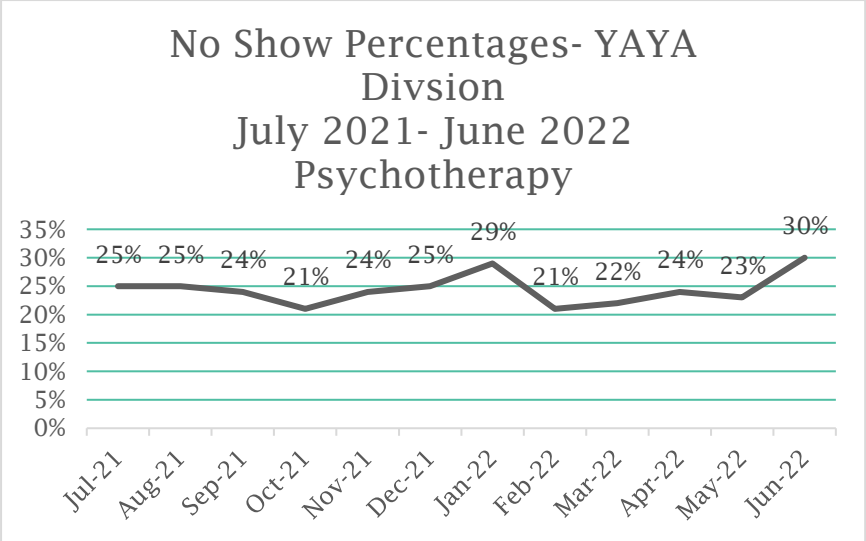
The improvement strategy for FY 21-22 consisted of monitoring clinicians' high no show rates. Clinicians that have no show rates higher than the established benchmark of 25 percent received individualized consultation with their clinical supervisor and/or program supervisor for case consultation, training, as appropriate, engagement strategies, and/or other treatment approaches in efforts to improve client show rates. With these consultations and trainings it is expected for clinicians to implement learned intervention directly to their client during sessions and receive the appropriate care. The MHP seek to increase show rates to psychotherapy services for individuals seeking mental health treatment as part of their recovery.

The interventions implemented are included in Table 44.

Table 44. PIP – Non-Clinical Interventions

Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
Provide engagement strategies, skill building trainings and case consultations to clinicians with high no show rates to improve engagement, retain client in therapy and decrease the no show rates to psychotherapy.	Consumers who are receiving psychotherapy services within the YAYA Division.	#2	July 2021

The chart below indicates the no show rates to psychotherapy:



During the PIP period of July 2021 through June 2022, data shows that no shows decreased, with the exception of January 2022 and June 2022, and maintained a range of 21 percent to 30 percent no show rates.

The PIP task force met regularly since the inception of the PIP to monitor the progress of the interventions and documented the MHP's work in a Clinical PIP Roadmap.

2) Clinical – Multi-Disciplinary Team

As a part of the QM Unit monitoring activities, the QM Unit reviews the Triage admission report, which indicated high readmission rates to the Triage Unit (5150 holds) within a 12-month period and/or immediately after being discharged, indication no care coordination in between levels of care and with other service providers. Contributing factors to readmission rates may include but not limited to lack of care coordination, lack of engagement, applied intervention and/or treatment goals not addressing the presenting problems.

There were a total of 573 Triage (5150) admissions and 159 re-admissions to the Triage Unit for FY 20-21. Out of the 159 re-admissions, 136 were active clients receiving outpatient mental health treatment. Of the 573 admissions, 89 individuals were re-admitted 2 to 6 times. In an effort to mitigate these readmissions and prevent the need for a higher level of care, the Mental Health Triage & Engagement Services (MHTES) Division conducted Multidisciplinary Team (MDT) meetings with the client's current treatment team and/or other service providers involved in the client's care.

The meetings consist of evaluating the client's history, status, barriers, medication adherence if applicable, discharge planning and any other treatment recommendations. These MDT meetings allow all external/internal agencies to maintain united toward the client's mental health recovery and planning according to the client's needs and reduce readmission to the Triage

Unit and/or move clients to higher psychiatric care. During the MDT meetings the client's service coordinator is responsible for communicating with the client and ensuring all providers follow through with recommendations as appropriate to the client's desire.

The improvement strategy and intervention consisted of coordinating and tracking Multi-Disciplinary Team (MDT) meetings after clients meets at least one of the following criteria, three or more admissions in the last 12 months, re-admissions within prior to 30 days of the last admission and "high risk clients," such with multiple suicidal attempts.

The PIP initiated in July 2021 in efforts to decrease readmissions by point 10 percent by one year of the PIP.

The interventions implemented to date are included in Table 45.

Table 45. Multi-Disciplinary PIP Clinical Interventions

Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
Provide coordination of MDT meetings who are readmitted to the Triage Unit and enhance client's care after moving to a lower level of care.	Consumers who have been readmitted to the Triage Unit and have met medical necessity criteria for outpatient services and are admitted to the Triage Unit as a 5150 hold/crisis intervention.	#1	July 1, 2021

During the PIP period of July 2021 through June 30, 2022, data indicates an increase in the readmissions for active clients by point 5 percent. There were a total of 429 admissions and 108 readmissions for FY 21-22. This is a decrease from FY 20-21's Triage admissions/readmissions. This PIP provided a positive change for the MHP as the total admissions/ readmissions for the Triage Unit decreased and clients were provided with united aftercare services for continuous readmissions and high risk clients.

Additionally, the QM Unit identified a total of 244 total admissions for active clients within July 2021 through June 2022. As a result, 60 Multidisciplinary Team Meetings were completed which provided an opportunity for internal/external agencies to maintain care coordination and overall improve aftercare services to client's after a 5150 hold/crisis intervention.

The PIP task force met regularly since the inception of the PIP to monitor the progress of the interventions and documented the MHP's work in a Clinical PIP Roadmap.

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The MHP will begin new Clinical and Non-Clinical PIPs for FY 22-23.

- The MHP's PIP Task Force will meet regularly to monitor the progress of Clinical and Non-Clinical PIPs goals and objectives.

- ICBHS will participate in the CalAIM Behavioral Health Quality Improvement Program (BHQIP) to support the implementation of the CalAIM initiative. With the support of the Information Systems Unit the QM Unit will participate and monitor the following milestone:
  - Milestone 3d: Leverage improved data exchange capabilities to improve quality and coordination of care related to the following measure: Follow-up after emergency department visits for mental illness.

- The QM Unit will document the MHP's work for both the Non-Clinical and Clinical PIPs in Roadmaps.

D. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Performance Outcomes System

The Performance Outcomes System (POS) is being developed in accordance with legislative mandates to improve outcomes and inform decision-making for children and youth receiving Medi-Cal Specialty Mental Health Services. It establishes processes for compiling information from multiple sources in order to better understand the results of Medi-Cal SMHS provided to children and youth under 21 years of age. The intent of the system is to gather information relevant to particular mental health outcomes to provide useful summary reports for ongoing quality improvement and to support decision-making.
The reports that will be produced are as follows: statewide aggregate data; population-based county groups; and county-specific data. These reports help meet the intent of the Legislature, as stated in Welfare and Institutions Code Section 14707.5, to develop a performance outcomes system for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services that will improve outcomes at the individual, program, and system levels and inform fiscal decision-making related to the purchase of services.

a. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

The MHP is required to post its EPSDT POS measures (Attachment I) on its Department website. These measures are generated and reported by DHCS each year. During FY 21-22, the MHP posted these reports as required.

The MHP's EPSDT POS measures are included as an attachment to the ICBHS Quality Improvement Work Plan. The QM Unit is responsible for monitoring this data to identify trends that may require quality improvement interventions.

The first series of charts and tables focus on the demographics of children and youth under 21 who are receiving Specialty Mental Health Services based on approved claims for Medi-Cal eligible beneficiaries. Specifically, this includes demographics tables of this population by age, gender, and race/ethnicity. Two types of penetration information are provided. Both penetration rates tables are also broken out by demographic characteristics. Utilization of services data are shown in terms of dollars, as well as by service, in time increments. The snapshot

table provides a point-in-time view of children/youth arriving, exiting, and continuing services over a two-year period. The time to step down table provides a view over the past four years of the time to step-down services following inpatient discharge.

Where possible, the reports provide trend information by displaying information for four Fiscal Years (FY). A FY is from July 1st to June 30th. Utilization of services reports are shown in terms of dollars, as well as by service in time increments. The snapshot report provides a point-in-time view of children arriving, exiting, and continuing services over a two-year period. The final report provides a view over the past four years of the time to step-down services (i.e., time to next contact after an inpatient discharge). ***Note:*** *The time to step-down report has a change in methodology from the first report produced in February 2015. In the initial report only outpatient services provided at least one day after the inpatient discharge were included in the calculations. On subsequent reports, any outpatient service that occurs on or after the inpatient discharge is included in the analysis.*

b. Overview of the MHP objectives, scope, and planned activities for FY 22-23:

- The MHP will post its EPSDT POS data to the ICBHS website annually, as required.

- The QM Unit will monitor the MHP's EPSDT POS measures to identify opportunities for improvement.

DRUG MEDI-CAL ORGANIZED DELIVERY STYSTEM (DMC-ODS)

A. State Mandated Areas

1. Service Delivery Capacity

As the DMC-ODS Plan for the County of Imperial, ICBHS provides SUD services in a rural area that extends 4,482 square miles. Described below are the current number, types, and geographical distribution of SUD services within the DMC-ODS Plan's delivery system and Federal Network Adequacy Standards for FY 21-22.

a. Overview of ICBHS objectives, scope, and activities for FY 21-22:

The QM Unit compiled information on the current number, type, and geographical distribution of SUD services provided by ICBHS through staff providers and subcontracted providers. The information provided includes the geographic distribution of services, the target population, the type of service, the number of contacts provided in FY 21-22. The types and number of services provided were retrieved from ICBHS electronic information system, AVATAR.

ICBHS ensures that regardless of where a person enters the ICBHS system, that person receives an initial intake assessment at one of the SUD clinics closest to the individual's place of residence, which will determine level of care. ICBHS and contracted providers make accommodations to serve persons with physical disabilities, including vision and hearing impairments, if needed. In addition, services are made available to all individuals with mobility, communication, or cognitive impairments as required by federal and state laws and regulations.

During FY 21-22, a total of four DMC certified sites provided services to Imperial County residents. The treatment sites for SUD included two Adult Outpatient Clinics one in El Centro and one in Calexico and two Adolescent Outpatient Clinics also located in El Centro and Calexico.

1) ICBHS Direct Service Providers

a) Geographic Location and Target Population

ICBHS makes every effort to bring services to all areas of the county and to make those services easily available and accessible for Imperial County residents, ensuring that staff is allocated according to the cultural needs of the population it serves. ICBHS currently has four sites providing SUD treatment services.

ICBHS provides SUD services to clients that reside in the southern, central, northern, and eastern regions of the county. The geographic distribution within the regions is as follows:

i. Adult SUD Programs
ICBHS has one adult DMC certified SUD outpatient clinic located El Centro which is one of the major population center of Imperial County.

Residents ages 18 and over in the central and northern region of Imperial County receive services through this program. Additionally, a second clinic is located in Calexico which serves individuals ages 18 and over who reside in the southern region of Imperial County.

ii. Adolescent SUD Programs

ICBHS has one adolescent DMC certified SUD outpatient clinic located in El Centro, which is one of the major population centers of Imperial County. Youth, through the age of 18, diagnosed with a substance use and who reside in the central and northern regions of Imperial County receive services through this program. Additionally, a second clinic is located in Calexico which serves youth through the age of 18 who reside in the southern region of Imperial County.

b) Type and Services Provided

DMC SUD treatment services are provided based on an assessment of whether the beneficiary meets SUD Program medical necessity criteria for services.

ICBHS provides quality professional SUD treatment services for individuals suffering from substance use. ICBHS offers on site outpatient and intensive outpatient treatment in various forms of services that are based on the individuals' needs and assessment. On site Services include Outpatient Treatment, Intensive Outpatient Treatment, Medication Assisted Treatment, Case Management, and Recovery Services.

Outpatient treatment services (ASAM Level 1) consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents. On the other hand, Intensive Outpatient Treatment (ASAM Level 2.1) services are provided for a minimum of nine hours with a maximum of nineteen hours a week for adults and for a minimum of six hours with a maximum of nineteen hours a week for adolescents.

The components of outpatient treatment services and Intensive Outpatient Treatment (IOT) include: Intake; Individual Counseling; Group Counseling; Family Therapy; Patient Education; Medication Services; Collateral Services; Crisis Intervention Service; Treatment Planning; and Discharge Services. Services can be provided in any appropriate setting in the community either in-person or by telephone, with the exception of group counseling services which must be provided face-to-face.

ICBHS integrated the use of additional Medication Assisted Treatment (MAT) into the SUD clinics. SUD programs offered MAT beyond the required NTP services to ensure beneficiaries have access to a full complement of medications to support SUD treatment and recovery. ICBHS extended the use of MAT interventions into the SUD clinics by expanding the use of medications for:

- Opiate overdose prevention- Naloxone (Narcan);
- Opiate use treatment - Buprenorphine- Naloxone (Suboxone) and Naltrexone (oral and extended release);
- Reduction of alcohol craving - Naltrexone, extended release injectable (Vivitrol), and Acamprosate (Campral);
- Alcohol withdrawal management - Librium (chlordiaxepoxide), Gabapentin, and Clonidine (Catapres); and
- Opioid Use Management - Sublocade (buprenorphine) injection

MAT services are provided to beneficiaries at the Adult El Centro SUD Program based on clinical need and the beneficiaries consent.

Case management services are provided to beneficiaries enrolled at an ICBHS SUD clinic (ASAM 1 or 2.1). Case management services assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community resources. Services can be provided in any appropriate setting in the community as long as the services are affiliated with a DMC certified location and they can be delivered in-person or by telephone.

Recovery Services may be provided to beneficiaries based on a self-assessment or provider assessment of relapse risk. Beneficiaries receiving MAT, including NTP services, may receive recovery services. Beneficiaries may receive recovery services immediately after incarceration regardless of whether or not they received SUD treatment during incarceration. The service components of recovery services are individual and/or group counseling, recovery monitoring, relapse prevention services, education and job skills, family support, support groups, and ancillary services. Recovery services can be provided in the home or in any appropriate setting in the community either in-person, via telehealth, or by telephone.

The type of services, number of contacts for FY 21-22 are shown in Table 46 by program. The number of contacts is the total number of services for all geographic regions served by each SUD Program of ICBHS.

Table 46. Beneficiaries Served by SUD Programs

SUD Programs	FY 19-20 Beneficiaries	FY 20-21 Beneficiaries	FY 21-22 Beneficiaries
Adolescent SUD Services	163	86	175
Adult SUD Services	518	541	672
Total	**681**	**627**	**847**

Tables 47 and 48 indicate by type of service the number of clients for FY 20-21. This information is provided for each of ICBHS SUD service divisions.

Table 47. Type of Service and Number of Clients
Adolescent SUD Services

Type of Service	Number of Clients FY 19-20		Number of Clients FY 20-21		Number of Clients FY 21-22	
	ODF	IOT	ODF	IOT	ODF	IOT
Assessment	176	9	102	2	171	7
Group Counseling	125	7	3	0	95	2
Individual Counseling	167	14	95	6	187	8
Case Management	46	10	46	4	134	7
Crisis Intervention	0	0	0	0	7	3
Medication Assisted Treatment	1	2	2	2	5	2
Family Therapy	3	0	0	0	2	0
Recovery Services	11	0	21	1	24	0

Table 48. Type of Service and Number of Clients
Adult SUD Services

Type of Service	Number of Clients FY 19-20		Number of Clients FY 20-21		Number of Clients FY 21-22	
	ODF	IOT	ODF	IOT	ODF	IOT
Assessment	306	226	474	276	157	581
Group Counseling	158	141	78	40	44	117
Individual Counseling	298	273	472	274	196	717
Case Management	135	201	256	235	120	525
Crisis Intervention	6	6	10	9	10	6
Medication Assisted Treatment	73	103	121	122	87	301
Family Therapy	5	6	2	3	0	1
Recovery Services	105	4	127	9	24	87
Withdrawal Management 2.0	-	-	1	1	2	0

2) ICBHS Contracted Providers

a) Geographic Location and Target Population

As part of ICBHS' efforts to ensure the appropriate level of care is available to Imperial County residents, ICBHS may make referrals to the Narcotic Treatment Program (NTP) and/or Residential Treatment providers. ICBHS provided SUD services in FY 21-22 through in-county and out-of-county contracted providers.

i. *In-County*
During FY 21-22, ICBHS had one contract provider for NTP services. NTP services were provide in NTP-licensed clinics located in Calexico and in El Centro. This provider has services available for all individuals that reside in all geographic areas of the county; however, it has primarily served the 18+ age group due to beneficiaries between the ages of 0-17 not seeking these services.

ii. *Out-of-County*
During FY 21-22, ICBHS had three DMC certified contracted providers for residential treatment services. The residential programs provided adolescent and adult residential treatment services, which is limited to 14 day detox services. Volunteers of America provided level of care 3.1, 3.2, 3.3, and 3.5; Tarzana Treatment Centers 3.1, 3.2, 3.3, 3.5, 3.7, 4.0 & OTP Level 1; and Clare Matrix 3.1, 3.2, and 3.5. The providers are designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. Towards the end of the fiscal year Volunteers of America submitted a 30-day written notification of early termination of contracted services making April 29, 2021, the last contracted day of service.

b) Type and Services Provided

Narcotic treatment and residential treatment services are available, based on medical necessity and the individualized treatment plan, to all beneficiaries residing in Imperial County who meet the established medical necessity criteria and pertinent ASAM level of care.

The NTP contracted provider offers narcotic treatment in various forms of services that are based on the individuals' needs and assessment. The components of NTP services include: Intake; Individual and Group Counseling; Patient Education; Medication Services; Collateral Services; Crisis Intervention Services; Treatment Planning; Medical Psychotherapy; Recovery Services, and Discharge Services. NTP expanded their services in FY 20-21 by providing non-controlled medications approved by the FDA, such as buprenorphine, disulfiram, and naloxone for providing medication assisted treatment to patients with a substance use disorder.

The Residential Treatment provider offers residential treatment in a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder

diagnosis. Residential treatment services are provided to both non-perinatal and perinatal beneficiaries. This includes both adults and adolescents. The components of Residential treatment services include: Intake; Individual and Group counseling; Patient Education; Family Therapy; Safeguarding Medications; Collateral Services; Crisis Intervention Services; Treatment Planning; Transportation Services; Case Management; and Discharge Services.

The number and types of services provided by contracted providers to Imperial County residents in FY 21-22 is displayed in Table 49.

Table 49. Contracted Providers
Type of Service and Number of Beneficiaries

Contracted Provider	Type of Service	FY 19-20 Beneficiaries*	FY 20-21 Beneficiaries*	FY 21-22 Beneficiaries*
Narcotic Treatment Program	Buprenorphine/Naloxone	-	14	13
	NTP – Dose Methadone	422	364	306
	Individual Counseling	369	357	301
	Group Counseling	398	311	283
NTP Total		**1,189**	**1,046**	**903**
Residential Treatment Services	ASAM Level 3.1	27	15	28
	ASAM Level 3.2	20	36	27
	ASAM Level 3.3	0	0	2
	ASAM Level 3.5	8	26	22
	ASAM Level 3.7	0	0	0
	ASAM Level 4.0	0	0	0
	OTP – Level 1	0	0	0
Residential Treatment Services Total		**55**	**77**	**79**

**Reflects a duplicated count of beneficiaries.*

3) *Federal Network Adequacy Standards*

Network adequacy standards were developed pursuant to Title 42 of the Code of Federal Regulations. Network adequacy standards include time, distance, and timely access requirements with which ICBHS must comply, taking into consideration the urgency of the need for services and the assurance of adequate capacity of services in regard to the number and type of providers, age groups served by each provider, as well as the language capabilities of each.

Standards for the Imperial County DMC-ODS Plan are as shown in Table 50:

Table 50. Timely Access/Time and Distance Standards

Provider Type	Timely Access	Time and Distance
Outpatient Services	Within 10 business days from request to appointment	Up to 60 miles or 90 minutes from the beneficiary's place of residence
Opioid Treatment Program Services	Within 3 business days from request to appointment	Up to 60 miles or 90 minutes from the beneficiary's place of residence

ICBHS direct county providers and contracted providers are required to offer a timely appointment to beneficiaries, or a provider acting on behalf of the beneficiary, when a medically necessary service is requested.

Reporting requirements include accessibility analyses confirming compliance with the time and distance standards for both children/youth and adults. Provider data that includes provider counts by type, licensure, National Provider Identification numbers, site locations, ages served, cultural competence, and language capabilities are also included in the reporting, as is the expected utilization of services, language line utilization, and grievances and appeals regarding access to services.

ICBHS submitted the Network Adequacy Certification Tool (NACT) to DHCS by August 16, 2022, providing the required information. ICBHS will monitor network adequacy and report all required information to DHCS on an annual basis as required.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the number, type, and geographic distribution of SUD services and will report to the QIC at least annually.
- The QIC will evaluate and make recommendations to members of management, when appropriate, regarding the number, type and geographic distribution of SUD services.
- ICBHS will ensure service delivery capacity to meet the needs of beneficiaries.
- ICBHS will monitor its network adequacy and submit the NACT and supporting information to DHCS on an annual basis as required.

2. Accessibility of Services

The QM Unit monitors the accessibility of services through the responsiveness of the 24-hour beneficiary access line, the timeliness of routine appointments, the timeliness of services for urgent conditions, and access to after-hours care.

a. Overview of the DMC-ODS objectives, scope, and planned activities for FY 21-22:

1) Responsiveness of the 24-Hour Beneficiary Access Line

The QM Unit monitors the responsiveness of the ICBHS 24-hour beneficiary access line (BAL) quarterly and reports findings to the QIC at least quarterly. The QIC reviewed reports on September 9, 2021, November 11, 2021, February 10, 2022 and May 12, 2022. The QIC agreed with the recommendations made for the Access Unit to: ensure all calls are answered as required within the set ring standard established by ICBHS. To ensure to discus with the caller the different options available regarding the grievance process; to provide information for callers, as requested; to ensure urgent condition calls are transferred to the Triage unit, as required; ensure all calls are logged under the correct category of Substance Use; ensure all calls are logged in the Access Log, including the name of the caller.

The QM Unit's monitoring process entails conducting random test calls, during business hours and after hours, in both English and Spanish, Imperial County's threshold language, to verify that the BAL is available to beneficiaries 24/7. Test calls determine the ability of Access Unit staff to provide information related to: 1) available SUD services, 2) referrals to DMC-ODS providers, 3) information about how to use the beneficiary problem resolution and fair hearing process, and 4) referrals to services for urgent conditions and medical emergencies. Test callers also assess the Access Unit staff's ability to determine urgency of applicable test calls; whether or not calls were answered within the standard of five rings; and whether or not TTY/TDY services, interpreting services, or materials related to beneficiary protection processes, the Provider Directory, and the Beneficiary Handbook are available upon request. The level of knowledge regarding services, helpfulness, and professionalism are also considered. The test calls, made at random times of the day and days of the week, verified that the 24-hour toll-free telephone line was in operation 24 hours a day, seven days a week.

During FY 21-22, the QM Unit conducted a total of 48 test calls, 24 during business hours and 24 after hours. The Access Unit was 96 percent compliant in the test call criteria evaluated and logged 77 percent of the applicable calls, as indicated in Table 51. Findings were compiled into quarterly reports and presented to QIC.

Table 51. Statewide 24-Hour Toll-Free Telephone Line

Test Call Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Language Capability	100%	75%	88%
SUD Access Information	100%	78%	87%
Urgent Condition Information	100%	100%	100%

Beneficiary Resolution and Fair Hearing Process	89%	67%	83%

Access Log Criteria	Percentage of Test Calls That Met Log Requirements		
	Business Hours	After Hours	All Calls
Name of the caller	82%	80%	81%
Date of the request	88%	95%	92%
Initial disposition of the request	76%	90%	84%

Additionally, the QM Unit verified that Access Unit staff determined urgency of after-hours calls in 100 percent of the applicable test calls. The Access Unit's ring standard, which is answering the calls within five rings for both business hours and after-hours calls, was met for 92 percent of the calls made. The test callers requested seven (7) SUD Program Brochures, two (2) provider directories, and four (4) Beneficiary Handbooks. All written information was received as requested.

2) Timeliness of Routine Appointments

ICBHS has established a seven working day standard to offer a routine appointment for SUD services from the time of the initial request. Beneficiaries may access SUD services through referral from other agencies, by contacting the 24-hour BAL, contacting one of the SUD treatment facilities, or by walking into one of the ICBHS SUD clinics.

The QM Unit is responsible for monitoring the timeliness of routine appointments for SUD services and reporting findings to the QIC at least quarterly. The QIC reviewed Timeliness of Routine Appointments quarterly reports on September 21, 2021, November 21, 2021, February 22, 2022 and May 22, 2022. The QIC concurred with the recommendation to ensure routine appointments are offered within seven working days of the initial request and enter corresponding appointment data into the AVATAR system and document appointment outcome.
During FY 21-22, the source documents utilized in the reviews were the SUD Timeliness to Intake Appointment and Access Log reports, generated from AVATAR, which identify the date of initial contact with ICBHS, the date of the first offered intake appointment, and the number of working days between the date of initial request and the date of the first offered intake appointment.

By evaluating the data gathered in FY 21-22, the QM Unit verified that ICBHS and its providers offered services within seven working days of the initial request 100 percent of the time. This is an increase in compliance rate compared to last fiscal year as indicated in Table 52.

Table 52. Timeliness of Routine SUD Appointments

Review Period	Requests for Routine Appointments	Appointments Offered Within 7 Day Standard	Appointments Offered Over 7 Day Standard	Compliance Rate
FY 21-22	1,163	1162	1	99%
FY 20-21	808	740	68	92%
FY 19-20	1,098	352	746	32%

During FY 21-22, the SUD treatment programs met all except one request of the ICBHS seven-day standard for offering a routine appointment.

During FY 20-21, a Performance Improvement Project was formed to improve timeliness of services. The SUD treatment program implemented a pre-screening process for both SUD treatment programs last fiscal year. This strategy consisted in modifying the admission process by having pre-screening, which determine the type and severity of the individual's substance use. Upon meeting criteria during the screening, clients are admitted to treatment rather than waiting for an appointment to be fully assessed before starting services. A significant improvement was made during FY 20-21, where the average went from 10 days to three days for timeliness to routine appointments. This FY 21-22 the average was four days.

3) Timeliness of Services for Urgent Conditions

ICBHS has established a one-hour standard, from the time of the initial request, to provide a service for an urgent condition, which is defined as a condition that disrupts normal activities of daily living and requires assessment by a health care provider and, if necessary, treatment within 24-72 hours.

The QM Unit monitors the timeliness of services for urgent conditions quarterly and reports findings to the QIC quarterly. The QIC reviewed reports on November 11, 2021; February 10, 2022; and May 10, 2022. The QIC agreed with the recommendations made for Crisis After-Hours staff to ensure all requests for services to treat an urgent condition are logged as required and to provide a service for an urgent condition within the one hour standard.

The QM Unit compares the time and date of initial requests for urgent services on the Access Log (requests made after-hours, weekends, and holidays) and the SUD Program Logs (requests made during working hours) to the time and date of initial contact for services on the Crisis Log Report and the Crisis and Referral Desk Log to determine if services are provided within one hour of initial beneficiary request.

By evaluating the data gathered in FY 21-22, the QM Unit was able to verify that ICBHS provided services for urgent conditions within one hour of initial beneficiary request 57 percent of the time, which reflects a decrease compared to FY 20-21, as seen in Table 53.

Table 53. Timeliness of Services for Urgent Conditions

Review Period	Requests for Urgent Conditions	Requests Within 1 Hour Standard	Compliance Rate
FY 21-22	14	8	57%
FY 20-21	12	8	67%
FY 19-20	2	1	50%

4) Access to After-Hours Care

The QM Unit is responsible for monitoring access to after-hours care and reporting findings to the QIC at least quarterly. The QIC reviewed reports on November 11, 2021; February 10, 2022; and May 10, 2022. During FY 21-22 there were no recommendations made to the QIC.

The QM Unit compares the After-Hours Access Log, which identifies the beneficiary's request for after-hours care, to the Crisis Log Report, which identifies contacts made to the beneficiary by After-Hours Crisis and Referral staff, to determine whether or not all requests for after-hours care were logged as required.

By evaluating the data gathered in FY 21-22, the QM Unit was able to verify compliance for access to after-hours care 86 percent of the time, as seen in Table 54.

Table 54. Access to After-Hours Care

Review Period	After-Hours Requests	Verified	Compliance Rate
FY 21-22	7	6	86%
FY 20-21	7	7	100%
FY 19-20	1	1	100%

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23

- The QM Unit will monitor the timeliness of requests for routine appointments, timeliness of services for urgent conditions, access to after-hour care, and the 24-hour beneficiary line and report findings, including identified trends and recommendations, to the QIC at least quarterly.

- The QIC will review and evaluate the Timeliness of Routine Appointments Report, the Timeliness of Services for Urgent Conditions Report, the Access to After-Hours Care Report, and the 24-Hour Toll-Free Telephone Line Report and will make recommendations to management, as appropriate.

- The QM Unit will randomly monitor the statewide 24 hour toll-free beneficiary access line to ensure the 1-800 number is available 24 hours a day, seven days per week; provides information in beneficiaries' primary language;

provides information on how to access substance use disorder services, including substance use disorder services required to assess medical necessity criteria; services needed to treat urgent conditions; language capability, and how to use the beneficiary problem resolution and fair hearing processes.

- The Access Unit Supervisor will meet with Access staff and Access after-hours staff on a monthly basis and as needed. During these meetings and as necessary, staff will be educated on the types of SUD services available to ensure the SUD information provided is accurate and up to date. In addition, staff will be reminded of the importance of logging all calls received in order to improve compliance.

3. Beneficiary/Family Satisfaction

The QM Unit assesses beneficiary/family satisfaction through the beneficiary/family satisfaction survey; beneficiary grievances, appeals, and fair-hearings process; and requests to change persons providing services.

a. Overview of DMC-ODS objectives scope, and planned activities for FY 21-22:

1) Beneficiary/Family Satisfaction Survey

During FY 21-22, ICBHS administered the Statewide Treatment Perception Survey (TPS) during fall 2021 to consumers receiving services at all provider sites. The state-developed survey tools were administered in the threshold languages of English and Spanish. The TPS uses a point-in-time method that targets all consumers receiving face-to-face SUD services from county-operated and contract providers during a two-week semi-annual sampling period throughout the state of California.

In an effort to promote beneficiary/family participation, the QM Unit provided a specialized “Treatment Perception Survey Data Collection Training” to SUD and Narcotic Treatment Program staff, which included the TPS “Things to Remember” list for staff. Additionally, the QM Unit engaged DMC-ODS staff in promoting participation by providing information regarding the upcoming survey, the importance of the survey, and the need to maintain a high level of consumer participation.

24 youth surveys were completed during FY 21-22. Youth participants reported high satisfaction perception in most areas, with the lowest perception area “Cultural Sensitivity” rating at 54.5 percent. Survey findings for youths are summarized in Table 55, including a side-by-side comparison with FY 20-21 findings.

Table 55. Satisfaction Rates - Youth Treatment Perception Survey

Survey Area	FY 20-21	FY 21-22
Convenient Location	100%	82.6%
Convenient Time	100%	83.3%
Good Enrollment Experience	100%	87.0%
Worked with Counselor on Goals	100%	91.3%
Received the Right Services	100%	87.5%
Treated with Respect	100%	95.8%
Counselor Listened	100%	95.7%
Positive/Trusting Relationship with Counselor	100%	91.7%
Cultural Sensitivity	91.7%	54.5%
Counselor Interested in Me	100%	87.5%
Liked Counselor	100%	95.8%
Counselor Capable of Helping	100%	100%
Health/Emotional Needs Being Met	100%	95.8%
Helped with Other Issues/Concerns	100%	91.3%
Provided Family Services	100%	90.0%
Better Able to Do Things	100%	82.6%
Overall Satisfied with Services	100%	91.7%
Recommend Services	100%	95.7%

A total of 253 adult consumers completed the survey during FY 21-22. Adult participants reported high satisfaction perception in all areas, with the lowest perception area “Convenient Location” rating at 88.8 percent. Survey findings for adults are summarized in Table 56, including a side-by-side comparison with FY 20-21 findings:

Table 56. Satisfaction Rates - Adult Treatment Perception Survey

Survey Area	FY 20-21	FY 21-22
Convenient Location	80.6%	88.8%
Convenient Time	86%	91.6%
I Chose my Treatment Goals	89%	92.8%
Staff Gave Me Enough Time	92.9%	93.6%
Treated with Respect	89.5%	93.2%
Understood Communication	90.6%	96.0%
Cultural Sensitivity	87%	93.7%
Work with Physical Health Care Providers	85.5%	90.8%
Work with Mental Health Providers	81.5%	89.1%
Better Able to Do Things	88.3%	94.4%
Felt Welcomed	90.5%	94.0%
Overall Satisfied with Services	88.3%	91.7%
Got the Help I Needed	88.9%	91.2%
Recommend Agency	89%	92.4%

The results of the FY 21-22 TPS were provided to management, as appropriate, and an overview of the survey results were presented to SUD staff.

During FY 21-22, as a result of the EQRO's recommendation during its FY 20-21 review to address year over year variances in TPS results and increase the amount of TSP surveys completed, ICBHS gave all ICBHS DMC-ODS providers UCLA's TPS guidelines. In addition, all providers were furnished with the links for the online survey and QR Codes for their individual program in order to assist them in conducting the TPS successfully. DMC-ODS providers were also provided with UCLA's presentation that provided detailed information regarding the electronic TPS, the TPS flyer, and survey instrument files for those who would prefer to administer a paper survey. Many of the DMC-ODS clients struggled due to not having the needed technology such as a cell phone, computer or tablet with internet capability.

2) *Beneficiary Grievances, Appeals, and Fair Hearings*

The QM Unit monitors all Medi-Cal beneficiary grievances, appeals, and fair hearing data, completes quarterly reports, and reports findings to the QIC on a quarterly basis. The QIC reviewed reports on December 9, 2021, March 10, 2022, June 9, 2022 and September 8, 2022. The QIC agreed with the recommendation made for ICBHS to make its best efforts to ensure beneficiary satisfaction.

During FY 21-22, ICBHS received two grievances. There were no appeals or expedited appeals submitted. The two grievances were submitted under the

categories of Staff Behavior Concerns and Other. The two grievances received were resolved by the end of the next business day. The two grievances were resolved to the beneficiary's satisfaction.

It is the responsibility of ICBHS deputy directors/managers to investigate grievances and appeals. The Patients' Rights Advocate provides technical assistance to management and staff to assure that beneficiary protection requirements were met.

ICBHS provided management and line staff with technical assistance regarding the Grievance and Appeal System changes in accordance with CFR Title 42 to ensure: a) ICBHS staff are knowledgeable regarding the new grievance and appeal system requirements; b) beneficiaries are provided with a grievance resolution within the timeframe of disposition of standard grievances and appeals; c) beneficiaries are provided with all required templates and informational notices; d) beneficiaries are provided with a NOABD Grievance and Appeal Timely Resolution when ICBHS fails to act within the timeframes of disposition of standard grievances and appeals. In addition, ICBHS updated the grievance and appeal logs in order to closely monitor the processes to ensure compliance with all new requirements, including new established timeframes, and issuance of NOABD, as appropriate.

3) Requests to Change Persons Providing Services

During FY 21-22, the QM Unit monitored requests to change persons providing services and reported to the QIC at least annually. The QIC reviewed the report on October 14, 2021 and April 14, 2022. No recommendations were made.

During FY 21-22, ICBHS received seven requests to change persons providing services from Medi-Cal beneficiaries, due to Disagreement with Diagnosis, Uncomfortable with Provider, Communication Difficulties with Provider, Provider Gender Preference and Dissatisfaction with the Provider. The clinical manager assigned to the SUD programs evaluated each request to change persons providing services and discussed the reason for the request with the client/authorized representative, unless unable to contact. All clients/authorized representatives were notified of the decision by telephone, by mail, or in person within the requisite 14 working days.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor and assess beneficiary/family satisfaction, requests to change person providing services, and report its findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will monitor and assess beneficiary/family satisfaction, grievances, appeals, fair hearing requests, and report its findings, including identified trends and recommendations, to the QIC on a quarterly basis.

- The QM Unit will provide training on beneficiary protection processes at least annually to ensure compliance with all grievance and appeal requirements.

- The QIC will review and evaluate the Beneficiary/Family Satisfaction Report; Grievance, Appeals, and State Fair Hearing Report; Request to Change Practitioner Report; and Consumer Satisfaction Survey Report and make recommendations to management, as appropriate.

- The QM Unit will monitor and assess beneficiary/family satisfaction by conducting a Treatment Perception Survey of DMC-ODS beneficiaries and contracted providers' beneficiaries and report the findings, including identified trends and recommendations, to the QIC at least annually.

- ICBHS will review all requests to change person providing services and will consider approval of the requests, as appropriate.

- ICBHS will ensure beneficiaries are provided with a decision to their request for change of person providing services within the required timeframe.

4. Service Delivery System and Meaningful Clinical Issues Affecting Beneficiaries, Including the Safety and Effectiveness of Medication Practices

The QM Unit monitors the DMC-ODS service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices, through the Medication Monitoring, Quality of Care, and chart reviews.

During FY 21-22, as part of the CalAIM initiative, DHCS provided guidance regarding criteria to access DMC-ODS services for adults and children; documentation reform; and treatment during the assessment period prior to diagnosis. ICBHS plans to train all current providers on these new policies by September 30, 2022. All new providers will be trained on these policies upon hire. These policy changes have been incorporated into the QM Unit's monitoring of the DMC-ODS service delivery system for FY 22-23.

a. Overview of DMC-ODS objectives, scope, and planned activities for FY 21-22:

1) Medication Monitoring

The QM Unit monitors the Medication Monitoring reviews and reports findings to the QIC at least annually. The QIC reviewed the annual Medication Monitoring Reviews Report on June 22, 2022, and no recommendations were made, as no areas were identified as opportunities for improvement.

The Medical Director and a pharmacist conduct the Medication Monitoring reviews monthly. Utilizing a review tool, the Medical Director and pharmacist monitor the ICBHS and NTP service delivery system to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries' system-wide; review medication practices for adult

individuals receiving Medication Assisted Treatment (MAT); and address any quality of care concerns or outliers identified related to medication use.

The charts are randomly selected from a team center list compiled from AVATAR and team centers when an identified concern warrants further review. The QM Unit compiles the data by provider, identifying opportunities for improvement and areas of concern. All reports are provided to the Medical Director, including a copy of all tools completed. Each individual provider is given a copy of their individual report with completed tools attached. The QM Unit also ensures that management receives a copy of reports and completed tools, as appropriate.

Report findings, including areas of concern and areas identified as opportunities for improvement, and discussed with the ICBHS Medical Director. Areas at 85 percent or below are identified as opportunities for improvement.

Due to COVID-19, the only medication monitoring reviews conducted during FY 21-22 were for the NTP service delivery system. The Medical Director reviewed 47 charts from the NTP provider. The NTP provider was 100 percent compliant in all of the 20 areas evaluated.

2) Chart Reviews

The QM Unit is responsible for conducting chart reviews to monitor if ICBHS is following documentation standards as set forth in Title 22 regulations, the DMC-ODS contract, and ICBHS policies and procedures. This process is instrumental in identifying billing issues as well as opportunities for improvement.

The QM Unit compiles findings and presents a report to the QIC at least annually. The QM Unit compiles findings and presents a report to the QIC at least annually. Areas below the benchmark of 70 percent are identified as opportunities for improvement.

Areas below the benchmark of 70 percent are identified as opportunities for improvement.

The QM Unit conducted charts reviews on an ongoing basis, with charts randomly selected from a team center list compiled from AVATAR. A review tool with the following seventeen categories was utilized: 1) Medical Necessity; 2) Assessment; 3) Physical Examination; 4) Beneficiary Record; 5) Treatment Plan; 6) Continuation of Care; 7) Outpatient Services; 8) Intensive Outpatient Services; 9) Sign-in Sheet; 10) Case Management Services; 11) Medication Assisted Treatment Services- Other Medication Assisted Treatment; 12) Physician Consultant Services; 13) Perinatal Services; 14) Recovery Services; 15) Care Coordination & Continuity of Care; and 16) Other Areas of Review.

The QM Unit compiled the data by team identifying opportunities for improvement and areas of concern, as appropriate. Team reports were

provided to the individual team supervisors and managers, as appropriate. Supervisors were given a month timeframe to respond to areas identified as opportunities for improvement. Areas that fell below the 70 percent benchmark required a Corrective Action Plan. Each team manager had to review the potential corrective action plan and sign for approval. The QM Unit would approve the Corrective Action Plan, prior to the implementation, and followed up with each team to ensure the Corrective Action Plan was completed.

During FY 21-22, the QM Unit reviewed a total of 40 clinical charts for ICBHS, of which 20 charts were for the Adolescents SUD program and 20 charts for the Adults SUD program. Additionally, the QM Unit reviewed 20 charts from its contracted NTP provider and 12 charts from its contracted residential providers.

ICBHS met the 70 percent benchmark in all of the areas reviewed, with the exception of the following:

Continuation of Services

- Does the documentation for the justification of continued services indicate that all of the following have been considered: Documentation of the beneficiary's most recent physical examination? - 36 percent compliance.

Outpatient Services

- Is the frequency of follow-up provided in accordance with the beneficiary's treatment plan?
  – 52 percent compliance.
- If the beneficiary did not attend the total required number of hours for services per week, is there documentation that shows that the provider ensured that the minimum required hours of services were made available to the beneficiary?
  – 52 percent compliance.

Intensive Outpatient Services

- Is the frequency of follow-up provided in accordance with the beneficiary's treatment plan?
  – 25 percent compliance.
- If the beneficiary did not attend the total required number of hours for services per week, is there documentation that shows that the provider ensured that the minimum required hours of services were made available to the beneficiary?
  – 25 percent compliance.

Medication Assisted Treatment Services- Other MAT

- Do the progress notes identify the star and end times for service, travel, and documentation time?
  – 67 percent compliance.

Care Coordination & Continuity of Care

- If a beneficiary is Limited English Proficient (LEP), is there evidence that interpreter services were offered, if applicable?
  – 30 percent compliance.
- Were services offered in the beneficiary's preferred language?
  – 42 percent compliance.
- If the need for language assistance is identified in the assessment, is there documentation linking beneficiaries to culture-specific and/or linguistic services?
  – 22 percent compliance.
- Is there documentation of who provided the interpreter services?
  – 30 percent compliance.
- When applicable, was treatment specific information provided to beneficiaries in an alternative format (i.e. brail, audio, large font, etc.)?
  – 25 percent compliance.
- Did transitions to other levels of care occur no later than 10 business days from the time of assessment or reassessment with no interruption of current treatment services?
  – 67 percent compliance.
- For adolescents, did the program provide or arrange for alcohol and drug testing?
  – 10 percent compliance.

For the NTP contracted providers, opportunities for improvement were identified in the areas of Criteria for Patient Selection, Beneficiary's Record, Assessment, Maintenance Treatment Plan, Individual and Group Counseling, Medication Dosage Levels, Take-Home Medication Privileges, Sign-in Sheets, Perinatal Services, Medication Assisted Treatment Services – Other Medication Assisted Treatment and Other Areas of Review. Findings were presented to NTP treatment programs on December 8, 2021 and June 3, 2022.

In addition, residential contracted providers' opportunities for improvement were identified in the areas of Assessment, Beneficiary Records Treatment Plan, Individual and Group Counseling, Sign-in Sheets, Case Management, Discharge Plan, Discharge Summary and Other Areas of Review. Findings were presented to Clare Matrix on March 9, 2022, Volunteers of America on March 9, 2022, and Tarzana on May 4, 2022.

The QM Unit issued plans of correction to each contracted provider to ensure that the appropriate corrections were made, as applicable, and that processes were established to ensure future compliance with documentation standards requirements.

Additionally, the Compliance Unit worked closely with clinical staff to ensure that services claimed were in accordance with ICBHS contract with DHCS DMC-ODS as well as ICBHS policies and procedures. Any claims for services that were not in compliance were disallowed as required.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices, through medication monitoring and QOC chart reviews and report its findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Medication Monitoring Report and Documentation Standards Report and make recommendations to management, as appropriate.

- ICBHS will implement appropriate interventions when individual occurrences of potentially poor quality of care are identified.

- The Medical Director and pharmacist will conduct medication monitoring reviews for beneficiaries receiving medication services.

- The QM Unit will update its monitoring process to verify the MHP is in compliance with the CalAIM policy initiatives of criteria to access DMC-ODS services for adults and children; documentation reform; treatment during the assessment period prior to diagnosis.

- The QM Unit will monitor documentation standards for DMC-ODS services and present findings to management, as well as report findings, including trends and recommendations, to the QIC at least annually.

- ICBHS will implement strategies to address areas identified as opportunities for improvement through the Medication Monitoring and chart reviews in an effort to improve compliance and meet the standards set forth in both the contract with DHCS and the MHP's policies and procedures.

5. Timeliness of Services of the First Dose of NTP Services

a. Overview of the DMC-ODS objectives scope, and planned activities for FY 21-22:

The current timeliness standard for providing a NTP appointment from the date of request is three working days. The current intake process for NTP allows for clients to be offered an appointment or be seen on a walk-in basis at each clinic. The QM Unit monitors the timeliness of services of the first dose of NTP services quarterly and reports findings to the QIC at least annually. The QIC reviewed the Timeliness of Services of the First Dose of NTP Services report on April 14, 2022. No recommendations were made.

During FY 21-22, the source document utilized in the review was the NTP Access Log report, completed by the NTP clinics, which identifies the date of initial contact with the NTP to request an intake appointment, the intake appointment date, and the date the first dose was given. Once the NTP Access Log report is received by the QM Unit a Quality Improvement Specialist (QIS) measures the

number of working days between the date of initial request and the date of the first offered intake appointment and prepares the quarterly report identifying the findings.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the NTP clinics were able to offer the first dose of NTP services within three working days of the initial request for all clients, with the exception of one client which reflects a decrease in the compliance rate compared to FY 20-21, as seen in Table 57:

Table 57. Timeliness of Services of the First Dose of NTP Services

Time Period	Intake Appointments	Met 3 Work-Day Standard	Did Not Meet Timeliness Standard	Compliance Rate	Average Wait Time for NTP Dose
FY 21-22	97	96	1	99%	0 days
FY 20-21	90	90	0	100%	0 days
FY 19-20	145	145	0	100%	0 days

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the Timeliness of Services of the First Dose of NTP Services and report findings, including identified trends and recommendations, to the NTP provider at least annually.

6. *NTP Utilization of Methadone and Non-Methadone (MAT)*

a. Overview of the DMC-ODS objectives scope, and planned activities for FY 21-22:

The QM Unit monitors the utilization of methadone and non-methadone medication treatment for Narcotic Treatment Program (NTP) and reports findings to NTPs at least annually.

The monitoring process entails collecting data related to the different medications used in the NTP programs from the NTP MAT Services Report from Avatar. This report tracks all that received services in NTP along with the type of medication received, admission date, and demographic information. The Quality Improvement Specialist (QIS) reviews the data and prepares the quarterly report identifying the findings.

During FY 21-22 recommendations were made to the Narcotic Treatment Programs (NTPs) to offer when medically necessary the required medications which include Buprenorphine, Disulfiram, and Naloxone.

During FY 21-22, there were a total of 310 clients receiving medication used in the NTP programs. The majority of clients received Methadone as seen in Table 58.

Table 58. Utilization of Methadone and non-Methadone (MAT)

NTP - Medications	Unduplicated Clients
Methadone	301
Buprenorphine-Mono	1
Buprenorphine-Naloxone Combination	8
Disulfiram	0
Naloxone- Nasal Spray	0
Total	**310**

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the utilization of Methadone and non-methadone medication treatment to ensure Narcotic Treatment and report findings, including identified trends and recommendations are communicated to management and Narcotic Treatment Programs.

7. Continuity and Coordination of Care with Physical and Mental Health Care Providers and Other Human Services Agencies

The QM Unit monitors the continuity and coordination of care with Physical Care Providers (PCPs) and other human services agencies used by its beneficiaries by providing information, training, and consultation to PCPs and other human services agencies and through memorandums of understanding.

a. Overview of DMC-ODS objectives, scope, and planned activities for FY 20-21:

1) Coordination with physical and mental health care providers and other human service agencies

Training & Education

As of September 2022, SUD staff has received training through a series of CalAIM webinars to ensure a smooth transition and understanding of CalAIM's initiative. Part of this training includes: CalAIM overview, access to services, assessment, diagnosis and problem list, progress notes, and care coordination. In addition, the SUD program updated its policies and procedures to ensure compliance with the state's plan.

ICBHS has continued to provide training to SUD treatment providers on various evidence-based practices such as dialectical behavioral therapy, Matrix model, seeking safety, and motivational interviewing to ensure that treatment services are geared toward the specific treatment needs of clients.

During April 2022, ICBHS was awarded the opportunity to be part of the DHCS Contingency Management (CM) Pilot Program. CM is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants. CM is the only treatment that has demonstrated robust positive outcomes for individuals living with stimulant use

disorder, including reduction or cessation of drug use and longer retention in treatment. All staff were provided with training on the implementation of CM. The SUD program will implement the CM pilot program in December 2022.

On December 22, 2021, ICBHS received approval to be part of the DHCS Naloxone Distribution Project to combat opioid overdose related deaths throughout Imperial County. Naloxone is a medicine that rapidly reverses an opioid overdose, as it is an opioid antagonist. This project aims to address the opioid crisis by reducing opioid overdose deaths through the distribution of free naloxone to clients, family members, and other support systems. To implement the project, SUD developed a distribution plan, policies and procedures, and provided trainings on information regarding the administration of naloxone, client and employee distribution, and storage and disposal. As of August 2022, more than 252 units have been distributed to staff, clients, and their families. SUD will submit future applications to continue with this project with the goal of preventing opioid overdoses throughout the county

Mental Health Services

ICBHS has integrated, as much as possible, the provision of mental health and SUD treatment services. ICBHS has systems in place to ensure that consents for release of information are obtained from the client to facilitate the exchange of information between treatment providers and the coordination of care to address both the mental health and SUD needs of clients. Treatment providers take a team approach when working with this population and address crisis and emergency situations and provide linkage to other ancillary services to prevent homelessness, incarcerations, isolation, and hospitalizations.

SUD Bridge Collaboration

ICBHS continues to work in collaboration with El Centro Regional Medical Center (ECRMC) to continue care coordination for clients in needing SUD and MAT services. ICBHS has an SUD Navigator onsite at ECRMC Emergency Room Monday through Friday to be available for client in need to be pre-screened to SUD Treatment and successfully linked to outpatient treatment for MAT and other SUD services. This has allowed Imperial to expand MAT to those individuals who enter the emergency room. Imperial has established a protocol with ECRMC in which clients who are treated with buprenorphine at the emergency room are bridged to the ICBHS outpatient clinic for continuity of care. This partnership has allowed for timely access to services as clients can walk into the emergency room 24/7 and begin treatment immediately. Imperial has designated appointments for ECRMC clients to ensure that they access services at outpatient clinics within seven days from their release from the hospital.

Criminal Justice System

Adult SUD Treatment programs and Imperial County Sherriff's Office (ICSO) are currently in a partnership to expand access to MAT in the County criminal justice setting. Through this partnership, SUD and ICSO meet on a monthly basis to ensure clients receiving MAT at the County Jail are successfully

linked to outpatient SUD treatment upon release from incarceration. As a result of an influx of court orders, the SUD Treatment programs have provided services that include pre-screenings, assessments, and care coordination to clients who are incarcerated. During FY 21-22, 108 incarcerated clients were provided with SUD treatment services and, whenever necessary, clients were linked to residential facilities mental health services, recovery housing and other community services upon their release from jail.

Increase in School Partnerships

Due to ongoing collaborative effort the Adolescent SUD Program established two new partnerships with two school sites, Southwest High School and Desert Oasis, this resulted in additional referrals and an increase of caseload. SUD Treatment Programs continues to promote SUD services to ensure all regions throughout Imperial County are served.

2) Memorandum of Understanding with Manage Care Plans

ICBHS maintains Memorandums of Understanding (MOU) with two Medi-Cal Managed Care Plans (MCPs) that enroll beneficiaries covered through DMC-ODS. The MOUs address referral protocols between plans, the availability of clinical consultation, management of a beneficiary's care, procedures for providing beneficiaries with services necessary to the treatment of SUD covered by the DMC-ODS and a process for resolving disputes between ICBHS and the MCP that includes a means for beneficiaries to receive medically necessary services.

During FY 20-21, quarterly meetings were held between ICBHS upper management team and MCP representatives to aid ICBHS in working collaboratively with the MCPs to ensure that processes affecting client continuity of care are appropriate and effective.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will consult with clinical services regarding continuity and coordination of care with physical and mental health care providers and other human services agencies, as appropriate.

- The QM Unit will identify the number of dual diagnosed clients under each program and analyze data associated with this population.

- The QM Unit will continue to attend quarterly meetings with its MCPs in order to ensure continuity of care for beneficiaries receiving services through the MCPs.

- The QM Unit will implement strategies to address the EQRO's FY 2021-2022 recommendation to take steps to address care coordination with mental health providers.

8. Provider Complaints and Appeals

The QM Unit monitors provider disputes with the DMC-ODS concerning the processing or payment of a provider's claim to the DMC-ODS. The QM Unit also monitors provider appeals through the written appeals submitted to the DMC-ODS by providers for denial or modification of requests for authorization.

a. Overview of DMC-ODS objectives, scope, and planned activities for FY 20-21:

The QM Unit monitors provider complaints and appeals and reports the findings to the QIC at least annually. The QIC reviewed the Provider Complaints and Appeals Report on July 14, 2022. No recommendations were made.

During FY 21-22, the QM Unit fulfilled the DMC-ODS' provider relations responsibilities, as needed. All providers are encouraged, as outlined in the provider contracts, to present complaints to the Provider Relations staff by telephone, in person, or in writing. Provider Relations staff makes every effort to resolve complaints quickly and at the lowest possible level. If providers are not satisfied with the outcome of the complaint process, they are provided information on the appeals process.

During FY 21-22, no complaints were reported to the QM Unit, as indicated in Table 59.

Table 59. DMC-ODS Provider Complaints

Period	Number of Complaints	Reason for Complaint	Resolved	
			Yes	No
FY 21-22	0	N/A	N/A	N/A
FY 20-21	0	N/A	N/A	N/A
FY 19-20	0	N/A	N/A	N/A

The QM Unit's objective for FY 21-22 of tracking all providers' complaints in order to monitor provider satisfaction with the DMC-ODS was achieved.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-24:

- The QM Unit will monitor provider complaints and appeals and report findings, including identified trends and recommendations, to the QIC at least annually.
- The Provider Relations staff will provide technical assistance to providers and/or DMC-ODS staff as needed to resolve complaints at the lowest possible level.
- The QM Unit will monitor provider complaints through the Provider Complaint Log by checking entries on a regular basis and incorporating findings in the Provider Complaints and Appeals Report, as appropriate.

9. Strategies to Reduce Avoidable Hospitalizations

In an effort to identify any potential quality of care issues and trends in occurrences, the QM Unit tracks the admissions and readmissions of all Imperial County beneficiaries who are admitted into an inpatient hospital.

The QM Unit monitoring process consisted of collecting data related to hospitalizations from the programs' SUD Related Hospitalizations Log. This report identified the total number of hospitalizations and the client status (active/inactive) at ICBHS at time of hospital admission. The report also documents the number of days the client was hospitalized, the number of ICBHS – SUD program episodes prior to the hospitalization, and the timeliness of follow-up care after hospital discharge.

a. Overview of DMC-ODS objectives, scope, and planned activities for FY 21-22:

The QM Unit's monitoring process consisted of collecting data related to hospitalizations from the programs' SUD Related Hospitalizations Log during FY 21-22. The log identifies the level of care the beneficiary received prior to hospitalization, as well as the timeliness and follow-up care received upon discharge. If any hospitalizations are reported, the QM Unit will also document ICBHS' efforts to prevent the hospitalization.

During FY 21-22, there were 11 hospitalizations made by SUD treatment programs, as indicated in Table 60.

Table 60. Hospitalization Admissions and Readmissions

Review Period	Number of Hospitalizations
FY 21-22	11
FY 20-21	4
FY 19-20	0

Current efforts being made by the SUD treatment programs to prevent hospitalizations include regularly assessing clients, using the ASAM criteria, throughout the course of treatment to ensure that their SUD treatment needs are met, reducing the risk of emergencies and hospitalizations.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor hospital admissions and readmissions and report findings, including identified trends and recommendations, to the QIC at least annually.

- The SUD treatment programs will continue to implement strategies to reduce avoidable hospitalizations.

B. Additional DMC-ODS QI Activities

1. Notices of Adverse Benefit Determination

ICBHS and its contracted network providers are required to provide Medi-Cal beneficiaries, or their representative, with a Notice of Adverse Benefit Determination (NOABD) when ICBHS or its providers take any of the following actions: 1) Denies or limits authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) Reduces, suspends, or terminates a previously authorized service;3) Denies, in whole or in part, payment for a service; 4) Fails to provide services in a timely manner; 5) Fails to act within the required timeframes for standard resolution of grievances and appeals; or 6) Denies a beneficiary's request to dispute financial liability.

ICBHS and its contracted network providers must provide beneficiaries with a written notice of the adverse benefit determination and the NOABD must explain the following:

1. The adverse benefit determination ICBHS or one of its contracted network providers has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The NOABD shall explicitly state why the beneficiary's condition does not meet specialty mental health services medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations; and
4. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Decisions must be communicated to the beneficiary within the following timeframes:

- For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214;
- For denial of payment, at the time of any action denying the provider's claim; or,
- For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two business days of the decision.

Additionally, the decision must by communicated to the provider by telephone of facsimile and then in writing.

The following attachments must be included with each NOABD:

1. "NOABD Your Rights"
   The "NOABD Your Rights" provides beneficiaries with the following required information pertaining to the NOABD:
   a. The beneficiary's or provider's right to request an internal appeal with ICBHS within 60 calendar days from the date on the NOABD;
   b. The beneficiary's right to request a State hearing only after filing an appeal with ICBHS and receiving a notice that the Adverse Benefit Determination has been upheld;
   c. The beneficiary's right to request a State hearing if ICBHS fails to send a resolution notice in response to the appeal within the required timeframe;
   d. Procedures for exercising the beneficiary's rights to request an appeal;
   e. Circumstances under which an expedited review is available and how to request it; and,
   f. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420.
2. Nondiscrimination Notice
3. Language Assistance Taglines

1) Notices of Adverse Benefit Determination (NOABD) - Denial of Authorization for Requested Services

The NOABD-Denial notice is used when ICBHS determines that Medi-Cal beneficiaries do not meet medical necessity criteria and, therefore, no SUD services will be provided. The NOABD-Denials were issued by clinicians at intake assessment and also by counselors at pre-screening at the program sites.

The QM Unit monitored the issuance of the NOABD-Denial and reported its findings to each division on a quarterly basis.

The QM monitoring process consists in comparing the NOABDs issued to Medi-Cal beneficiaries to the NOABD Denial Log Report from Avatar. The QM Unit utilizes the NOABD Denial Log Report to review all NOABDs issued to beneficiaries who were screened out by the SUD programs. Additionally, the QM Unit utilizes the Detail of Discharges by Program Report from Avatar to ensure all ICBHS Medi-Cal beneficiaries who were discharged due to not meeting medical necessity, were issued an NOABD, as required. For the Narcotic Treatment Programs (NTPs), the monitoring process consists in comparing the copies of the NOABDs issued to Medical beneficiaries to the NOABD Denial Log which are both provided by NTP. The data obtained is used to determine the timeliness of issuance is within the two-day standard. The date of decision on the NOABD is compared to the date the NOABD was given or mailed to the beneficiary.

In FY 21-22, ICBHS screened out a total of 119 Medi-Cal beneficiaries. ICBHS issued a total of 118 NOABDs. One NOABD was not issued as required. Six NOABDs were issued outside of the two-day timeliness standard. In addition, there were a total of four NOABDs not issued in the beneficiary's primary

language. 118 NOABDs included enclosed information and 12 Medi-Cal beneficiaries were provided with proper referrals.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the programs had a compliance rate of 95 percent for issuing NOABDs to Medi-Cal beneficiaries who did not meet medical necessity criteria for SUD treatment services and 5 percent were issued outside the required two-day standard. Table 61 reflects the data for the last three fiscal years.

Table 61. NOABDs - Denial of Authorization for Requested Services

Review Period	Screened Out Medi-Cal Beneficiaries	NOABDs Issued Within 2 Day Standard		NOABDs Issued Outside 2 Day Standard		NOABDs Not Issued	
FY 21-22	119	112	95%	6	5%	1	1%
FY 20-21	46	42	91%	2	4%	2	5%
FY 19-20	42	41	98%	1	2%	0	0%

2) *Notices of Adverse Benefit Determination (NOABD) – Termination of a Previously Authorized Service*

The NOABD-Termination of a Previously Authorized Service is issued to Medi-Cal beneficiaries when ICBHS terminates, reduces, or suspends a previously authorized service. Notification must be issued to the beneficiary at least 10 days before the date of the action. The NOABD-Terminations were issued by the SUD programs upon the decision to terminate, reduce, or suspend an authorized services.

The QM Unit monitors the issuance of NOABDs and reports findings to each division on a quarterly basis.

The monitoring process consists of reviewing all NOABDs issued by comparing the names and dates on the NOABDs to the names and dates recorded on the Avatar report NOABD Termination Log to determine if the NOABDs were issued within the 10 day standard. The QM Unit verifies whether or not each NOABD is issued in beneficiary's primary language, is client driven, and contains the required enclosed information for Medi-Cal beneficiaries. The QM Unit utilizes the Detailed Discharge by Program (BHS) from Avatar to ensure all Medi-Cal beneficiaries who had terminated, reduced, or suspended services were issued a NOABD, as required. For the Narcotic Treatment Programs (NTPs), the monitoring process consists in comparing the copies of the NOABDs issued to Medical beneficiaries to the NOABD Termination Log which are both provided by NTP.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the SUD programs had a compliance rate of 97 percent for issuing NOABD-Terminations to Medi-Cal beneficiaries. Table 62 reflects that data for the last three fiscal years.

Table 62. NOABDs – Termination of a Previously Authorized Service

Review Period	Clients with Terminated, Reduced, or Suspended Services	NOABDs issued	NOABDs Issued Within 10 Day Standard		NOABDs Issued Less Than 10 Day Standard	
FY 21-22	1,265	1,265	1,222	97%	43	3%
FY 20-21	1,273	1,273	1,103	87%	170	13%
FY 19-20	1,010	1,010	887	88%	123	12%

The QM Unit worked with team centers to educate staff on the importance of issuing NOABDs when reducing, suspending or terminating a previously authorized service at least ten days prior to the date of action.

3) *Notice of Adverse Benefit Determination (NOABD) – Delays in Grievance/Appeal Processing*

NOABDs for Grievance & Appeal Timely Resolution are issued to Medi-Cal beneficiaries when ICBHS fails to act within the timeframes for resolution of grievances (90 calendar days), standard appeals (30 calendar days), or expedited appeals (72 hours from receipt). ICBHS' deputy directors/managers' responsibility to issue the NOABDs Grievance & Appeal Timely Resolution as appropriate.

The QM Unit is responsible for monitoring the issuance of NOABDs and reporting findings to management on a quarterly basis. During FY 21-22, there were no NOABDs Grievance & Appeal Timely Resolution required to be issued by ICBHS.

4) *Notices of Adverse Benefit Determination (NOABD) – Failure to Provide Timely Access*

NOABDs for Timely Access are issued to Medi-Cal beneficiaries or their representatives when ICBHS, or its providers, fail to provide services in a timely manner. Providers are required to comply with the timely access standards as established by DHCS and ICBHS, taking into account the urgency of the need for services. Timely access standards refers to the number of business days in which ICBHS and its providers must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service. ICBHS and its providers must comply with the following timely access standards:

- For requests for initial routine SUD services, within seven business days from request to appointment, as established by ICBHS;
- For requests for outpatient SUD services, other than opioid treatment programs (OTPs), within 10 business days from request to appointment; and,
- For OTPs, within 3 business days from request to appointment.

The QM Unit is responsible for monitoring the issuance of NOABDs for Timely Access and reporting findings. The QM Unit monitored the issuance of the NOABD-Timely Access and reported its findings to each division on a quarterly basis.

During FY 21-22, the source documents utilized in the reviews were the SUD Timeliness to Initial Intake Appointment Report in Avatar to verify whether ICBHS met the seven working-day timeliness standard for the initial request for routine substance use disorder services. For Narcotic Treatment Programs (NTP), the Access Log and Timely Access Log were utilized to verify the three-day standard was met. The QM Unit verifies that NOABDs are issued within three working days and that NOABDs are clear and client driven. Appointments scheduled outside timeliness standards were noted as being outside the timeliness standard, therefore requiring the issuance of an NOABD to Medi-Cal beneficiaries.

By evaluating the data gathered in FY 21-22, the QM Unit verified that the MHP offered 1 appointment over the set seven day standard as a next available appointment. The compliance rate was 99 percent for issuing NOABDs for Timely Access to Medi-Cal Beneficiaries, as required. Additionally, 20 appointments were scheduled outside the seven-day standard due to client's choice.

For the NTP, 1 appointment was offered over the set three-day standard. An NOABD was issued as required. 20 appointments were scheduled outside the three- day standard due to client's choice.

Table 63 reflects the data for the last three fiscal years.

Table 63. Timeliness of Routine SUD Appointments

Review Period	Medi-Cal Requests for Routine Appointments	Appointments Offered Over Seven-Day Standard as Next Available	NOABDs Issued	Compliance Rate
FY 21-22	874	1	0	99%
FY 20-21	614	53	53	100%
FY 19-20	811	511	511	100%
Review Period	**Medi-Cal Requests for OTP Services**	**Appointments Offered Over 3-Day Standard as Next Available**	**NOABDs Issued**	**Compliance Rate**
FY 21-22	225	1	1	100%
FY 20-21	90	0	N/A	N/A
FY 19-20	145	0	N/A	N/A

The QM Unit worked with the Access Unit to educate staff on the importance of issuing NOABDs within the three-day standard and to Medi-Cal beneficiaries only.

5) ***Notices of Adverse Benefit Determination (NOABD) – Dispute of Financial Liability***

NOABDs for Dispute of Financial Liability are issued to Medi-Cal beneficiaries or their representatives when ICBHS or its providers denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

During FY 21-22, there were no disputes of financial liability submitted by Medi-Cal beneficiaries; therefore, there were no NOABDs issued.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the issuance of NOABDs when ICBHS makes or intends to make an adverse benefit determination and report findings, as appropriate.

- The QM Unit will review and evaluate NOABD reports and make recommendations to the QIC, as appropriate.

- The SUD programs will implement corrective action(s) to ensure the NOABD-Termination is issued at least 10 days prior to the date of action.

2. Request for a Second Opinion

The QM Unit monitors requests for a second opinion in an effort to ensure beneficiary satisfaction. ICBHS provides for a second opinion by a licensed SUD professional when ICBHS or its providers determine that the beneficiary is not entitled to SUD services based on the lack of medical necessity.

a. Overview of ICBHS objectives, scope, and planned activities for FY 21-22:

The QM Unit monitors all Medi-Cal beneficiary requests for a second opinion, completes a report biannually, and reports findings to the QIC at least annually. The QIC reviewed the report on April 14, 2022. No recommendations were made.

During FY 21-22 ICBHS did not receive any requests for a second opinion from Medi-Cal beneficiaries.

The QM Unit's objective for FY 21-22 to monitor and assess beneficiary/family satisfaction in the area of requests for a second opinion and report its findings, including identified trends, to the QIC at least annually was achieved.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor requests for a second opinion and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Request for Second Opinion Report and make recommendations to management, as appropriate.

3. No Show Rates

To maximize service delivery capacity and expand the service delivery to residents of Imperial County in the DMC-ODS system, the QM Unit monitors, tracks, and analyzes the no show rates for ASAM Assessment**,** Medication for Addiction Treatment (MAT) and the individual counseling appointments.

a. Overview of the DMC-ODS objectives, scope, and planned activities for FY 21-22:

The QM Unit monitors the no show rates of the county operated SUD treatment programs on a quarterly basis and reports finding to the QIC at least annually. The monitoring process entailed collecting data on all clients' appointments that were scheduled for an ASAM Assessment, MAT, and individual counseling appointments during FY 21-22.

The source document utilized to collect data was the "SUD No Show Report" from MyAvatar. Data collected was related to appointments by category that identified show, no show, cancelled, and rescheduled.
No show rates were determined by dividing the number of no show client appointments (numerator) by the total number of appointments scheduled (denominator). Appointments that were rescheduled or canceled are not included in the calculation.

During FY 21-22, the SUD programs implemented strategies to decrease the no show rates to their ASAM Assessment appointments, including, but not limited to, the following: conducting three retention calls to ensure clients attend their scheduled appointments. Additionally, the QM Unit conducted an in-depth analysis to evaluate what may be impacting low attendance rates. Areas reviewed included, but were not limited to, client, provider, team, and day and time of the week. Findings were included in the quarterly reports presented to the SUD programs' management team.

1) ASAM Assessment Appointments

The QM Unit monitors no show rates to ASAM assessment appointments and reports findings to the QIC at least annually. The QIC reviewed a report on March 10, 2022. Members concurred with the recommendations for the SUD treatment programs to ensure all retention calls efforts are conducted and entered in MyAVATAR based on their strategy to decrease no show rates.

On February 13, 2020, the QIC program established the following benchmarks for the no show rates to ASAM assessment appointments:

- Adolescent SUD Program- 40 percent
- Adult SUD Program – 55 percent

Report findings reflect that the DMC-ODS no show rate to ASAM assessment appointment was 33 percent during FY 21-22. No trends identified with provider, hours of operation, or days of the week. The results by program are summarized in Table 64.

Table 64. No Show to Initial Intake Appointment

Review Period	Adolescent		Adult		SUD Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	41	28%	305	34%	346	33%
FY 20-21	46	49%	385	41%	431	42%
FY 19-20	46	69%	792	63%	838	63%

2) Medication Assisted Treatment (MAT)

The QM Unit monitors no show rates to MAT appointments and reports findings to the QIC at least annually. The QIC reviewed a report on April 14, 2022. Members concurred with the recommendations for the Adult SUD Program to develop and implement strategies to decrease the no show rate to MAT services appointment and to establish a benchmark for Adolescents programs.

The QIC established the following benchmarks for the no show rates to MAT appointments:

- Adults Program- 30 percent on January 21, 2021
- Adolescent Program- 50 percent on April 14, 2022

Report findings reflect that the DMC-ODS no show rate to MAT appointments was 27 percent during FY 21-22. No trends identified with provider, hours of operation, or days of the week. The results by program are summarized in Table 65:

Table 65. No Show to Medication for Addiction Treatment Appointment

Review Period	Adolescent		Adult		SUD	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	6	33%	416	27%	422	27%
FY 20-21	6	50%	330	27%	336	28%
FY 19-20	7	47%	253	31%	260	32%

3) Individual Counseling Appointments

The QM Unit monitors no show rates to individual counseling appointments and reports findings to the QIC at least annually. The QIC reviewed a report on April 14, 2022. Members concurred with the recommendations to

ensure all appointment codes are entered correctly for monitoring purposes and to implement strategies to decrease the no show rates to the individual counseling appointments, including efforts to engage individuals who have repeated no shows and to establish a benchmark for individual counseling services for Adolescent and Adult programs.

On April 14, 2022, the QIC program established the following benchmarks for the no show rates to individual counseling appointments:

- Adolescent SUD Program- 41 percent
- Adult SUD Program – 50 percent

Report findings reflect that the no show rate to individual counseling appointments was 36 percent during FY 21-22. No trends identified with provider, hours of operation, or days of the week. The results by program are summarized in Table 66:

Table 66. No Show to Individual Counseling Appointment

Review Period	Adolescent		Adult		SUD	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 21-22	245	29%	1,597	38%	1,842	36%
FY 20-21	233	41%	1,729	50%	1,962	49%

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the no show rates to ASAM assessment appointments, individual counseling appointments, and MAT appointments and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will monitor attendance rates to group counseling appointments and report findings, including identified trends and recommendations, to the QIC at least annually.

4. Timeliness of Clinical Services

The QM Unit monitors the timeliness of clinical services through the timeliness of initial medication assisted treatment request to first medication assisted treatment appointment, timeliness from initial request to ASAM assessment, and timeliness from ASAM assessment to first clinical appointment.

a. Overview of the DMC-ODS objectives, scope, and planned activities for FY 21-22:

1) Timeliness of Initial Medication Assisted Treatment (MAT) Request to First Medication Assisted Treatment Appointment

The QM Unit monitors all clients who received MAT services. The source document utilized is the MAT Timeliness from AVATAR. Information is gathered from AVATAR for each applicable client's treatment history such as the date of initial MAT request and the first scheduled MAT appointment.

The QM Unit monitors the timeliness from the initial MAT request to the first MAT appointment and reports the findings to QIC at least annually. The QIC reviewed a report on April 14, 2022. No recommendations were made.

Table 67 summarizes the findings for measuring the length of time from initial MAT request to first MAT appointment.

Table 67. Timeliness of Initial Medication Assisted Treatment Request to First Appointment

Clinic	MAT Request (Assessment)	Applicable MAT Appointments	Continued with MAT Treatment	Average Time of First Appoint. (work-days)	Range
FY 21-22	229	150	71%	13 days	56 days
FY 20-21	163	84	52%	10 days	53 days
FY 19-20	44	34	77%	11 days	55 days

2) Timeliness from Initial Request to ASAM Assessment

The QM Unit monitors the timeliness from initial request to completion of the ASAM Assessment. The monitoring process entails collecting data from the SUD Client Current List to identify the number of days it takes to complete an ASAM Assessment from the date services were initially requested.

The QM Unit monitors the timeliness from the initial requests to ASAM assessment and reports the findings to QIC at least annually. The QIC reviewed a report on May 12, 2022. No recommendations were made.

During FY 21-22, there were a total of 428 requests for services with an average length of time from initial request to ASAM assessment of 13 days, as illustrated in Table 68.

Table 68. Timeliness from Initial Request to ASAM Assessment

Review Period	Total Number of Requests	Average Length of Time from Initial Request to ASAM Assessment
FY 21-22	428	13 days
FY 20-21	532	9 days
FY 19-20	503	8 days

3) Timeliness from ASAM Assessment to First Clinical Appointment

The QM Unit monitors the timeliness from ASAM assessment to first clinical appointment and reports findings to the QIC at least annually. The QIC reviewed a report on April 14, 2022, and no recommendations were made.

The monitoring process entailed reviewing the number of days between the ASAM assessment date and the date of the first scheduled service appointment were calculated to determine the length of time. The average length of time calculated in days was then determined for all applicable clients. The first clinical service in this measure are the claims for services provided under outpatient and intensive outpatient treatment program which include assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, case management, and/or recovery services.

During FY 21-22, there were a total of 541 clients who received their first clinical service with an average length of time from ASAM assessment to first clinical appointment of 6 days, as illustrated in Table 69:

Table 69. Timeliness from ASAM Assessment to First Clinical Appointment

Review Period	Received ASAM Assessment	Received 1st Clinical Assessment	Percentage-received 1st Clinical Service	Average Time 1st DMC Clinical Service (work-days)	Range
FY 21-22	604	541	90%	6 days	70 days
FY 20-21	592	436	74%	5 days	27 days
FY 19-20	619	529	85%	7 days	47 days

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the Timeliness of Initial MAT Request to First MAT Appointment, Timeliness from Initial Request to ASAM Assessment, and Timeliness from ASAM Assessment to First Clinical Appointment and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will review and evaluate the Timeliness of Initial MAT Request to First MAT Appointment, Timeliness from Initial Request to ASAM Assessment, and Timeliness from ASAM Assessment to First Clinical Appointment and will make recommendations to management, as appropriate.

5. Residential Treatment Services

The QM Unit monitors residential treatment admissions, length of time from need to admission, timeliness of follow-up encounters post-residential discharge, and withdrawal management admissions and readmissions for all Imperial County residents referred to residential treatment services.

a. Overview of the DMC-ODS objectives scope, and planned activities for FY 21-22:

1) Residential Treatment Admissions

The QM Unit monitors the County's residential treatment admissions by conducting an annual assessment of all residential treatment admissions. During FY 21-22, there were a total of 79 admissions into residential treatment. The findings by division are included below in Table 70:

Table 70. Residential Treatment Admissions

Program	Admissions	ASAM Level of Care			
		3.1	3.2	3.3	3.5
FY 21-22	79	28	27	2	22
FY 20-21	81	18	33	0	30
FY 19-20	55	21	26	0	8

Note: Data represents duplicated admissions.

There were three readmissions to residential treatment during FY 21-22.

2) Length of Time from Need to Admission

The QM Unit monitors the length of time from determining the need for residential treatment to admission to a residential facility on a monthly basis and reports findings to the QIC at least annually. The QIC reviewed a report on December 9, 2021, and June 9, 2022. The QIC agreed with the recommendation for the SUD program to ensure to document interim services provided to the individual as he/she is awaiting admission to the residential treatment program.

The monitoring process entails reviewing the SUD Program – Residential Treatment Services Log, which identifies the date of the ASAM assessment when the client met the residential level of care and the date of the client's admission date into residential treatment services.

During FY 21-22, there were a total of 66 ASAM assessments determining residential treatment level of care. Of those, 66 were admitted into a residential treatment program in an average of 81 days. A summary of the data for SUD program is included in Table 71.

Table 71. Length of Time from Determining of the Need to Residential Treatment Admission

Program	ASAM Assessments determining Residential Treatment	Total # of Residential Admissions	Average Time for Determination of Need to Residential Treatment Admission	Range (work-days)
Adolescents	2	2	18 days	17 days
Adults	64	64	28 days	81 days
Total	**66**	**66**	**28 days**	**81 days**

3) Follow-up Encounters Post-Residential Discharge

The QM Unit monitors the timeliness of follow-up encounters post-residential discharge and reports findings to the QIC at least annually.
The monitoring process entailed reviewing the data on a monthly basis for all clients who were discharged from residential treatment services to identify if the client received an appointment within the seven working day timeliness standard.

During FY 21-22, there were a total of 42 clients that were discharged. Of the 42 clients that returned to Imperial County after discharge, 36 (86 percent) received their follow-up encounter post-residential treatment within the seven-day working standard. The average wait time to receive an appointment was five days. A summary of the data for SUD program is included in Table 72:

Table 72. Timeliness of Services Post-Residential Discharge

Review Period	Discharged Clients	Met 7 Work-Day	Did Not Meet the Timeliness Standard	Compliance Rate	Average Time for Follow-Up Encounter Post-Residential Discharge
FY 21-22	42	29	7	86%	5 days
FY 20-21	49	37	12	76%	4 days
FY 19-20	41	33	8	80%	4 days

4) Withdrawal Management Admissions & Readmissions

The QM Unit monitors the County's withdrawal management readmissions by conducting an annual assessment of all readmissions that occurred within 30 days of discharge.

During FY 21-22, there were a total of 27 admissions into withdrawal management, for a total of one (1) unduplicated client admissions. Of those 27

admissions, one (1) readmission occurred within 30 days of discharge, resulting in a 4 percent readmission rate. The Annual Residential Withdrawal Management Admission and Readmission Report will be presented to QIC on December 7, 2022. The findings by division are included in Table 73.

Table 73. Withdrawal Management Admissions & Readmissions

Division	LOC 3.2 Total Admissions	Readmission Timeframe				
		1-7 Days	8-14 Days	15-21 Days	22-30 Days	30+ Days
FY 21-22	27	1	0	0	0	0
FY 20-21	35	1	0	0	0	1
FY 19-20	21	0	0	0	0	1

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the annual residential treatment admissions and readmissions, the length of time from determination of need to residential treatment admission, timeliness of follow-up encounters post-residential discharge, and withdrawal management admissions and readmissions and report findings, including identified trends and recommendations, to the QIC at least annually.

- ICBHS will ensure all clients in need of a follow-up after residential discharge are offered an appointment within seven days of discharge from residential treatment services.

6. Underutilization and Overutilization of Services

The QM Unit evaluates the utilization of SUD programs annually to determine the quality of services provided based on each beneficiary's needs. The report identified a comprehensive data for beneficiary claim data to identify potential instances of both low and high utilization and to identify QI actions necessary to ensure beneficiaries receive the optimum quality and level of services information.

The Utilization of services means the total actual units of services used by clients and participants further defined as the count of persons with initial admissions and subsequent admission (s) to an episode of care.

a. Overview of DMC-ODS objectives, scope, and planned activities for FY 21-22:

The QM Unit monitoring process consisted of determining the overall utilization of DMC-ODS services and what strategies may be implemented to ensure treatment services meet the needs of each beneficiary.

In FY 21-22, the QM Unit evaluated the SUD Treatment Utilization services for calendar 2021 to ensure beneficiaries received optimum services. A total of 838 unduplicated medical beneficiaries met medical necessity criteria and received services through SUD treatment programs, as shown in Table 74.

Table 74. Utilization Services

SUD Treatment program	Total Beneficiary Count	Utilization of Services	
		High-Cost Beneficiaries Count	Low-Cost Beneficiaries Count
Adolescent	144	15	129
Adult	694	73	621
TOTAL	**838**	**88**	**750**

The high cost beneficiaries are those who SUD treatment cost were at 90th percentile, which equal at least $12,779.51 in claims during the reporting period.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will evaluate the utilization of services annually to ensure beneficiaries receive the optimum quality and level of services and report findings, including identified trends and recommendations, to the QIC at least annually.

C) Performance Improvement Projects

a. Overview of DMC-ODS objectives scope, and planned activities for FY 21-22:

1) Clinical – Enhancing Engagement and Retention

During the FY 19-20 EQRO review, Imperial County was recommended to conduct a deeper analysis of CalOMS discharge data as the Imperial administrative discharge rate was identified to be much higher than the combined overall for all DMC-ODS counties. Upon further review, it was determined that 75 percent of the discharges belonged to clients that did not complete treatment and were discharged with unsatisfactory progress while 24 percent of the discharges belonged to clients that did not complete treatment and were discharged with satisfactory progress. The remaining one percent of the discharges belonged to clients that did not complete treatment due to incarceration or death.

This PIP initiated in September 2020 after the QM Unit identified that both the Adult and Adolescent SUD programs have a high percentage of CalOMS administrative discharges. This PIP move forward for a second year during FY 21-22 to decrease the rate of administrative discharges with unsatisfactory progress from 70 percent to 65 percent. The issue has been that clients are not engaging in treatment and they stop attending their scheduled appointment, requiring the SUD treatment programs to submit CalOMS administrative discharges.

During the first year of the PIP (2020-2021), the SUD program attempted to achieve this goal by implementing Motivational Interviewing (MI) techniques in the treatment of all adult and adolescents clients. Although MI techniques increase client engagement during sessions, it did not provide significant progress in improving client retention amongst the adult and adolescent population. By the end of June 2021, an improvement of 70 percent was accomplished.

During the second year of the PIP (2021-2022), due to the minimal progress utilizing MI intervention, the PIP committee agreed to implement Contingency Management (CM) along with MI for both adults and adolescent clients. The SUD Treatment team staff was trained in the implementation of CM as an as an evidence-based intervention to target negative behaviors, emphasize the importance of treatment attendance and negative drug screens by providing an immediate reward/incentive by reinforcing positive behaviors.

The study question for this PIP is as follows: *Will the implementation of the Contingency Management Program reflect a decrease of administrative discharges with unsatisfactory progress from 70% to 65%.*

The interventions implemented to date are Included in Table 75:

Table 75. Enhancing Engagement and Retention PIP – Clinical Intervention

Intervention		Intervention Target Population	Date Intervention Began	Frequency of Intervention Application	Corresponding Process Indicator(s)
1	Motivational Interviewing	Adult and Adolescents receiving services	10/01/2020	On-going	#1
2	Contingency Management	Adult and Adolescents receiving services	7/1/2022	On-going	#2

The PIP concluded as of June 2022. The intervention implemented during FY 21-22 resulted in the percentage of administrative resulting in follow-up care upon discharge remaining at 73 percent. Despite not reaching the overarching goals of this PIP the second year, the SUD was still able to increase from 79 percent the first year to 73 percent the second year, an improvement of eight percent overall.

The PIP task force met regularly since the inception of the PIP to monitor the progress of the intervention and documented ICBHS' work in a Clinical PIP development and implementation tool.

2) *Non-Clinical – Improving the Timeliness of Routine Appointments*

The PIP committee reviewed the FY 2019-2020 Narcotic Treatment Program (NTP) American Society of Addiction Medicine (ASAM) data log and identified that a significant number of clients were accessed with an additional level of care within the ASAM beyond NTP. As chart reviews were conducted, it was identified that a significant number of charts had an indication the clients were not being referred to the proper Continuum of Care within ASAM.

This PIP initiated in September 2021, one of the potential causes of the problem identified is not having an established protocol that outlines the standardized referral process for the NTP program to follow when assessing clients to the proper Continuum of Care. Additionally, the lack of understanding by NTP programs and clients on what other services are available through DMC-ODS. SUD management developed a referral process that outlines the steps that should be followed by NTP once the client's level of care is identified (ranging from high to low intensity). The population affected by the problem are those clients accessing services at the NTP settings, which received an ASAM assessment reflecting that the individual meets a higher level of care aside from NTP. With the implementation of the process, current gaps in referral processes will be filled, and clients will be referred to the appropriate Continuum of Care. The SUD management developed a referral protocol; which was utilized to train NTP staff. The referral protocol outlines the steps that NTP shall follow when a client meets a different level of care within ASAM aside from NTP. Additionally, NTP staff will received educational material on the different levels of treatment that are available through DMC-ODS.

The study question for this PIP is as follows: *Will the use of a standardized SUD referral protocol for clients presenting a different level of care from NTP improve the outcome to successfully refer clients to their proper Continuum of Care within the ASAM in a timely manner?*

The interventions implemented to date are Included in Table 76.

Table 76. Improving the Timeliness of Routine Appointments PIP-Non Clinical Intervention

Intervention	Intervention Target Population	Date Intervention Began	Frequency of Intervention Application	Corresponding Process Indicator
Protocol Training	those clients accessing services at the NTP settings, which received an ASAM assessment reflecting that the individual meets a higher level of care aside from NTP	11/10/2020	One time training via zoom	#1
Educational Material (Residential Services)	NTP Staff	January 2022	Educational Material (via email)	#2

Despite the fact that this PIP was implemented during the COVID-19 global pandemic, no there was no significant improvement observed. This could had been a factor to consider, as clients were not interested in receiving a higher level of care aside from NTP after an ASAM assessment was completed due to COVID-19 expose and safety precautions. For this reason, the PIP concluded on June 2022.

The PIP task force met regularly since the inception of the PIP to monitor the progress of the interventions and documented ICBHS' work in a Non-Clinical PIP development and implementation tool.

As the SUD programs prepare for the changes in the California Advancing and Innovating Medi-Cal (CalAIM) initiative during fiscal year 22-23. The counties are expected to deliver three milestones, of which one will deliver PIPs. Among the three topics for submission, two are related to substance abuse programs: 1) Follow-up after emergency department visits for alcohol and drug abuse and dependence (FUA) and 2) Pharmacotherapy for opioid use disorder (POD). The SUD programs will focus on the deliverable and processes as well as its capabilities for collecting, exchanging, and analyzing data while implementing the topics to meet this requirement.

PIP task force members also discussed other topics for the upcoming fiscal year, including a PIP to decrease "No Show" rates for ASAM assessments.

a. Overview of the DMC-ODS objectives, scope, and planned activities for FY 22-23:

- The SUD PIP Task Force will continue to meet regularly to monitor the progress of Clinical and Non-Clinical PIPs goals and objectives.

- ICBHS will participate in the CalAIM Behavioral Health Quality Improvement Program (BHQIP) to support the implementation of the CalAIM initiative. With the support of the Information Systems Unit the QM Unit will participate and monitor the following milestone:
  - Milestone 3d: Leverage improved data exchange capabilities to improve quality and coordination of care related to the following measures: (1) Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) and (2) Pharmacotherapy for Opioid Use Disorder (POD).

- The QM Unit will document the SUD work for both the Non-Clinical and Clinical PIPs in Road Maps.

CULTURAL AND LINGUSITIC COMPETENCE

In an effort to provide services with sensitivity to the linguistic and cultural background of ICBHS beneficiaries in FY 21-22, ICBHS utilized the Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as the framework for its Cultural Competence Plan. The Cultural Competence Plan outlines the department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, and gender identity. As part of the Cultural Competence Plan, ICBHS will select specific trainings to increase the knowledge and proficiency of staff and evaluate the cultural and linguistic competence of services and staff through continuous QI activities, a staff cultural competence survey, and the department's penetration, retention, and service retention rates.

a. Overview of the ICBHS objectives, scope, and planned activities for FY 21-22:

1) Continuous Quality Improvement Plan

The QM Unit monitored the existing state mandated cultural and linguistic competence requirement under the QI Program. The process for monitoring entailed: 1) ensuring proficiency of staff and interpreters; 2) reviewing and assisting with updating ICBHS Cultural Competence Plan; and 3) monitoring the process for incorporating relevant cultural competence standards, such as access, quality of care, and quality management, into the QI Work Plan for FY 21-22. These QM monitoring activities support and foster a philosophy that attaining cultural and linguistic competence is an ongoing developmental process, which was designed around the framework of the CLAS Standard, as indicated in the Cultural Competence Plan.

a) Proficiency of Staff

<u>Cultural Competence Training Plan</u>
In an effort to plan ICBHS cultural competence training activities, the QM Unit and the Staff Development Unit produced an annual Cultural Competence Training Plan, which includes all training activities planned for the fiscal year for mental health and SUD program staff. The training plan includes a description of each training, data regarding the projected number of attendees, and dates of the trainings being offered. The plan is used by management to deliver effective training as well as meet the requirements of the Cultural Competence Plan.

<u>Cultural Competence Training Report</u>
In an effort to utilize data to gauge cultural competence training plan activities, the QM Unit and the Staff Development Unit produced an annual Cultural Competence Training Report summarizing training activities for the fiscal year for mental health and SUD program staff. The report includes data regarding the attendees and a synopsis of the pre- and post-tests. The report is used by management to assess the department's attempt to deliver effective training as well as monitor the

progress towards meeting requirements of the Cultural Competence Plan.

During FY 21-22, the QM Unit monitored ICBHS compliance with the requirement of attending at least one cultural competence training per year. Out of 534 ICBHS employees, 100 percent completed a cultural competence training as required, although it should be noted that 8 percent of the staff were unable to complete their training due to being out on medical leave. The QM Unit will monitor those staff upon report to ensure all employees receive the necessary cultural competence training.

Client Culture Training

In an effort to provide staff with an understanding that consumers of mental health services have a set of values, beliefs, and lifestyles that are developed as a result of their own personal experiences with mental illness, the mental health system, and their own ethnic culture, ICBHS provided the Client Culture Training for New Employees and the Client Culture Refresher Course accordingly to 212 mental health and SUD program staff during FY 21-22. The trainings covered areas such as definitions of client culture, three levels of staff cultural competence, stigma and anti-stigma facts, discrimination and social distance, early steps in the recovery movement, recovery definitions and SAMHSA is guiding principles of recovery, among other topics.

Language Assistance Services Training

During FY 21-22, the Access Unit supervisor provided two trainings to approximately 13 staff from the Access Unit and after-hours staff. The Access Unit supervisor provided training to SUD program and mental health staff on the use of language assistance services, policies, and procedures in order to improve staff knowledge of how to utilize language assistance services.

b) Proficiency of Interpreters

Interpreter Training for Staff and Interpreters

In an effort to ensure that staff have the proper skills and knowledge to provide accurate interpretation from one language to another, the ICBHS contracted with the National Latino Behavioral Health Association (NLBHA) to provide the Behavioral Health Interpreter Training. During FY 21-22, one interpreter trainings took place via Zoom on April 18-26, 2022, for 24 staff.

The interpreter training focused on many areas, including the complexity of language and how there are different communication styles within each cultural group. The training covered the verbal and non-verbal communication styles used by some cultural groups and how important it is to understand each communication styles in order to convey the right message, as well as how many cultures reflect either a high context (telling the whole story, indirect) or low context (straight

forward, direct) style of communication. Understanding the high and low context styles is crucial to the interpreter as it presents challenges for an interpreter who works with both.

In addition, the training covered the important roles of an interpreter: as a clarifier, the interpreter helps simplify technical terms; as a cultural broker, the interpreter provides cultural information to improve communication; as an advocate, the interpreter works on behalf of the client when their needs are not being met; and as a conduit, the interpreter provides verbatim or word for word interpreting and, as much as possible, not changing the message.

New Employee Orientation (Cultural Competence Training Course)
The CCT developed an eLearning cultural competence training course for new hires during FY 18-19. This training course allows for new hire staff to understand what cultural competence is and how ICBHS implements the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards in the department and our community. During FY 20-21, 178 staff received the new employee orientation eLearning course.

County Formal Testing Process
In an effort to ensure bilingual staff are proficient in the Spanish language, the County of Imperial has a formal testing process in place. The County's Department of Human Resources and Risk Management provides a written literacy test, which must be passed in order to be deemed bilingual and receive bilingual differential pay. A total of 66 ICBHS employees who utilize a language other than English when performing work duties through the mental health, substance use disorders, and administrative programs have passed the written literacy test.

c) Cultural Competence Taskforce

ICBHS has a Cultural Competence Taskforce (CCTF) committed to promoting the delivery of services and provision of information to residents of Imperial County in a manner that is responsive to and respectful of the individual attitudes, beliefs, customs, and practices of the various cultural and ethnic groups we serve.

In FY 21-22, the CCTF continued its work toward achieving its CY 2022 goals, which are based on the Culturally and Linguistically Appropriate Services (CLAS) Standards of Care. The CLAS Standards are intended to advance health equity, improve quality of care, and eliminate health disparities by establishing a blueprint for health and healthcare organizations. A complete report of activities is included in the 2022 Annual Cultural Competence Plan. Some of the CCTF achievements include:

- As part of CLAS standard Goal 5, offer language assistance to individuals who have limited English proficiency and/or communication needs, at no cost to them, to facilitate timely

access to all health care services. During FY 21-22, the CCTF reviewed the AT&T Language Line report findings on September 9, 2021. The report indicated that a total of 278 minutes were utilized for a total of $1,206.75 for interpretive services under the mental health services; while there were no calls identified for the SUD treatment services.

In addition, as part of Goal 5, the QM Unit's monitoring process entailed conducting random test calls, during business and after hours, in both English and Spanish, the County's threshold language. During the 21-22 the QM Unit followed the DHCS Protocol when conducting random test calls. The Access Logs were also reviewed to verify the test calls were logged, as required.

Test callers assessed Access Unit Staff's knowledge in the following areas: 1) language capability, 2) material alternative format, 3) request for TTY/TDY services 4) request for Interpreters Services, 5) Provider Directory and/or Beneficiaries Handbook was available upon request. The test calls are made at random times of the day and days of the week, verified that the 24-hour-toll-free telephone line was in operation 24 hours a day, seven-days a week.

During FY 21-22, CCTF reviewed the 24 hour-toll-free telephone line report on July 7, 2021 for mental health services and SUD services. The QM Unit for mental health services conducted a total of 12 test calls, 6 during business hours and 6 after-hours. The Access Unit was 100 percent compliant when providing services, including language capabilities. The QM Unit for SUD Services conducted a total of 12 test calls, 6 during business hours and 6 after-hours. The Access Unit was 100 percent compliant when providing services, including language capabilities. No recommendations were made.

- As part of CLAS Standard Goal 8, provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. During FY 21-22, the translation subcommittee reviewed two documents to ensure the accuracy of translation and cultural appropriateness. In addition, focus groups were conducted with ICBHS consumers to ensure documents were easy to understand and in the language commonly used by the populations serve. Feedback from the focus groups was incorporated, as appropriate. The following documents were reviewed and approved;
    - **Adult/Adolescent Screening: Tool** – The CCTF reviewed the brochure on May 12, 2021, and recommendations were provided to the appropriate program.

- **Illness Management and Recovery Modules 1-6 and 10-11**- The CCTF reviewed the modules, and recommendations were provided to the appropriate program.

During FY 21-22, the QM Unit actively participated in the Cultural Competence Task Force to ensure that QI activities are monitored as reflected on the Cultural Competence Plan Update, meeting the objective for this fiscal year.

d) Cultural Competence Plan Update

In an effort to ensure that quality assurance activities were incorporated into the Cultural Competence Plan (CCP), the QM Unit participated in the revision of the CCP Plan. During FY 21-22, the QM Unit prepared a CCP Update, which included the activities conducted by ICBHS CCTF. The CCP will be updated during FY 22-23 as required.

e) *Other Activities*

Informing Clients of Their Right to Language Assistance Services

In order to inform clients of the availability of language assistance services, the ICBHS displays posters that provide information on the interpreter services available through Language Line Solutions at all mental health and SUD clinics. Additionally, upon admission for treatment, all clients enrolling in a mental health or SUD clinic are informed by staff of the availability of interpreter services. Services are also offered by bilingual staff, as 85 percent of the workforce is bilingual and 92 percent is proficient in the Spanish language.

During FY 21-22, the Access and Benefits Workers continued to identify clients' primary language when scheduling appointments and logging if interpreter services were needed in languages other than the established threshold language, Spanish. To monitor if services are being offered to clients, the Access Unit supervisor reviews the Access Log to ensure that language assistance services are being offered to clients requesting them. The QM Unit conducts random test calls to assess if the Access Unit staff offers interpreter services.

Interpreter Services Contracts

In order to facilitate timely access to services, ICBHS contracts for interpreter services for in-person and over the phone interpreter services. ICBHS contracts with Deaf Communities of San Diego and Hanna Interpreting Services, independent contractors, for sign language translation and interpretation. In addition, the ICBHS allocates funds for the Language Line Solutions annually to provide interpreters services in languages not spoken by ICBHS staff.

Quality Improvement Committee

The CCTF chairperson participates in the QIC and attends on a monthly basis. The CCTF chairperson reports on activities, any issues/concerns, and progress towards meeting objectives under CLAS

Standards on behalf of the CCTF and makes recommendations, as appropriate.

Mental Health Service Act Steering Committee
The CCTF chairperson and other members of the CCTF are members of the Mental Health Services Act (MHSA) Steering Committee. The members actively participate in the planning of MHSA services, ensuring the inclusion of cultural competency, and provide input and make recommendations, as appropriate.

Quality of Care Processes
During FY 21-22, the QM Unit identified the following processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services:

i. Practice Guidelines
Practice guidelines reflect the current interpretations of best practices and special efforts given in respect to the unique values, culture, spiritual beliefs, lifestyles, and personal experiences in the provision of mental health services to individual consumers. All providers of ICBHS must abide by these practice guidelines, as appropriate, to ensure the best quality of services and determine outcomes of consumers from diverse cultures.

ii. Quality Improvement Review Committees
ICBHS has established three quality improvement review committees that have developed processes to review the following elements: 1) quality of care; 2) documentation requirements; 3) services provided in the beneficiary's primary language; 4) practice guidelines adherence; 5) outcomes; and 6) identify opportunity for improvement and training needs, as appropriate.

iii. Quality of Care Reviews
The focus of these reviews is the service delivery system, identifying meaningful clinical issues that affect beneficiaries, and outcomes of services to consumers from diverse cultures. If occurrences of potential poor quality of care issues are identified, the staff may recommend second level reviews.

iv. Medication Monitoring Reviews
The focus of these reviews is the service delivery system, meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices, and outcome of services to consumers of diverse cultures.

v. Grievances
Medi-Cal and non-Medi-Cal client grievances data is analyzed and comparison rates between the general population and ethnic

beneficiaries are analyzed to determine outcomes of services for consumers from diverse cultures.

vi. Documentation Standards Chart Reviews
The focus of these reviews is to ensure compliance with documentation requirement and identify meaningful clinical issues affecting beneficiaries, including cultural and linguistic appropriate delivery of service. Three specific issues are reviewed: 1) whether a language other than English was used; 2) evidence that interpreter service was offered, when applicable; and 3) the presence of documentation of linking beneficiaries to culture-specific services as described in the ICBHS Cultural Competence Plan.

2) Capacity of Service

A profile of the County of Imperial reflects that Hispanics account for 85 percent of the population and 76.5 percent speak a language other than English at home. The most recent DHCS data indicates Spanish is Imperial County's primary threshold language.

ICBHS ensures that specialty mental health services and SUD services are rendered by staff that are culturally competent and linguistically proficient to meet the needs of the population(s) served. This is measured by an analysis of human resources composition by location data in contrast with a population needs assessment data for each population category. The results of this analysis are presented by geographic region.

a) Direct Service Providers by Geographic Location

ICBHS provides services in the southern, central, northern, and eastern regions of the county. ICBHS direct service provider geographic distribution within regions, ethnicity, language capabilities, and cultural awareness is as follows:

i. Mental Health Services – Children Services
Southern Services
The average number of full-time equivalent staff allocated to provide children services in the southern region are:

- 0.85 percent full-time equivalent psychiatrists
- 1.60 percent full-time equivalent clinicians
- 1.45 percent full-time equivalent nurses
- 5.90 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 100 percent Hispanic with 83 percent fluent in Spanish. In addition, 42 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Central Services
The average number of full-time equivalent staff allocated to provide children services in the central region are:

- 1.65 percent full-time equivalent psychiatrists
- 6.37 percent full-time equivalent clinicians
- 2.73 percent full-time equivalent nurses
- 16.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 93 percent Hispanic with 80 percent fluent in Spanish. In addition, 50 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Northern Services
The average number of full-time equivalent staff allocated to provide children services in the northern region are:

- 0.80 percent full-time equivalent psychiatrists
- 3.32 percent full-time equivalent clinicians
- 1.54 percent full-time equivalent nurse
- 5.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 46 percent Hispanic with 46 percent fluent in Spanish. In addition, 15 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Eastern Services
The average number of full-time equivalent staff allocated to provide children services in the eastern region are:

- 0.05 percent full-time equivalent psychiatrists
- 0.22 percent full-time equivalent clinicians
- 0.06 percent full-time equivalent nurse
- 0.60 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 100 percent Hispanic with 100 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ii. Mental Health Services – Youth and Young Adult Services

Southern Services
The average number of full-time equivalent staff allocated to provide services to the youth and young adult population in the southern region are:

- 0.40 percent full-time equivalent psychiatrists
- 2.00 percent full-time equivalent clinicians
- 1.00 percent full-time equivalent nurse

- 4.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 92 percent Hispanic with 92 percent fluent in Spanish. In addition, 58 percent of staff report feeling knowledgeable about the Hispanic/Latino culture.

Central Services

The average number of full-time equivalent staff allocated to provide services to the youth and young adult population in the central region are:

- 1.26 percent full-time equivalent psychiatrists
- 2.00 percent full-time equivalent clinicians
- 1.00 percent full-time equivalent nurse
- 14.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 79 percent Hispanic with 62 percent fluent in Spanish. In addition, 50 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Northern Services

The average number of full-time equivalent staff allocated to provide services to the youth and young adult population in the northern region are:

- 0.48 percent full-time equivalent psychiatrists
- 2.00 percent full-time equivalent clinicians
- 1.00 percent full-time equivalent nurse
- 5.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 78 percent Hispanic with 44 percent fluent in Spanish. In addition, 61 percent of the staff reported feeling knowledgeable about the Hispanic/Latino culture.

iii. Mental Health Services – Adult Services

Southern Services

The average number of full-time equivalent staff allocated to provide adult services in the southern regions are:

- 1.30 percent full-time equivalent psychiatrists
- 2.00 percent full-time equivalent clinicians
- 1.90 percent full-time equivalent nurse
- 2.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 83 percent Hispanic with 58 percent fluent in Spanish. In addition, 67 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Central Services
The average number of full-time equivalent staff allocated to provide adult services in the central region are:

- 3.34 percent full-time equivalent psychiatrists
- 4.00 percent full-time equivalent clinicians
- 4.25 percent full-time equivalent nurse
- 11.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 80 percent Hispanic, with 69 percent fluent in Spanish. In addition, 51 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Northern Services
The average number of full-time equivalent staff allocated to provide adult services in the northern region are:

- 1.64 percent full-time equivalent psychiatrists
- 2.00 percent full-time equivalent clinicians
- 2.00 percent full-time equivalent nurse
- 4.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 86 percent Hispanic with 77 percent fluent in Spanish. In addition, 64 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Eastern Services
The average number of full-time equivalent staff allocated to provide adult services in the eastern region are:

- 0.11 percent full-time equivalent psychiatrists
- 0.10 percent full-time equivalent clinicians
- 0.10 percent full-time equivalent nurse
- 1.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 100 percent Hispanic with 100 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

iv. Mental Health Triage & Engagement Services
Central Services
The average number of full-time equivalent staff allocated to provide mental health triage and engagement services are:

- 1.10 percent full-time equivalent psychiatrists
- 4.15 percent full-time equivalent clinicians
- 3.00 percent full-time equivalent nurse
- 13.00 percent full-time equivalent mental health rehabilitation specialist/technicians

Staff is 95 percent Hispanic with 88 percent fluent in Spanish. In addition, 48 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

v. SUD Treatment Services – Adult Services

Southern Services

The average number of full-time equivalent staff allocated to provide adult services in the southern region are:

- 3.00 percent full-time equivalent SUD counselor
- 1.26 percent full-time Licensed Practitioner of the Healing Arts (LPHA)

Staff is 100 percent Hispanic with 100 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture

Central Services

The average number of full-time equivalent staff allocated to provide adult services in the central region are:

- 6.00 percent full-time equivalent SUD counselor
- 8.20 percent full-time Licensed Practitioner of the Healing Arts (LPHA)

Staff is 100 percent Hispanic with 100 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

vi. SUD Treatment Services – Adolescent Services

Southern Services

The average number of full-time equivalent staff allocated to provide adolescent services in the southern region are:

- 3.00 percent full-time equivalent SUD counselor
- 2.00 percent full-time Licensed Practitioner of the Healing Arts (LPHA)

Staff is 64 percent Hispanic with 45 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Central Services

The average number of full-time equivalent staff allocated to provide adolescent services in the central region are:

- 1.00 percent full-time equivalent SUD counselor
- 2.00 percent full-time Licensed Practitioner of the Healing Arts (LPHA)

Staff is 64 percent Hispanic with 45 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ICBHS direct service staff is 85 percent Hispanic with 94 percent fluent in Spanish. In addition, 89 percent of staff reported feeling culturally aware of the Hispanic/Latino culture. This is indicative of the cultural and linguistic composition of the county.

b) Number of Clients by Team and Region

In FY 21-22, the MHP provided services to 7,271 beneficiaries, unduplicated by division. Of these, 85 percent were Hispanic and 33 percent were Spanish speaking. The distribution by division is included in Table 77.

Table 77. Distribution of Beneficiaries by Division

Division	Number of Beneficiaries FY 21-22	Ethnicity		Language	
Children Services	2,265	90%	Hispanic	44%	Spanish
Youth and Young Adult Services	1,674	89%	Hispanic	28%	Spanish
Adult Services	2,503	81%	Hispanic	29%	Spanish
Mental Health Triage & Engagement	829	77%	Hispanic	21%	Spanish

In FY 21-22, the DMC-ODS Plan provided services to 847 beneficiaries, unduplicated by team. Of these, 80 percent were Hispanic and 17 percent were Spanish speaking. The distribution by division is included in Table 78.

Table 78. DMC-ODS Distribution of Beneficiaries by Division

Division	Number of Beneficiaries FY 21-22	Ethnicity		Language	
Adults SUD	672	77%	Hispanic	15%	Spanish
Adolescents SUD	175	89%	Hispanic	26%	Spanish

Tables 79-83 illustrate the ICBHS distribution of beneficiaries by team, as well as by region, ethnicity, and language.

Table 79. Children Services Beneficiaries Unduplicated by Team

Team	Service Region	Number of Beneficiaries FY 21-22	Ethnicity		Language	
Calexico FRC	Southern	523	97%	Hispanic	31%	Spanish
Calexico Vista Sands	Southern	31	94%	Hispanic	61%	Spanish
Team 5	Central	502	86%	Hispanic	40%	Spanish
Team 12	Central	592	89%	Hispanic	41%	Spanish
Team 6	Northern	628	88%	Hispanic	30%	Spanish
El Centro Vista Sands	Central	54	85%	Hispanic	35%	Spanish
Brawley Vista Sands	Northern	32	94%	Hispanic	34%	Spanish
San Pasqual FRC	Eastern	16	50%	Hispanic	31%	Spanish
PEI/TF-CBT	All Regions	69	91%	Hispanic	54%	Spanish
Innovation/First Steps to Success	All Regions	7	86%	Hispanic	14%	Spanish
MHSA/First Step to Success	All Regions	22	86%	Hispanic	50%	Spanish
Total		**2,476**	**90%**	**Hispanic**	**36%**	**Spanish**

During FY 21-22, 88 percent of Children Services' direct services staff were Hispanic with 78 percent fluent in Spanish. In addition, 42 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Table 80. Youth and Young Adult Beneficiaries Unduplicated by Team

Team	Service Region	Number of Beneficiaries FY 21-22*	Ethnicity		Language	
YAYA Calexico Anxiety and Depression	Southern	306	96%	Hispanic	58%	Spanish
YAYA Calexico FSP	Southern	98	94%	Hispanic	47%	Spanish
YAYA El Centro Anxiety and Depression (Team 1)	Central	523	91%	Hispanic	22%	Spanish
YAYA El Centro Anxiety and Depression (Team 2)	Central	225	91%	Hispanic	20%	Spanish
YAYA El Centro FSP	Central	196	84%	Hispanic	16%	Spanish
YAYA El Centro FRC	Central	43	81%	Hispanic	33%	Spanish
YAYA Brawley Anxiety and Depression	Northern	352	88%	Hispanic	22%	Spanish
YAYA Brawley FSP	Northern	126	83%	Hispanic	15%	Spanish
YAYA Brawley FRC	Northern	16	94%	Hispanic	25%	Spanish
HOPE	Northern	19	84%	Hispanic	16%	Spanish
AHLP	Central	15	80%	Hispanic	27%	Spanish
Total		**1,919**	**90%**	**Hispanic**	**28%**	**Spanish**

During FY 21-22, 81 percent of YAYA Services' direct services staff were Hispanic with 63 percent fluent in Spanish. In addition, 54 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Table 81. Adult Beneficiaries Unduplicated by Team

Team	Service Region	Number of Beneficiaries FY 21-22*	Ethnicity		Language	
Adult Calexico Anxiety & Depression Clinic	Southern	254	98%	Hispanic	61%	Spanish
Adult Calexico FSP	Southern	213	94%	Hispanic	47%	Spanish
Adult El Centro Anxiety and Depression Clinic - Team 1	Central	309	86%	Hispanic	37%	Spanish
Adult El Centro Anxiety and Depression Clinic - Team 2	Central	315	84%	Hispanic	39%	Spanish
Adult El Centro FSP-Team 1	Central	407	71%	Hispanic	15%	Spanish
Adult El Centro FSP-Team 2	Central	364	79%	Hispanic	18%	Spanish
Adult Brawley Anxiety & Depression Clinic	Northern	374	82%	Hispanic	25%	Spanish
Adult Brawley FSP	Northern	356	69%	Hispanic	10%	Spanish
San Pasqual FRC	Eastern	26	62%	Hispanic	23%	Spanish
Total		**2,618**	**81%**	**Hispanic**	**29%**	**Spanish**

During FY 21-22, 83 percent of Adult Services' direct services staff were Hispanic with 71 percent fluent in Spanish. In addition, 57 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Table 82. Beneficiaries Served at Mental Health Triage Unit Services Unduplicated by Team

Team	Service Region	Population	Number of Beneficiaries FY 21-22*	Ethnicity		Language	
Casa Serena	Service Region	All	75	77%	Hispanic	19%	Spanish
CCMU	Service Region	All	116	81%	Hispanic	22%	Spanish
CESS	Service Region	All	320	76%	Hispanic	19%	Spanish
Mental Health Triage	Service Region	All	495	80%	Hispanic	22%	Spanish
TESS	Service Region	Age 14+	162	75%	Hispanic	12%	Spanish
Total			**1,168**	**78%**	**Hispanic**	**20%**	**Spanish**

During 21-22, the direct service staff for Mental Health Triage & Engagement Services were 95 percent with 88 percent fluent in Spanish. In addition, 48 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Table 83. Adult SUD Beneficiaries Unduplicated by Team

Team	Service Region	Number of Beneficiaries FY 21-22*	Ethnicity		Language	
Adult Calexico	Southern	120	93%	Hispanic	45%	Spanish
Adult El Centro	Central	**552**	74%	Hispanic	8%	Spanish
Adolescent Calexico	Southern	**38**	95%	Hispanic	53%	Spanish
Adolescent El Centro	Central	**137**	87%	Hispanic	19%	Spanish
Total		**847**	**80%**	**Hispanic**	**17%**	**Spanish**

During FY 21-22, the direct service staff for the SUD programs were 89 percent with 83 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ICBHS ensures that beneficiaries have access to specialty mental health services and SUD treatment services that are culturally and linguistically competent by providing information and services in the beneficiary's preferred language. ICBHS also ensures that language assistance and interpretive services are available to all beneficiaries upon request. Interpretive services for Spanish speaking beneficiaries

are provided by bilingual staff (English and Spanish) and Language Line Services in all programs and clinics. Interpretive services in other languages are also available through Language Line Services. ICBHS also has American Sign Language Interpretive Services available for beneficiaries with speech and/or hearing impairments.

Based on the analysis by division, ICBHS direct service staff is culturally proficient in meeting the needs of clients, as shown in Tables 84 and 85.

Table 85. Comparison of MHP Client and Staff Cultural Profiles FY 21-22

Division	Ethnicity		Language		Cultural Awareness
	Client	Staff	Client	Staff (Fluent)	
Children Services	90% Hispanic	88% Hispanic	36% Spanish	78% Spanish	42% Hispanic
YAYA Services	90% Hispanic	81% Hispanic	28% Spanish	63% Spanish	54% Hispanic
Adult Services	81% Hispanic	83% Hispanic	29% Spanish	71% Spanish	57% Hispanic
MHTE Services	78% Hispanic	95% Hispanic	20% Spanish	88% Spanish	48% Hispanic
MHP	**85% Hispanic**	**97% Hispanic**	**33% Spanish**	**84% Spanish**	**57% Hispanic**

Table 85. Comparison of DMC-ODS Client and Staff Cultural Profiles FY 21-22

Division	Ethnicity		Language		Cultural Awareness
	Client	Staff	Client	Staff (Fluent)	
Adults SUD	77% Hispanic	100% Hispanic	15% Spanish	100% Spanish	100% Hispanic
Adolescent SUD	89% Hispanic	64% Hispanic	26% Spanish	45% Spanish	100% Spanish
SUD Total	**80% Hispanic**	**80% Hispanic**	**17% Spanish**	**83% Spanish**	**100% Hispanic**

ICBHS has the capacity to provide specialty mental health and SUD treatment services by staff that is culturally competent and linguistically proficient to meet the needs of the population(s) served.

3) Staff Cultural Competence and Linguistic Capabilities

In FY 21-22 the QM Unit assessed the cultural competence and linguistic capabilities of staff and the annual report is scheduled to be presented to QIC on October 12, 2022.

The QM Unit reviewed the survey tool before conducting the survey to ensure that state requirements and additional information for ICBHS was incorporated. The survey elements included: 1) staff identifying information; 2) ethnicity; 3) language capabilities; 4) interpretation; 5) cultural awareness; and 6) cultural training needs. In an effort to ensure that staff complete and return

the survey, ICBHS director has made this a mandatory survey. The survey was conducted during April 2022 for all ICBHS staff and contract providers.

A total of 582 surveys were completed by staff, which represents a 90 percent response rate.

The total number of surveys includes:

- 62 in administrative services
- 133 in direct services-licensed (includes licensed/registered interns)
- 127 in direct services-unlicensed, and;
- 200 in support services.

The total number of staff by division includes:

- 111 in Administration
- 100 in Adult Services
- 67 in Children Services
- 84 in Mental Health Triage & Engagement Services
- 50 in Substance User Disorder
- 72 in Youth and Young Adults Services
- 42 in contract providers

The number of staff is larger by division than by function as there were four staff members who are allocated in two divisions.

A Staff Cultural Competence Survey Report was prepared and included findings for ethnicity, linguistic capabilities, interpretation, cultural awareness, cultural training needs, and self-identified consumer/family member. The report was presented in two sections: results by function and results by division and function.

The overall results are as follows:

i. Staff Race
   - 78 percent – Hispanic/Latino
   - 15 percent – White
   - 7 percent – all other races

ii. Staff Ethnicity
   - 80 percent – Mexican/Mexican American
   - 7 percent – Not Hispanic
   - 13 percent – all other ethnicities

iii. Language Capabilities
   - 68 percent – Fluent in Spanish

iv. Interpretation
   - 27 percent of staff reported they have provided interpretation services for clients in the last year.

v. Cultural Awareness
- Staff reported feeling quite a bit knowledgeable to very knowledgeable of the population cultural staff work with; Hispanic (79%), Family Members of Mental Health Clients (72%), and Mental Health Clients (61%).

vi. Cultural Training Needs (top responses)
- 20 percent – Alaskan Native/American Indian
- 17 percent – LGBT
- 14 percent – Black/African American

4) *Penetration, Retention, and Service Retention Rates*

The QM Unit calculates and evaluates penetration and retention rates and service retention information annually to ensure that persons of diverse ethnic backgrounds access and are retained in the service delivery system and that numbers are consistent with their representation in the Medi-Cal eligible population. During FY 21-22, penetration, retention, and service retention rates were analyzed for mental health services and SUD treatment services.

The penetration rate is defined as the total unduplicated number of Medi-Cal beneficiaries served divided by the number of persons eligible for Medi-Cal. The penetration rates are calculated by obtaining the unduplicated number of Medi-Cal eligible beneficiaries from the DHCS website and the number of Medi-Cal beneficiaries served from AVATAR.

a) *Penetration Rates*

Mental Health Services

In FY 21-22, the QM Unit calculated and evaluated the mental health services penetration rate for FY 20-21 to ensure that persons of diverse ethnic backgrounds accessed the service delivery system. The 20-21 penetration rate was 7.29 percent, which is a decrease from FY 19-20 when the penetration rate was 8.85 percent as seen in Table 86:

Table 86. Penetration Rate - Mental Health Services

Review Period	Medi-Cal Eligible	ICBHS Beneficiaries Served	Penetration Rate
FY 20-21	84,654	6,168	7.29%
FY 19-20	79,792	7,064	8.85%
FY 18-19	78,021	6,361	8.15%

The following section includes the penetration rates by category for FY 20-21:

i. Ethnicity
The highest penetration rate by ethnicity was for Black/African American at 21.85% percent; the lowest penetration rate was for Asian/Pacific Islander at 0.00% percent.

ii. Gender
The penetration rate by gender continues to be higher for males at 8.10 percent than for females at 6.65 percent, when compared to the FY 19-20 penetration rates of 10.25 percent and 7.77 percent, respectively.

iii. Age
The highest penetration rate by age was for the 14 to 20 age group at 12.97 percent; the lowest penetration rate was for the 65+ age group at 0.45 percent. This is a change when compared to FY 19-20 penetration rates, which were higher for the 14 to 20 age group at 15.89 percent and lowest for the 65+ age group at 0.68 percent.

iv. Language
The penetration rate by language continues to be higher for English at 12.30 percent than for Spanish, the County's threshold language, at 4.07 percent, when compared to the FY 19-20 penetration rates of 14.83 percent and 5.09 percent, respectively.

v. City
The highest penetration rate by city was for Westmorland at 69.86 percent; the lowest penetration rate was for Calexico at 6.19 percent. This is consistent when compared to the FY 18-19 penetration rates, which were highest for Westmorland at 59.68 percent and lowest for Winterhaven at 5.12 percent.

Substance Use Disorder Treatment Services

In FY 21-22, the QM Unit calculated and evaluated the SUD treatment services penetration rate for FY 20-21 to ensure that persons of diverse ethnic backgrounds accessed the service delivery system. The FY 20-21 penetration rate was 0.74 percent, as seen in Table 87:

Table 87. Penetration Rate - SUD Treatment Services

Review Period	Medi-Cal Eligible	ICBHS Beneficiaries	Penetration Rate
FY 20-21	84,654	627	0.74%
FY 19-20	79,792	681	0.85%
FY 18-19	78,021	568	0.73%

The following section includes the penetration rates by category for FY 20-21:

i. Ethnicity
The highest penetration rate by ethnicity was for Black/African American at 4.55 percent and the lowest penetration rate was for Alaskan Native/American Indian and Asian/Pacific Islander at 0.00 percent.

ii. Gender
The highest penetration rate by gender was for males at 1.07 percent than for females at 0.48 percent.

iii. Age
The highest penetration rate by age was for the 26-64 age group at 1.41 percent and the lowest penetration rate was for the 12-20 and 65+ age group at 0.30 and 0.02 percent.

iv. Language
The highest penetration rate by language was for English at 1.61 percent than for Spanish, the County's threshold language, at 0.18 percent.

v. City
The highest penetration rate by city was for Westmorland at 5.66 percent and the lowest penetration rate was for Ocotillo and Winterhaven than other cities at 0.00 and 0.36 percent.

b) Retention Rates

The retention rate is defined as the percentage of new clients and ongoing who received two or more services by the number of new outpatients visits for each beneficiaries who met medical necessity with the mental health and/or substance use treatment services. This measures the rate at which new clients, in general, are retained in the system for treatment.

The methodology used to calculate the retention rate consisted of selecting the number of Medi-Cal beneficiaries who came in for an initial intake assessment, met medical necessity, and were provided two or more services. Crisis services, documentation, and/or travel time were excluded. Only actual services delivered were included. The focus was on outpatient follow-up after an initial visit.

Service retention is defined as the total number of services received from the county's health system. Service retention is calculated by obtaining the unduplicated number of beneficiaries who received one or more services during the fiscal year and distributing the services into six service retention categories. The service retention categories are analyzed by demographic groups to calculate which groups are the largest and smallest and which groups are the most and least retained. Analyzing service retention information across different demographic groups allows examination of the continuum of services provided to beneficiaries and provides an opportunity to address potential differences among the demographic groups

In FY 21-22, the QM Unit calculated and evaluated service retention for FY 20-21 to examine the continuum of services provided to beneficiaries and ensure that persons of diverse backgrounds were

retained in the service delivery system. Group differences found in the amount of services provided represent an opportunity for improvement.

Mental Health Services

The retention rate for FY 20-21 was 87 percent, which represents an decrease when compared to FY 19-20 when the retention rate was 91 percent, as seen in Table 88:

Table 88. Retention Rate- Mental Health Services

Review Period	Intake Assessments	Met Medical Necessity Criteria	Beneficiaries Who Received 2+ Services	Retention Rate
FY 20-21	3,093	2,800	2,448	87%
FY 19-20	3,005	2,550	2,309	91%
FY 18-19	3,336	2,942	2,634	90%

The following section includes service retention for FY 20-21:

i. Ethnicity/Race

The highest utilization of service by ethnic/race group was the Hispanic population with a total of 5,775 outpatient visits served of whom 420 (7%), received one (1) outpatient visit and the majority 3,483 (60%) received 12+ outpatient visits.

The lowest utilization of service by ethnic/race group was the Alaskan Native/American Indian population with a total of 40 outpatient visits served.

There were no other major disparities in ethnic groups as the groups tended to stay within the same ten-percentage range for each service category. There were two exceptions however: the lowest retention rate was 2% for outpatient visits for beneficiaries utilizing 2 outpatient visits for other groups and while the highest retention rate of 75% for outpatient visits for beneficiaries utilizing 12+ outpatient visits was also the Alaskan Native/American Indian group.

ii. Gender

The highest utilization of services by gender group was the female population with a total of 3,561 outpatient visits served, of whom 249 (7%) received one (1) outpatient visit and the majority 2,153 (61%) received 12+ outpatient visits.

The lower utilization of services by gender group was the male population with 3,243 outpatient visits served, of whom 227 (7%) received one (1) outpatient visit and the majority 1,973 (60%) received 12+ outpatient visits

There were no major disparities as females and males tended to stay within the same range for each category with the utilization of services.

iii. Age

The highest utilization of services by age group was the 6-17 population with a total of 2,663 outpatient visits served, of whom 178 (7%) received one (1) outpatient visit and the majority 1,689 (63%) received 12+ outpatient visits. The lowest utilization of services by age group was the 0-05 age group with 117 outpatient visits served, of whom 14 (12%) received one (1) outpatient visit and the majority 45 (38%) outpatient visits received 12+ outpatient visits.

There was a notable disparities in utilization of services; 0-5 age group outpatient visits in this group had a the lowest percentage of retention in the 12+ outpatient visits services with 38%, this is 39% below the highest percentage of 77% in the 65+ group. The lowest retention rate for all age groups was 1% for outpatient visits for beneficiaries utilizing two (2) services and the highest retention rate for all age groups was 77% for outpatient visits for beneficiaries utilizing 12+ services.

iv. Language

The highest utilization of services by language group was the English-speaking population with a total of 4,413 outpatient visits served, of whom 315 (7%) received one (1) outpatient visit and the majority 2,653 (60%) received 12+ outpatient visit.

The lowest utilization of services by language group was the Other category with a total of 13 outpatient visits served, of whom 1 (8%) received one (1) outpatient visit and the majority 7 (54%) received 12+ outpatient visit.

There were no major disparities in languages as both English and Spanish-speaking tended to stay within the same range for each category with the utilization of services.

v. City

The highest utilization of service was the Central region with a total of 3,505 outpatient visits served, of whom 253 (7%) received one (1) outpatient visit and the majority 2,086 (60%) received 12+ outpatient visits.

The lowest utilization of service was the Eastern region with a total of 63 outpatient visits served, of whom 2 (3%) received one (1) outpatient visit and the majority 38 (60%) received 12+ outpatient visits.

There were no major disparities as the groups tended to stay within the same ten percent range for each service category. However, it is

notable the Northern region had the highest retained outpatient visits for beneficiaries with 12+ services at 63%, and the Eastern region had the lowest retained outpatient visits for beneficiaries with 2 services at 2%.

Substance Use Disorder Treatment Services

FY 20-21 was 93 percent, which remain the same as FY 19-20 at 93 percent, as seen in Table 89:

Table 89. Retention Rate- Substance Use Disorder Treatment Services

Review Period	Intake Assessments	Met Medical Necessity Criteria	Beneficiaries Who Received 2+ Services	Retention Rate
FY 20-21	479	434	402	93%
FY 19-20	593	541	503	93%
FY 18-19	508	459	437	95%

The following section includes service retention for FY 20-21:

i. Ethnicity/Race

The highest utilization of service by ethnic/race group was the Hispanic population with a total of 512 outpatient visits served of whom 55 (11%), received one (1) outpatient visit and the majority 244 (48%) received 12+ outpatient visits.

The lowest utilization of service by ethnic/race group was the Alaskan Native/American Indian population with a total of eight outpatient visits served.

There were no major disparities in ethnic groups as the groups tended to stay within the same ten-percent range for each service category. There were two exceptions, however: the African American and White had the lowest retention rate of 6% outpatient visits for beneficiaries utilizing 3 services, when compared to the other groups, while Hispanics/Latino had the highest retention rate of 48% outpatient visits beneficiaries utilizing 12+ outpatient visits, when compared to other groups.

ii. Gender

The highest utilization of services by gender group was the male population with a total of 432 outpatient visits beneficiaries served, of whom 47 (11%) received one (1) outpatient visits and the majority 204 (47%) received 12+ outpatient visits.

The lowest utilization of services by gender group was the female population with 252 outpatient visits served, of whom 39 (15%) received one (1) outpatient visits and the majority 102 (40%) received 12+ outpatient visits.

There were no major disparities as females and males tended to stay within the same range for each category with the utilization of services.

iii. Age

The highest utilization of services by age group continues to be the 21- 44 population with a total of 462 outpatient visits served, of whom 63 (14%) received one (1) outpatient visits and the majority 207 (45%) received 12+ outpatient visits.

The lowest utilization of services by age group was the 65+ population with five outpatient visits.

There were no major disparities as the groups tended to stay within the same ten-percent range for each service category. The only exceptions were noted with the 18-20 age group: the highest retention rate of 51% for outpatient visits for beneficiaries utilizing 12+ services, when compared to other groups. Additionally, the same age group had the lowest retention rate of 2% for outpatient visits for beneficiaries utilizing one service, when compared to other groups.

iv. Language

The highest utilization of services by language group was the English-speaking population with a total of 582 outpatient visits for each beneficiaries served, of whom 75 (13%) received one (1) outpatient visits and the majority 257 (44%) received 12+ outpatient visits.

The lowest utilization of services by language group was the Spanish-speaking population with a total of 102 outpatient visits served, of whom 11 (11%) received one (1) outpatient visits and the majority 49 (48%) received 12+ outpatient visits.

There were no major disparities in languages as both English and Spanish-speaking tended to stay within the same range for each category with the utilization of services.

vi. City

The highest utilization of service by city of residence was the Central population with a total of 352 outpatient visits served, of whom 48 (14%) received one (1) outpatient visits and the majority 156 (44%) received 12+ services.

The lowest utilization of service by city of residence was the Eastern population with three outpatient visits served, of whom two (67%) received 12+ outpatient visits.

There were no major disparities as the groups tended to stay within the same ten-percent range for each service category. There were two exceptions, however: Eastern population had the lowest retention rate

of 0% for outpatient visits for beneficiaries utilizing 2-11 services, when compared to the other groups. Additionally, Northern population had the lowest retained outpatient visits of 5% when compared to the other groups in the 3 services category.

The ICBHS Penetration Rates Report and the Retention Rates and Utilization Rate Report for FY 20-21 were presented to the QIC on December 9, 2021. Both reports were also presented to the Cultural Competence Taskforce on January 12, 2022.

b. Overview of the ICBHS objectives, scope, and planned activities for FY 22-23:

- The QM Unit will monitor the three cultural competence standards of access, quality of care, and quality management for evidence of integration throughout the QI Program.

- In an effort to improve cultural competence, ICBHS will provide cultural competence training to staff at least annually.

- ICBHS will conduct an analysis of human resources composition by location data, including staff's ethnicity and language capabilities, in contrast with population need assessment data for each population category, including ethnicity and language, at least annually.

- ICBHS will provide staff with an annual mandatory client culture training that includes clients/consumers set of values, beliefs, and lifestyles that are molded in part by their personal experiences with mental illness, the mental health system and their own ethnic culture and for children and adolescents, the parent and/or caregiver's personal experience in working with multiple agency services.

- The QM Unit will survey all ICBHS staff annually to identify the ethnicity, linguistic capabilities, diverse cultural group awareness, and staff function in an effort to ascertain cultural competence and move towards a more culturally competent service delivery system.

- The QM Unit will calculate and evaluate the penetration, retention, and utilization rates annually to ensure that persons of diverse ethnic backgrounds access the service delivery system and are retained in services and in numbers consistent with their representation in the Medi-Cal eligible population.

- The QM Unit will actively participate in the Cultural Competence Task Force and ensure that QI activities are monitored as reflected in the annual Cultural Competence Plan.