County of Imperial

Behavioral Health Services

Quality Improvement Work Plan

FY 2023-2024

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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 It has been proven that outdated and inefficient processes are the main barriers and obstacles in the way of getting a high-quality job done.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 23-24 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, and 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. ICBHS' 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 approved 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. Implementation of needed QI activities.
j. Ensure the follow up of QI processes.

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) Continuity and coordination of care with physical health care providers (PCP) and other human services agencies;
   6) Provider Complaints and Appeals;
   7) Strategies to Reduce Avoidable Hospitalizations;
   8) Timeliness of Services;
   9) No Show Rates;
   10) Performance Improvement Projects.

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 first non-urgent services.
   b. Timeliness of urgent services.
   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. 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. 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.

6. 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.

7. 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 by reviewing authorization decisions in order to determine the consistency of the authorization process.

2. 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.

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.

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.

II. CalAIM Behavioral Health Initiative

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year DHCS initiative to improve the quality of life and health outcomes of the Medi-Cal population 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. The majority of these policy changes launched in 2022, but implementation will continue through 2027.

Through CalAIM, the following initiatives have been implemented by ICBHS:

- Criteria for Specialty Mental Health Services (SMHS) – updated the criteria for accessing SMHS, for both adults and beneficiaries under age 21, except for

psychiatric inpatient hospital and psychiatric health facility services, broadening the scope under which MHPs may provide SMHS in order to address beneficiaries' needs across the continuum of care and ensure that all Medi-Cal beneficiaries receive coordinated services and improved health comes. The definition of "medical necessity" was also realigned with Welfare and Institutions Code section 14184.402.

- Drug Medi-Cal Organized Delivery System (DMC-ODS) Policy Improvements – updated DMC-ODS, based on experience from the first several years of implementation, in order to improve beneficiary care and administrative efficiency.
- Documentation Redesign for Substance Use Disorder and SMHS – streamlined behavioral health documentation requirements for DMC-ODS and SMHS to align more closely with national standards. The goal of documentation reform is to improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective beneficiary care; address equity and disparities; and ensure quality and program integrity.
- No Wrong Door – implemented a "no wrong door" policy to ensure beneficiaries receive mental health services regardless of the delivery system where they seek care (i.e. MHP or MCP). This policy allows beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services by their contracted plan, even if the beneficiary is ultimately transferred to another delivery system due to their level of impairment and mental health needs.
- Standardized Screening and Transition Tools – required the implementation of standardized screening and transition of care tools. The screening tool determines the most appropriate Medi-Cal mental health delivery system (i.e. MHP or MCP) referral for beneficiaries who are not currently receiving mental health services when they contact the MHP or MCP seeking mental health services. The transition of care tool ensures that Medi-Cal beneficiaries receive timely and coordinated care when completing a transition of services to the other delivery system or when adding a service from the other delivery system to their existing mental health treatment.
- Behavioral Health Payment Reform – seeks to move counties away from cost-based reimbursement to enable value-based reimbursement structures that reward better care and quality of life for Medi-Cal beneficiaries.

ICBHS undertook three measures to fully implement the CalAIM behavioral health initiatives:

1) *Semi-Statewide Innovation Enterprise Health Record Project*
   ICBHS recognized the need for a modern electronic health record (EHR) to remain compliant with evolving state and federal standards. With support from the community and local stakeholders, ICBHS agreed to participate in the Semi-Statewide Innovation Enterprise Health Project, funded through the Mental Health Services Act (MHSA).

   The Semi-Statewide Innovation Enterprise Health Record Project includes several California counties who have a vision for an enterprise solution where the EHR goes beyond its origins to provide a tool that helps counties manage the diverse needs of the population they serve. The three key aims identified by this project are to:
   1. Reduce documentation by 30 percent to increase the time the workforce has to provide treatment services to clients.

2. Facilitate cross-county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties are able to test and adopt innovative practices with reduced administrative burden.

The Semi-Statewide Innovation Enterprise Health Record Project was developed to assist counties in serving their clients, while also being bult to integrate all CalAIM changes, including documentation redesign, payment reform, and data exchange.

On February 1, 2023, ICBHS was the first pilot county to go live with the new EHR: SmartCare by Streamline Healthcare Solutions, LLC. While piloting SmartCare, ICBHS worked closely with the California Mental Health Services Authority (CalMHSA), the project manager for the Semi-Statewide Innovation Enterprise Health Record Project, to learn, analyze, and refine the system prior to its go-live data for all other counties on July 1, 2023.

While SmartCare has provided many advancements that have assisted ICBHS in implementing CalAIM and other critical EHR components, there are currently some functionalities that are still in development or will be developed at a later date. As a result, for the purposes of this QI Work Plan, ICBHS is only able to report on data collected through the previous EHR up until December 31, 2022. It is anticipated that the subsequent QI Work Plan will report on a data set that reflects information collected through SmartCare.

2) *Behavioral Health Quality Improvement Program (BHQIP)*
DHCS created the BHQIP to support implementation of CalAIM. The CalAIM BHQIP is a structured incentive program, whereby ICBHS as both the MHP and DMC-ODS for Imperial County, may earn incentive payments by achieving certain CalAIM implementation milestones. These milestones are:

1. Goal 1: Payment Reform
    a. Implement new Current Procedural Technology/ Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes, modifiers, place of service codes, and taxonomy codes.
    b. Update county claiming systems to successfully submit 837 transactions to the Short-Doyle Medi-Cal (SD/MC) claiming system.
    c. Implement new Intergovernmental Transfer (IGT) agreement protocol.
2. Goal 2: Implementation of CalAIM Behavioral Health Policy Changes
    a. Implement standardized screening tools in compliance with DHCS guidance.
    b. Implement standardized transition of care tools in compliance with DHCS guidance.
    c. Implement revised documentation standards, including but not limited to, assessment domains, problem lists, progress notes, and applicable timeliness standards.
    d. Provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies, as outlined by DHCS in Behavioral Health Information Notices:
        - Criteria for DMC-ODS services

- Criteria to access Specialty Mental Health Services (SMHS) for adults and for children (including criteria related to trauma, child welfare involvement, and homelessness)
- Mandatory screening and transition tools for specialty and nonspecialty mental health
- Documentation requirements and assessment standards (SMHS and DMC-ODS)
- No wrong door (SMHS)
- Co-occurring diagnoses (SMHS and DMC-ODS)
- Treatment during assessment period, prior to diagnosis (SMHS and DMC-ODS)

3. Goal 3: Data Exchange
   a. Demonstrate improved data exchange capabilities.
      - Option 1: Demonstrate direct sharing of data with MCPs
      - Option 2: Demonstrate onboarding to a Health Information Exchange (HIE)
   b. Demonstrate an active Fast Healthcare Interoperability Resources (FHIR) application programming interface (API) that will allow the MHP and DMCODS to be compliant with CMS-mandated interoperability rules.
   c. Demonstrate that the MHP and DMC-ODS have mapped data elements to the United States Core Data for Interoperability (USCDI) standard set.
   d. Leverage improved data exchange capabilities to improve quality and coordination of care.

The purpose of this goal is to promote bi-directional data exchange between ICBHS and its MCPs in order to improve health outcomes and health equity through enhanced coordination of care.

As of the date of this QI Work Plan, ICBHS has submitted evidence to DHCS to support the completion of each required milestone.

3) *Training, Support, & Monitoring of Providers*
ICBHS developed the following processes to ensure providers are educated on CalAIM behavioral health policy changes and are implementing them accordingly:

1. Training – At the beginning of the first phase of the CalAIM behavioral health initiatives by DHCS in January 2022, ICBHS developed a CalAIM Overview Training that summarized the purpose and intent of CalAIM and described specifically what the CalAIM behavioral health initiatives are. This training was provided live so that providers could ask questions and readily receive a response. The goal of this training was to ensure providers understand what the goals of CalAIM are and what initiatives affect the behavioral health delivery system.

   Additionally, ICBHS enrolled all providers in the CalMHSA LMS System and required them to complete each training component as they became available. Topics covered by CalMHSA include: CalAIM Overview; Access to Services; Assessment; Diagnosis & Problem List; Progress Notes; Care Coordination; Screening; Administering the Adult & Youth Screening Tools; Transition of Care Tool; Administering the Transition of Care Tool; Discharge Planning; CPT

Coding for Direct Service Providers (SMHS); and CPT Coding for Direct Service Providers (DMC-ODS). New providers who join ICBHS are required to complete this training series as part of the onboarding training process.

As each phase of the CalAIM behavioral health initiatives have been implemented, ICBHS has also discussed them with providers through monthly staff meetings and contract provider monitoring meetings. During these meetings, providers were able to ask questions and seek clarification regarding what the new requirements are and what processes will be implemented.

The CalAIM initiative related to the implementation of standardized screening and transition of care tools was one that ICBHS spent a considerable amount of time training staff on. Imperial County was one of the counties who piloted the screening and transition of care tools during the pilot project led by DHCS. ICBHS piloted various ways of implementing the screening and transition of care tools to determine what process worked the best for providers, beneficiaries, and the local mental health system, before ultimately deciding to have staff assigned to the 24-hour toll-free telephone lines implement the screening tool. In the event a beneficiary walks in to a clinic to receive services, a mental health rehabilitation technician will complete the screening tool. ICBHS clinicians are responsible for completing the transition of care tool.

When the requirement to implement the standardized screening and transition of care tools was issued, ICBHS developed a protocol to guide staff on the process for utilizing the adult and youth screening tools. Staff were trained on the protocol and provided with a copy to reference back to when needed. ICBHS also updated its existing policy related to the screening and transition tools and provided training to staff on it as well.

2. Support – ICBHS supports providers in implementing CalAIM behavioral initiatives through several different means. First, county-operated providers attend monthly meetings where they are informed of changes related to CalAIM and are also able to ask questions and discuss concerns or ideas related to CalAIM and the associated policy changes. For contracted providers, ICBHS meets with them on a quarterly basis, at minimum, where they also are informed of any changes associated with CalAIM and are able to ask questions and discuss policy-related issues.

   Second, the Quality Management Unit hosts peer-led documentation review meetings. During these meetings, cases are reviewed to, among other things, discuss quality of care and how the CalAIM behavioral health initiatives tie into that, as well as how the services being provided and the corresponding documentation align with CalAIM standards. During these meetings, providers are also able to ask questions and discuss concerns or ideas related to CalAIM policy changes.

   Third, ICBHS developed two email distribution lists to which providers may direct their CalAIM related questions. For policy related questions, providers may contact ICBHSCalAIM@co.imperial.ca.us. For questions related to the implementation of SmartCare, providers may contact

ICBHSEHR@co.imperial.ca.us. Both email distribution lists are assigned to staff who have the expertise necessary to appropriately advise providers and answer their questions.

3. Monitoring – The ICBHS Quality Management Unit and Compliance Unit are primarily responsible for monitoring providers and ensuring compliance with state and federal requirements. As each phase of the CalAIM behavioral health initiatives have been implemented, these units updated their monitoring tools and processes to ensure monitoring standards aligned with the new requirements issued by DHCS. Monitoring activities are conducted through data reviews, chart reviews, programmatic reviews, and site visits. When instances of non-compliance or opportunities for improvement are identified, a corrective action plan is issued. Providers are also monitored more closely to ensure corrections or improvements are made, as appropriate.

   Among county-operated providers, program supervisors monitor implementation of CalAIM behavioral health policy changes through monthly chart reviews. Program supervisors utilize a chart review tool that has questions related to access and medical necessity criteria, documentation guidelines, and No Wrong Door. Deficiencies identified by program supervisors are discussed with providers, with program supervisors providing one-to-one training and additional monitoring when needed.

The ICBHS FY 23-24 QI Work Plan incorporates all CalAIM behavioral health policy changes that have been initiated to date. The QI activities completed during FY 22-23 and the objectives identified for FY 23-24 reflect all monitoring activities completed by the Quality Management Unit and the Quality Improvement Committee, including those affected by CalAIM behavioral health initiatives.

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 22-23.

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

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, beneficiary demographics, the number of contacts provided in FY 22-23. The types and number of services provided between July 1, 2022, and January 31, 2023, were retrieved from the EHR, AVATAR, while the types and number of services provided from February 1, 2023, to June 30, 2023, were retrieved from the new EHR, SmartCare.

As the Mental Health Plan for Imperial County, ICBHS is responsible for providing or arranging medical necessary SMHS. Imperial County residents may access SMHS in person by walking into one of the MHP's outpatient clinics (during hours) or by calling the MHP's toll-free telephone number (during and after hours). Access staff assigned to the 24-hour toll-free telephone line will provide information on how to access SMHS including services needed to treat an urgent condition. If determined that the beneficiary meets screening criteria for SMHS, the MHP will coordinate an appointment for an initial assessment at any of the MHP outpatient clinics near the beneficiary's city of residence. If the MHP determines that SMHS are medically necessary to ameliorate the beneficiary's mental health condition, a mental health professional will help the beneficiary in deciding which services they would like to receive based on their presenting needs.

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 35 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*

Southern Services

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.

Central Services

Children Services in the central region are provided at two outpatient clinics, a MHSA Prevention and Early Intervention program, the Middle School Behavioral and Educational Program, and the Vista Sands Program. 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 family resource center. 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 and YAYA El Centro Full Service Partnership program 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 YAYA El Centro FRC is a school-based program that school-aged youth may access through school or self-referral.

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 and the YAYA Brawley Anxiety and Depression Program 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. The YAYA Brawley FRC is a school-based program that school-aged youth may access through school or self-referral.

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 and Adult El Centro Full Service Partnership programs 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 Full Service Partnership 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.

The Casa Serena program provides alternative treatment to individuals suffering psychiatric emergencies. Casa Serena offers comfort rooms to individuals promoting a calm environment. This therapeutic approach is accessible to clients experiencing emotional distress and is intended to assist individuals identify and de-escalate symptoms causing the distress. Services provided by Casa Serena will promote tranquility, mindfulness, and the reinforcement of coping skills. Casa Serena comfort rooms are designed to be age appropriate and are accessible to children and adolescent from ages 0-13; youth and young Adults from ages 14-25; and adults from age 26 and older. The goal of Casa Serena is to create an empowering environment and provide clients with tools to eliminate the future need of a 5150 application and/or psychiatric hospitalization. Casa Serena is an additional resource available to clients suffering from mental health and/or substance use disorder and may require the space and time to regulate their emotions.

b) Services Provided

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

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 and the total MHP are included in Table 1.

Table 1. Beneficiaries Served by Division and MHP

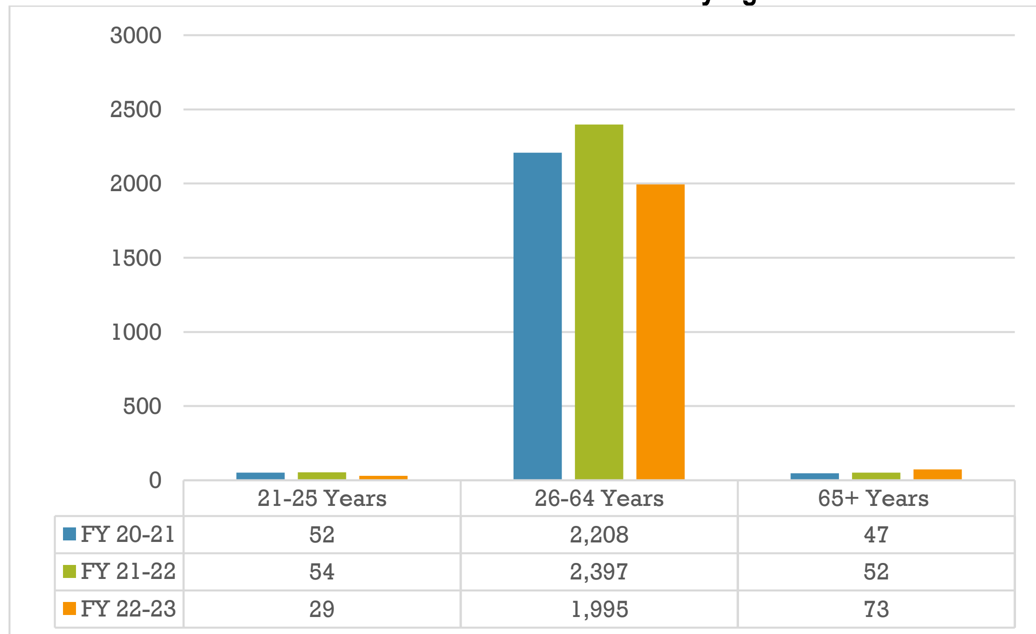
Division	FY 20-21	FY 21-22	FY 22-23
Adults Services	2,307	2,503	2,097
YAYA Services	1,601	1,674	1,403
Children Services	2,124	2,265	1,874
MHTES	618	829	685
MHP	**6,892**	**7,739**	**6,059**

**July 1, 2022, through December 31, 2022*

The following tables show demographic information by age, gender, ethnicity, city of residence, language, and diagnosis for beneficiaries served by each division of the MHP for FY 22-23.

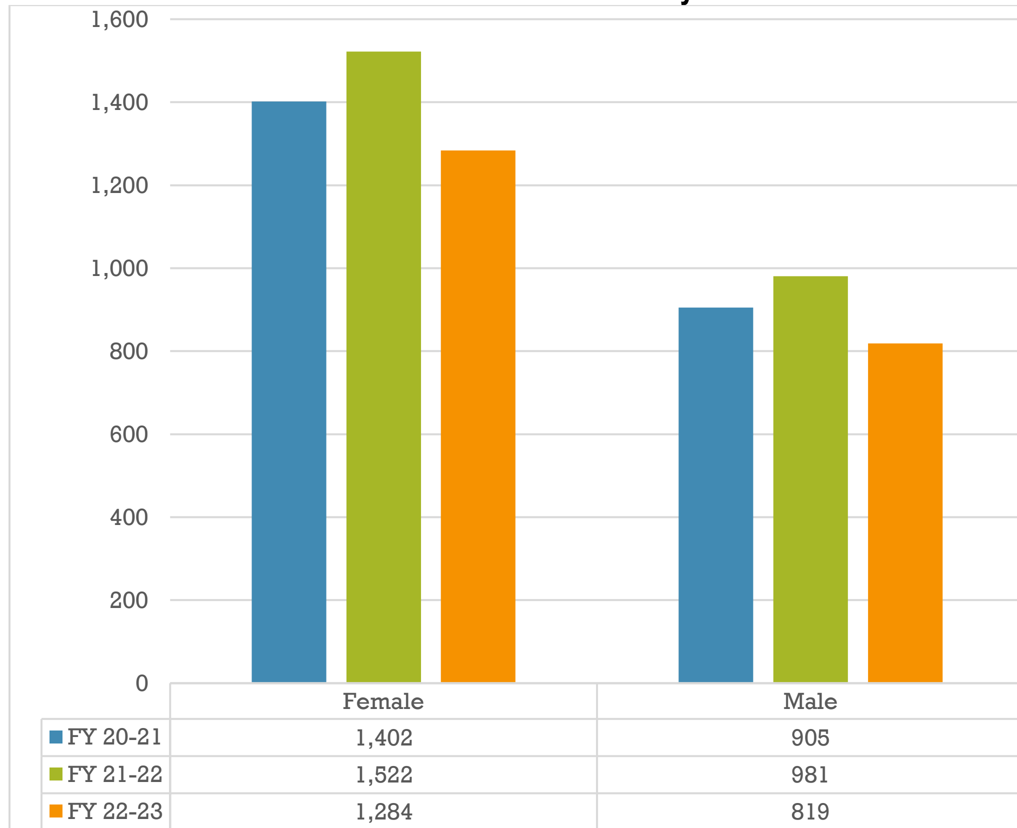
Table 2-7 indicate demographic information for beneficiaries served by Adult Services.

Table 2. Adult Served by Age



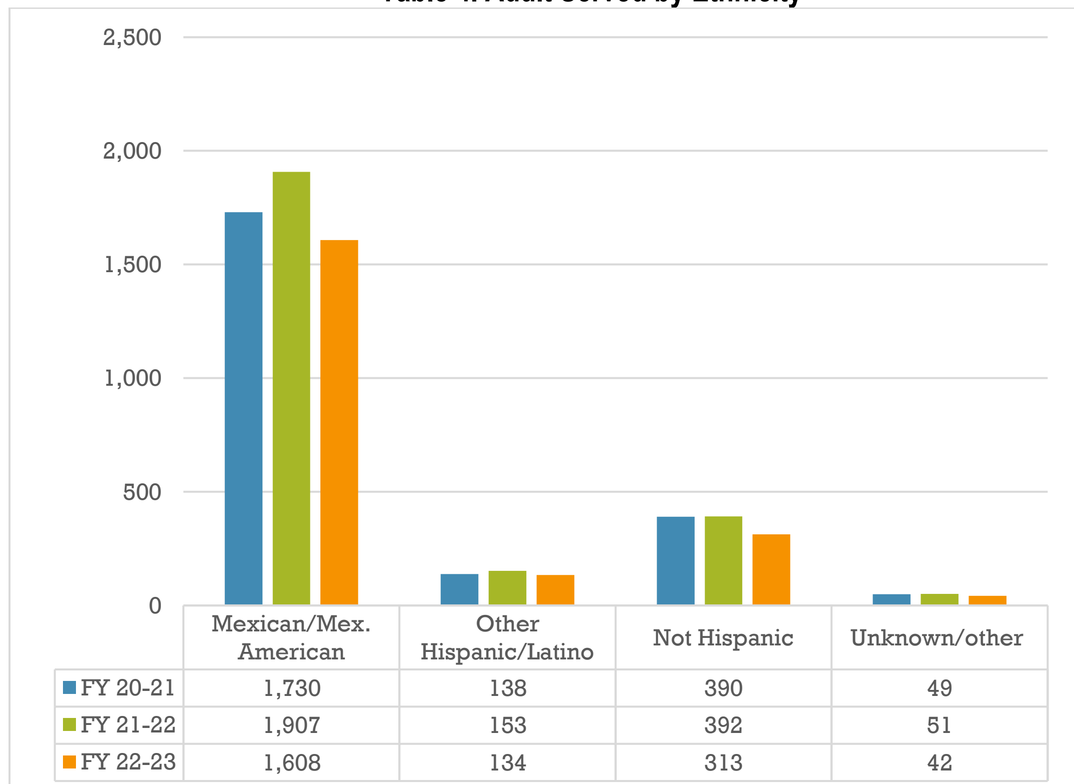
	21-25 Years	26-64 Years	65+ Years
FY 20-21	52	2,208	47
FY 21-22	54	2,397	52
FY 22-23	29	1,995	73

Table 3. Adult Served by Gender



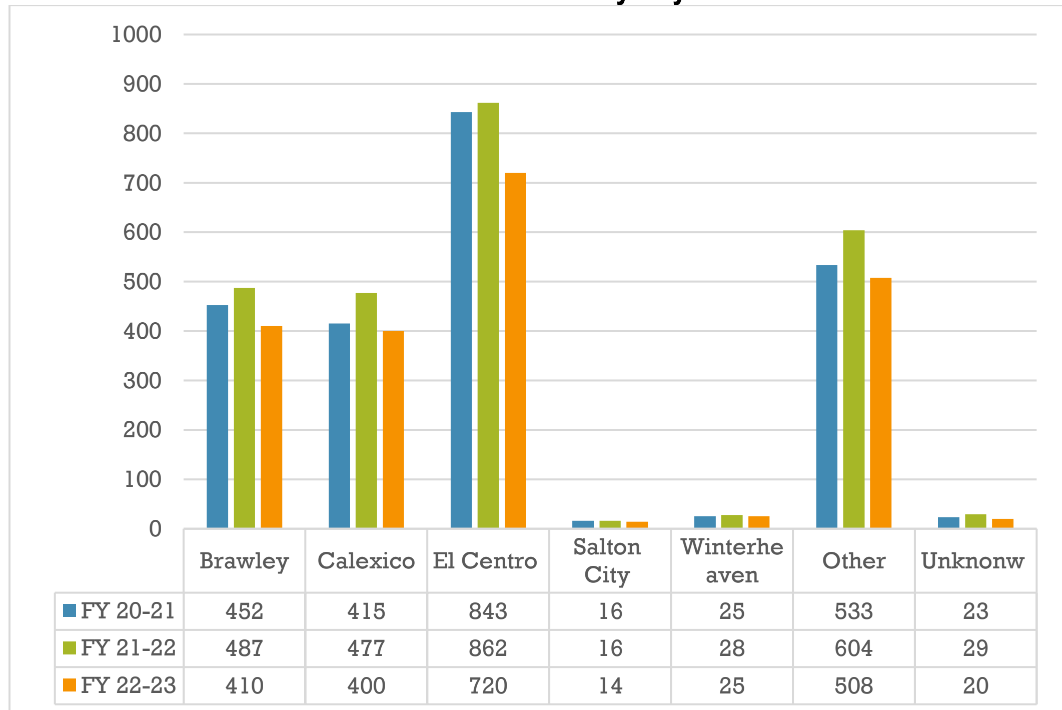
	Female	Male
FY 20-21	1,402	905
FY 21-22	1,522	981
FY 22-23	1,284	819

Table 4. Adult Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 20-21	1,730	138	390	49
FY 21-22	1,907	153	392	51
FY 22-23	1,608	134	313	42

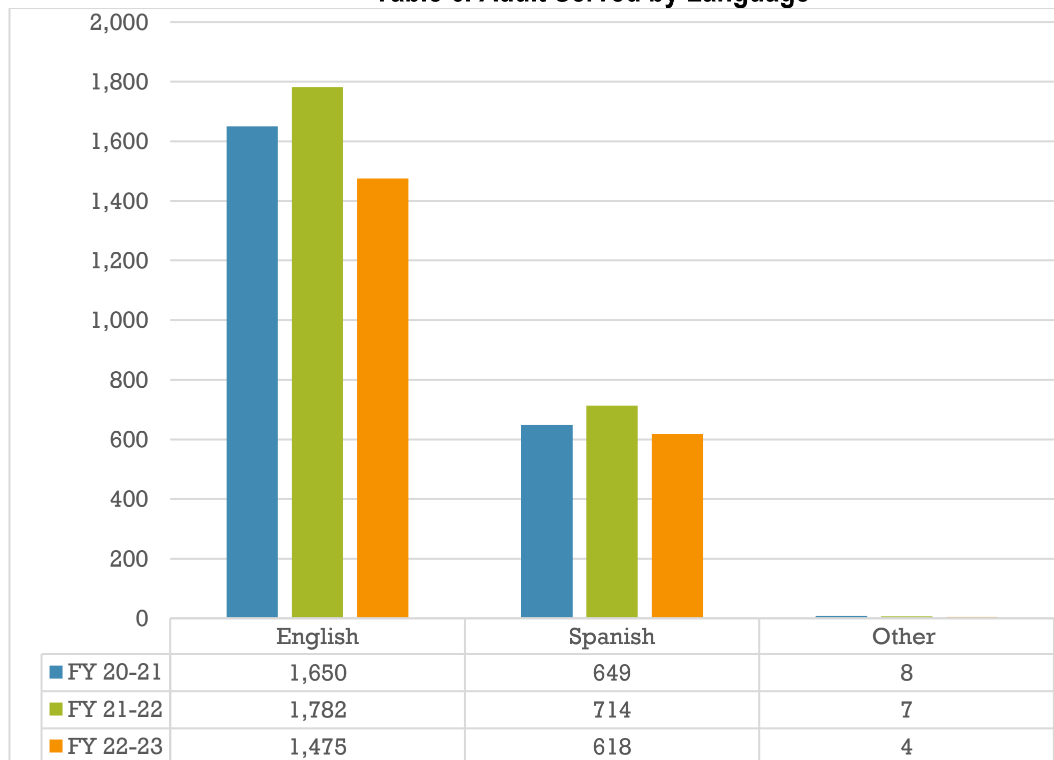
Table 5. Adult Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 20-21	452	415	843	16	25	533	23
FY 21-22	487	477	862	16	28	604	29
FY 22-23	410	400	720	14	25	508	20

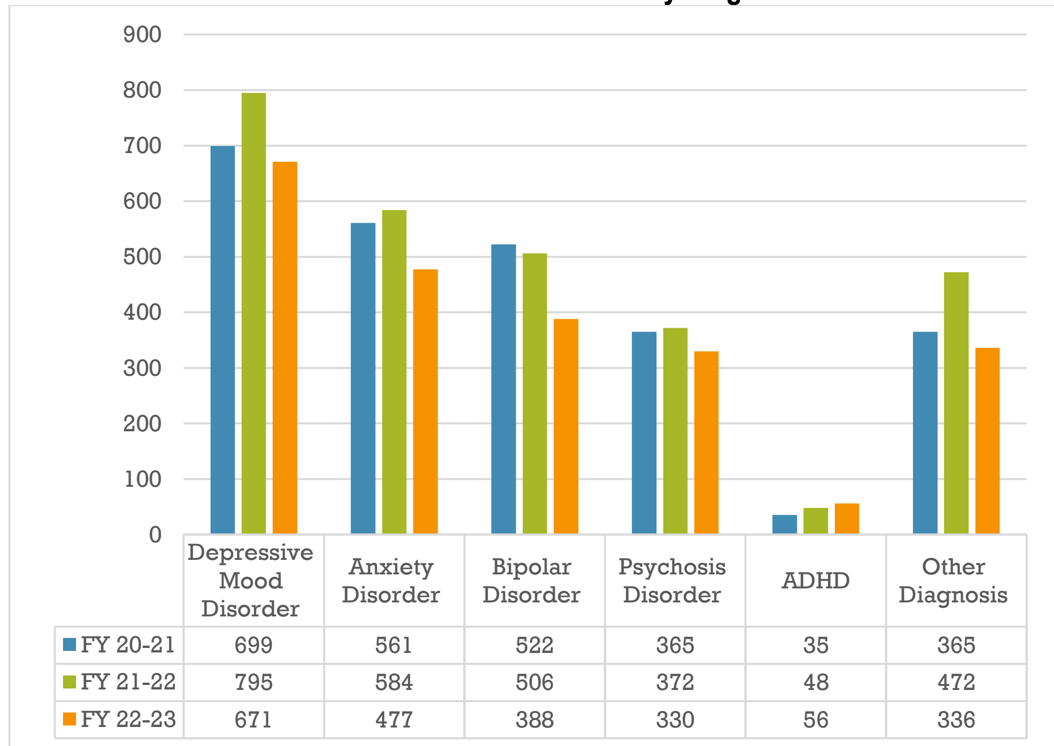
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Table 6. Adult Served by Language



	English	Spanish	Other
FY 20-21	1,650	649	8
FY 21-22	1,782	714	7
FY 22-23	1,475	618	4

Table 7. Adult Served by Diagnosis

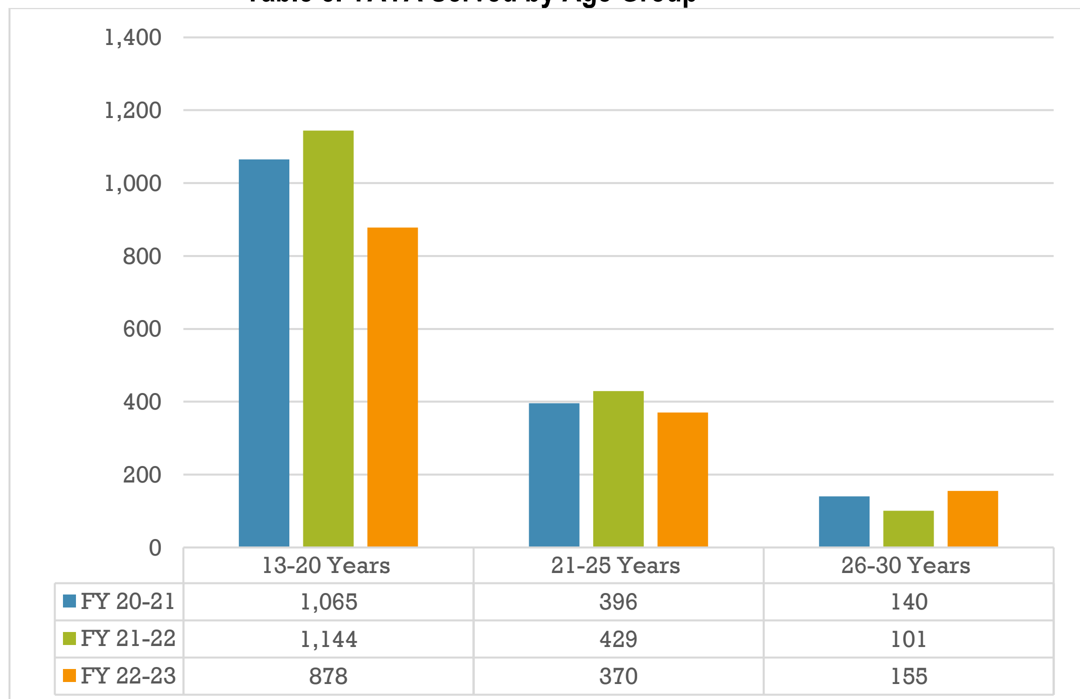


	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 20-21	699	561	522	365	35	365
FY 21-22	795	584	506	372	48	472
FY 22-23	671	477	388	330	56	336

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

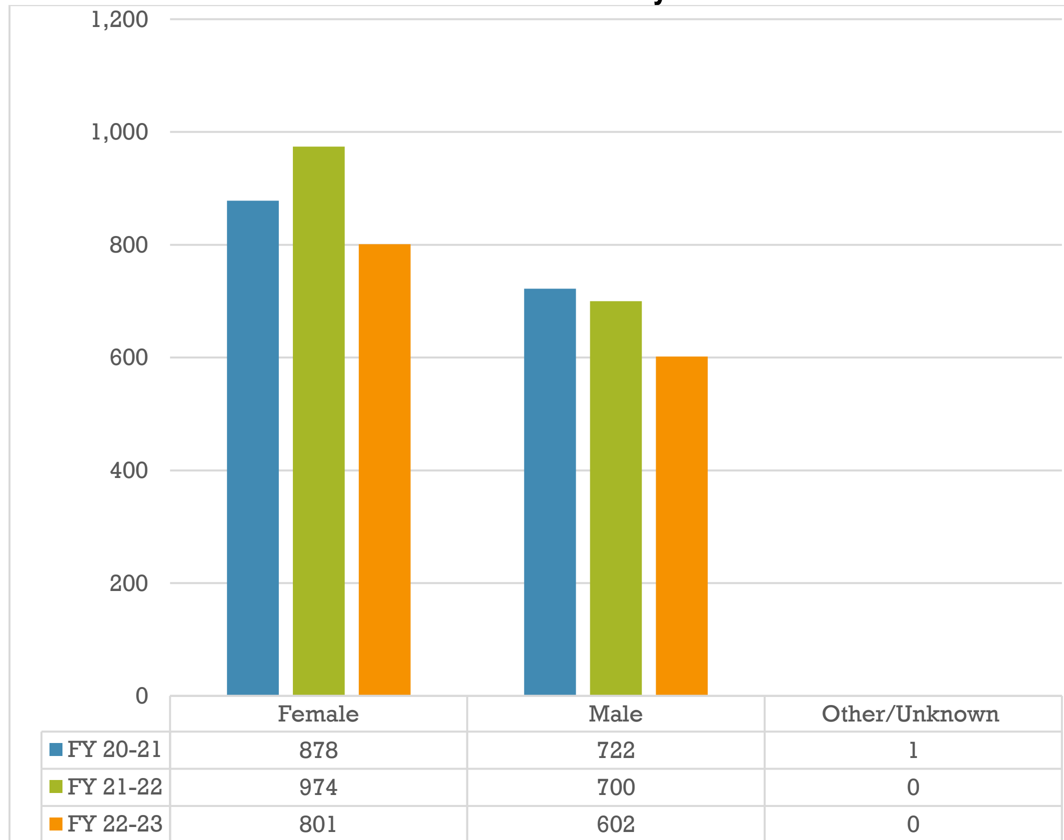
Table 8-13 indicate demographic information for beneficiaries served by YAYA Services.

Table 8. YAYA Served by Age Group



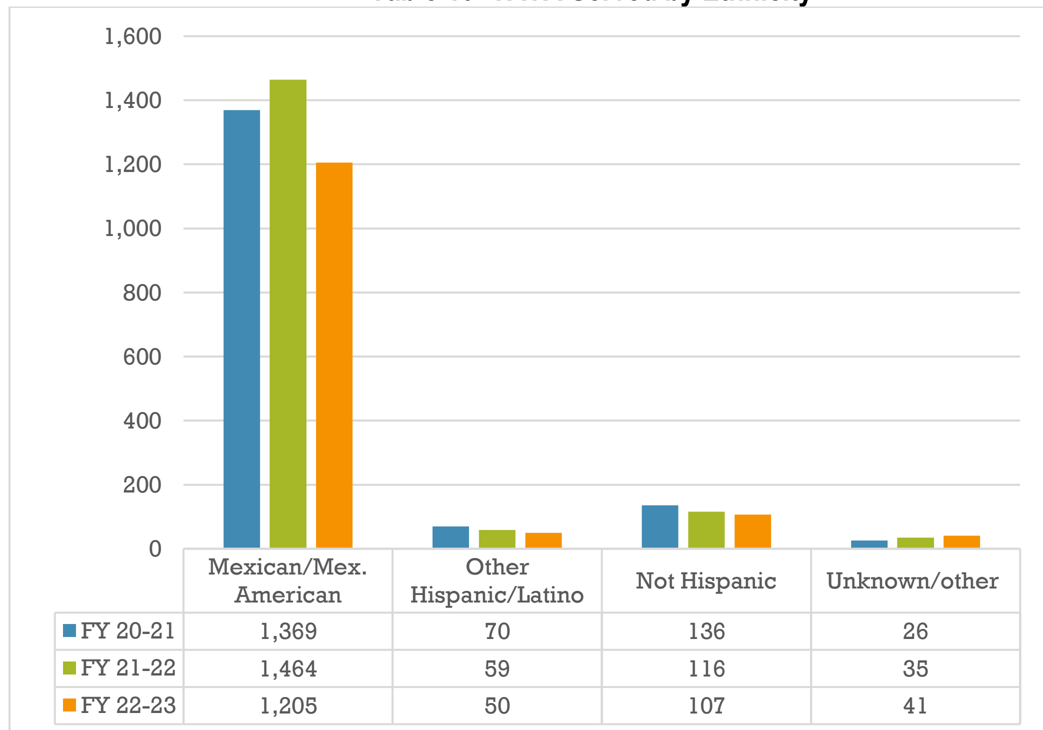
	13-20 Years	21-25 Years	26-30 Years
FY 20-21	1,065	396	140
FY 21-22	1,144	429	101
FY 22-23	878	370	155

Table 9. YAYA Served by Gender



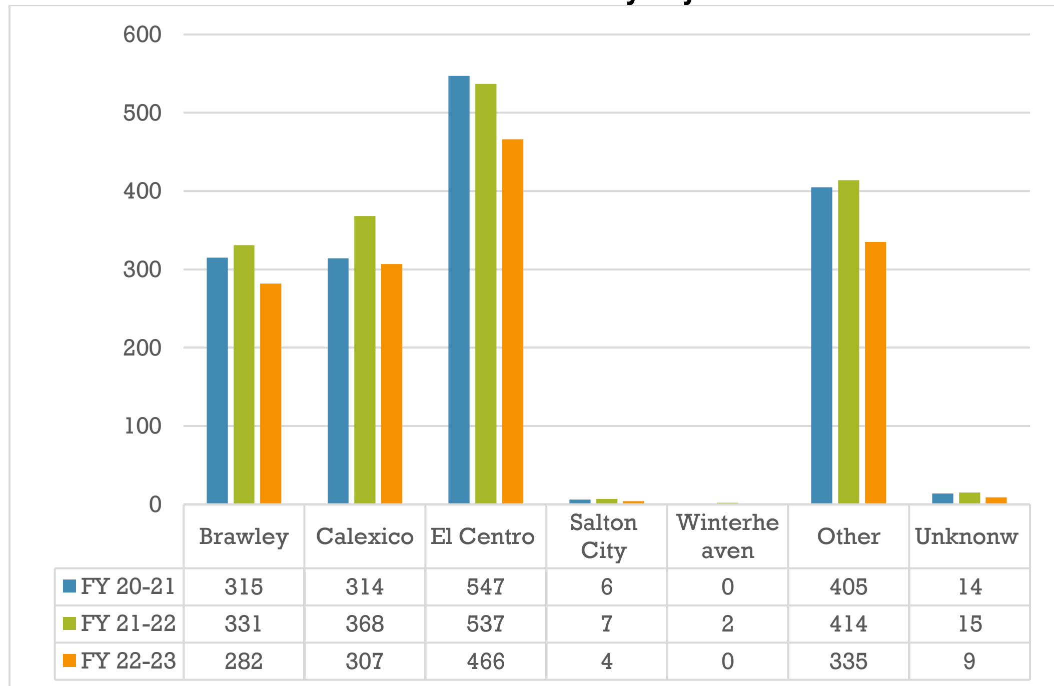
	Female	Male	Other/Unknown
FY 20-21	878	722	1
FY 21-22	974	700	0
FY 22-23	801	602	0

Table 10. YAYA Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 20-21	1,369	70	136	26
FY 21-22	1,464	59	116	35
FY 22-23	1,205	50	107	41

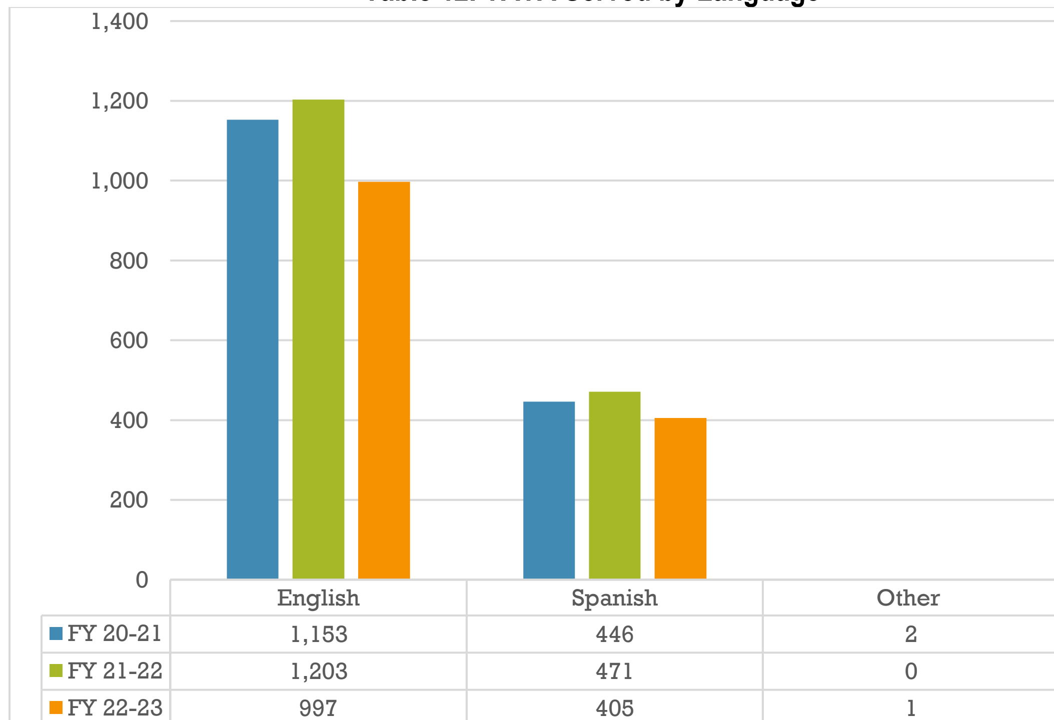
Table 11. YAYA Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 20-21	315	314	547	6	0	405	14
FY 21-22	331	368	537	7	2	414	15
FY 22-23	282	307	466	4	0	335	9

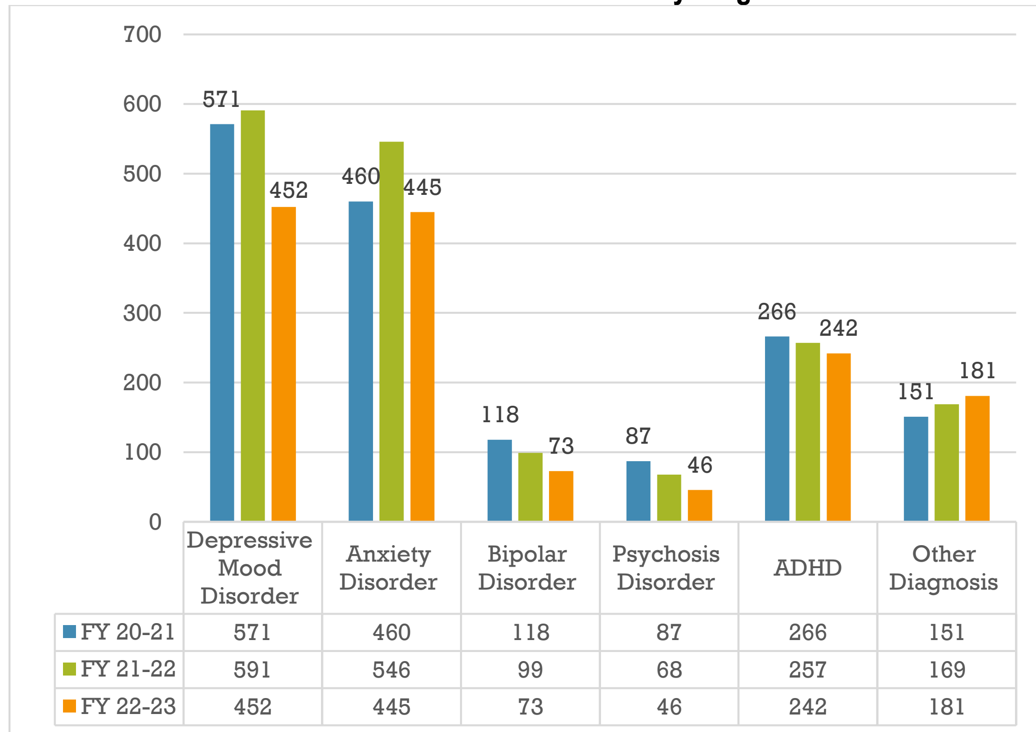
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Table 12. YAYA Served by Language



	English	Spanish	Other
FY 20-21	1,153	446	2
FY 21-22	1,203	471	0
FY 22-23	997	405	1

Table 13. YAYA Served by Diagnosis

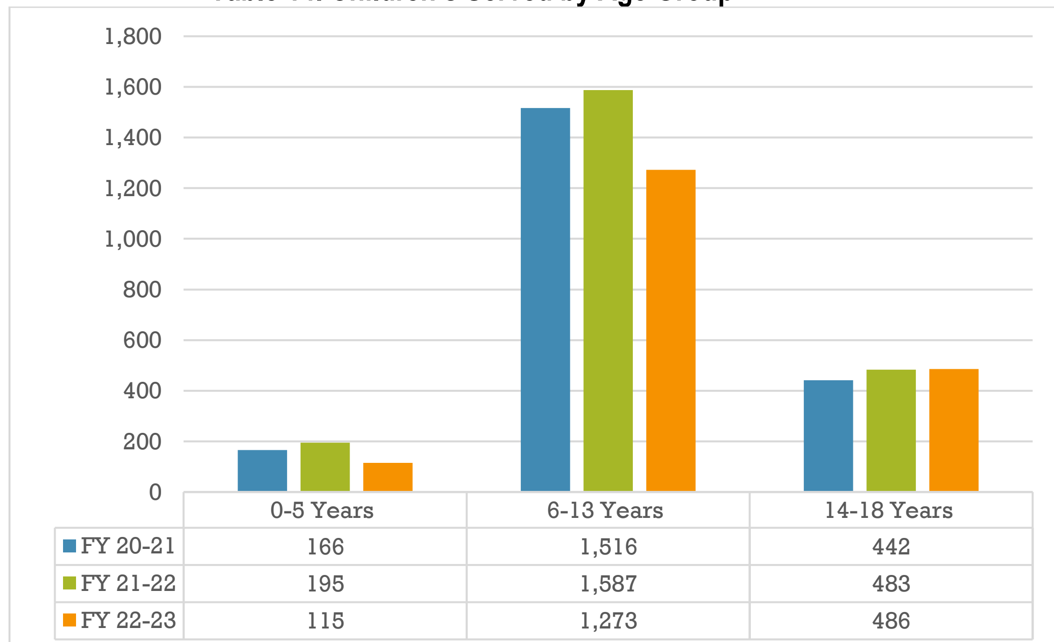


	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 20-21	571	460	118	87	266	151
FY 21-22	591	546	99	68	257	169
FY 22-23	452	445	73	46	242	181

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

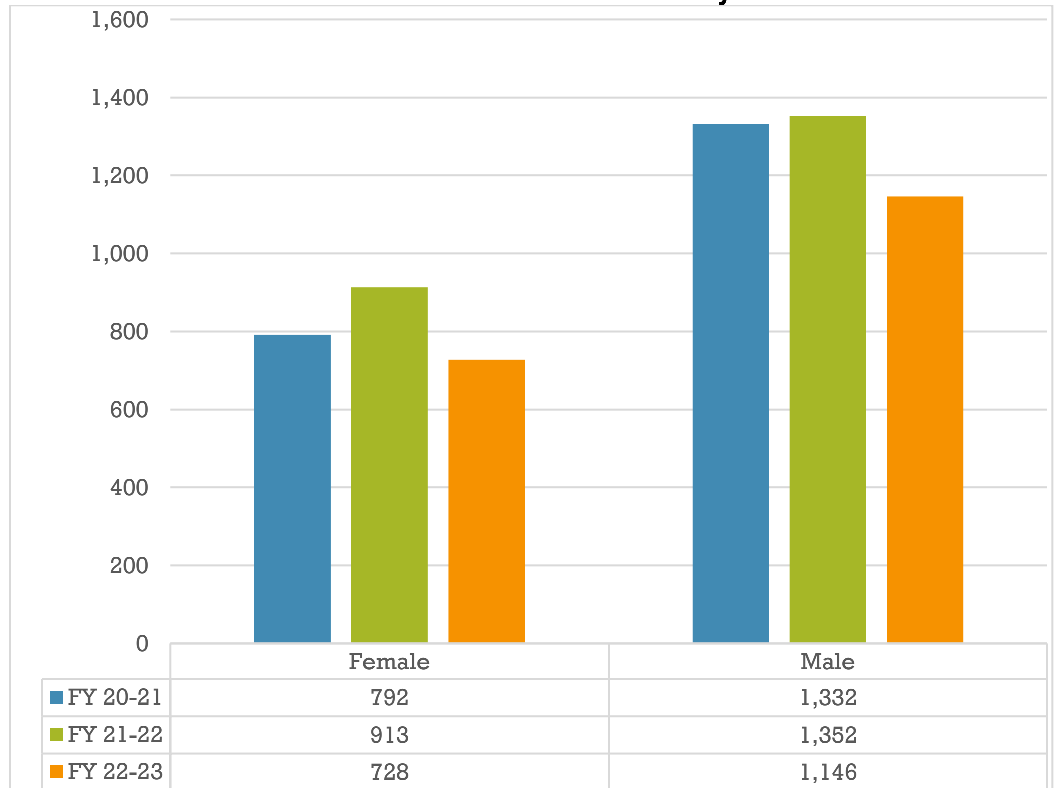
Table 14-19 indicate demographic information for beneficiaries served by Children Services.

Table 14. Children's Served by Age Group



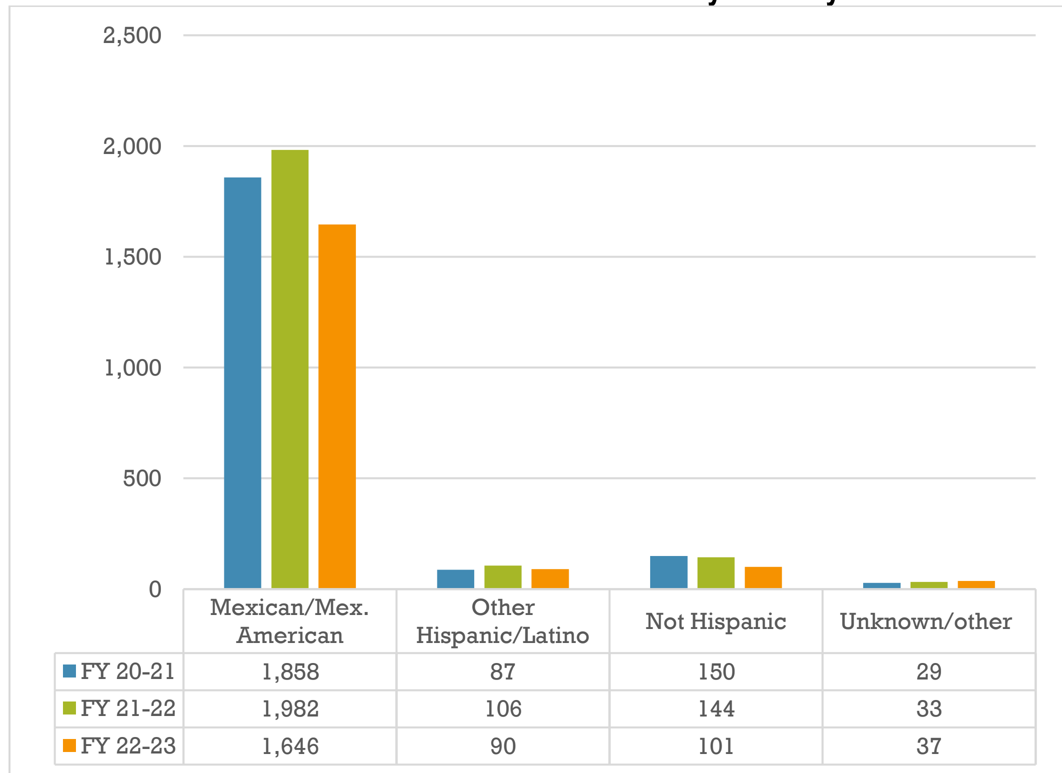
	0-5 Years	6-13 Years	14-18 Years
FY 20-21	166	1,516	442
FY 21-22	195	1,587	483
FY 22-23	115	1,273	486

Table 15. Children's Served by Gender



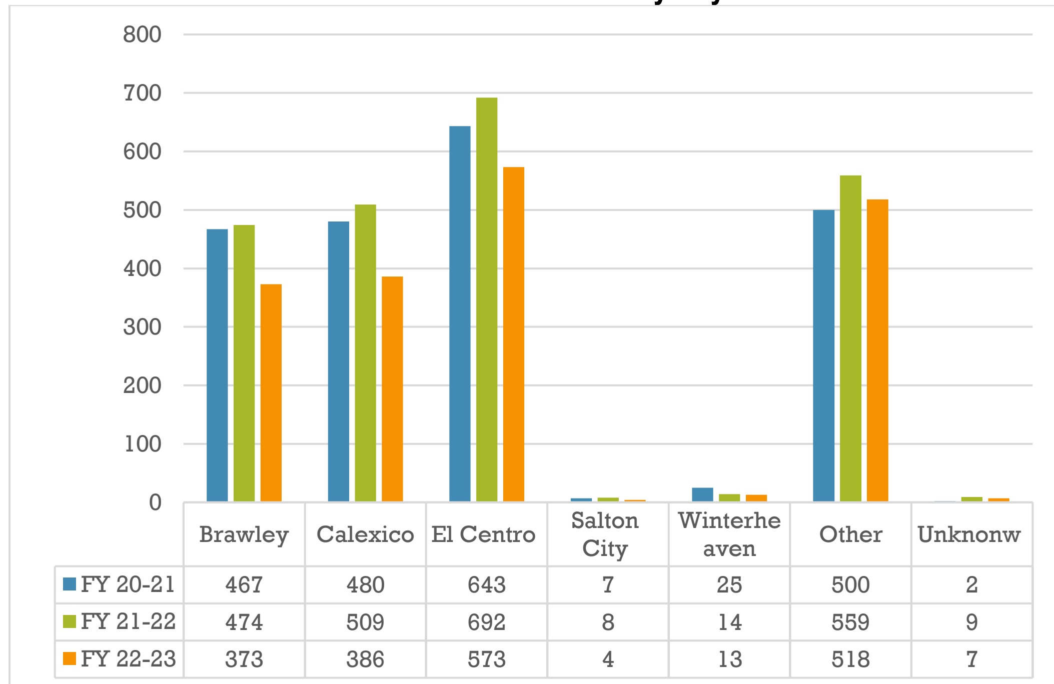
	Female	Male
FY 20-21	792	1,332
FY 21-22	913	1,352
FY 22-23	728	1,146

Table 16. Children's Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 20-21	1,858	87	150	29
FY 21-22	1,982	106	144	33
FY 22-23	1,646	90	101	37

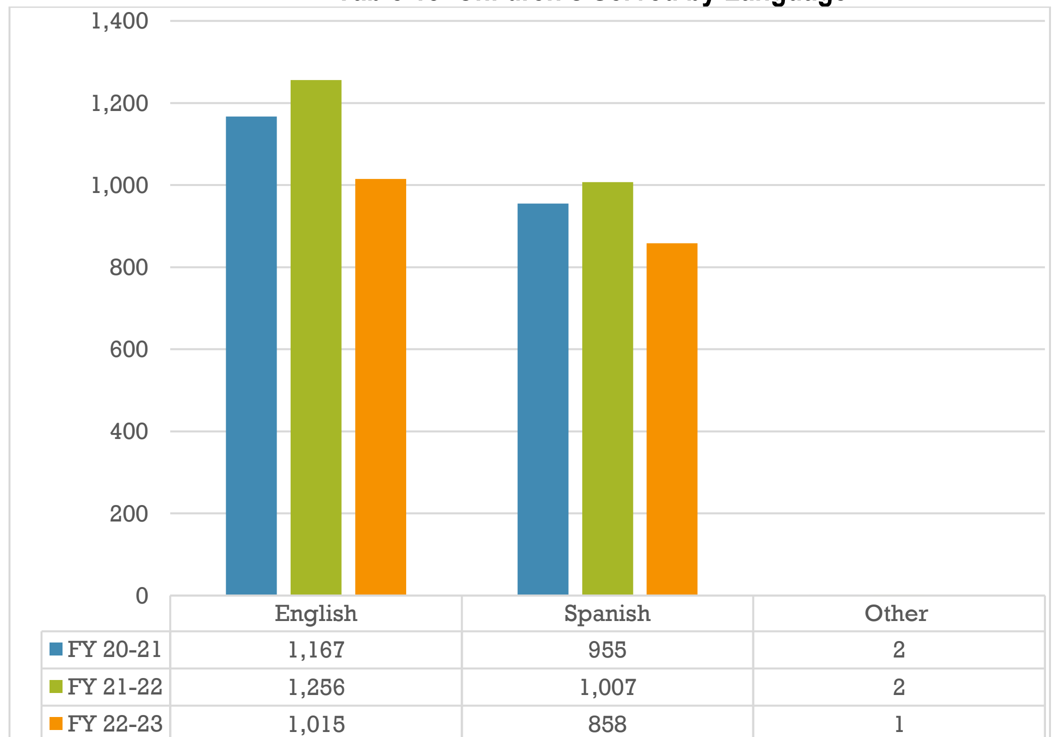
Table 17. Children's Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 20-21	467	480	643	7	25	500	2
FY 21-22	474	509	692	8	14	559	9
FY 22-23	373	386	573	4	13	518	7

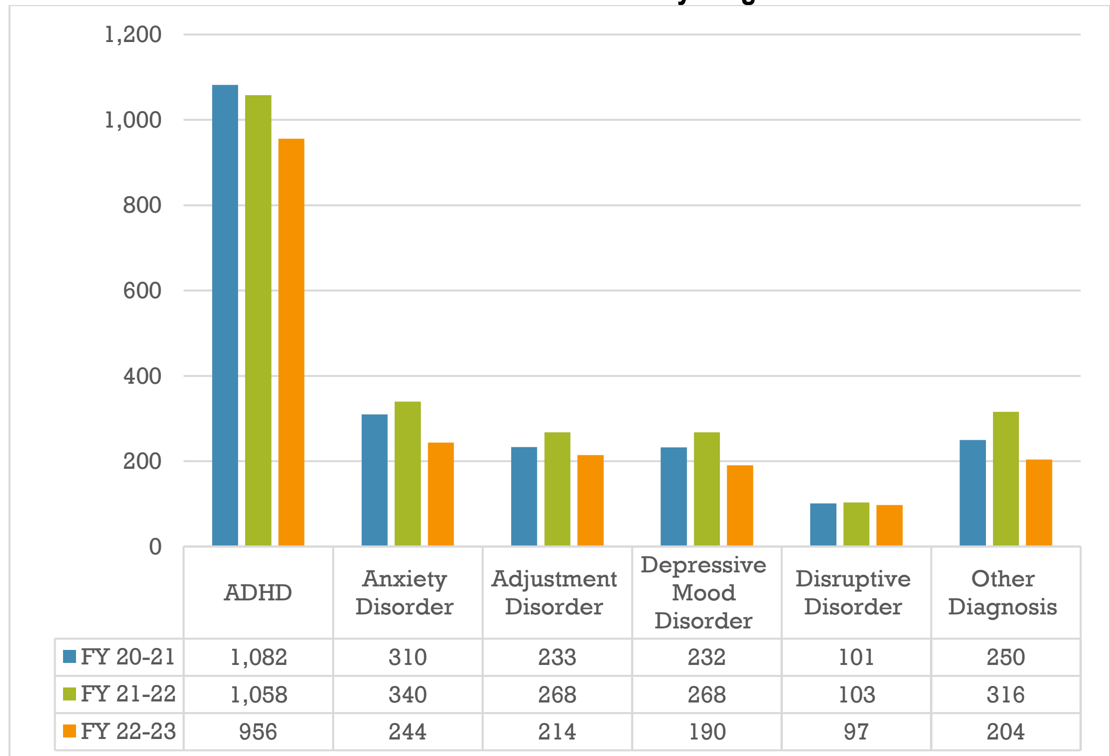
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Table 18. Children's Served by Language



	English	Spanish	Other
FY 20-21	1,167	955	2
FY 21-22	1,256	1,007	2
FY 22-23	1,015	858	1

Table 19. Children's Served by Diagnosis

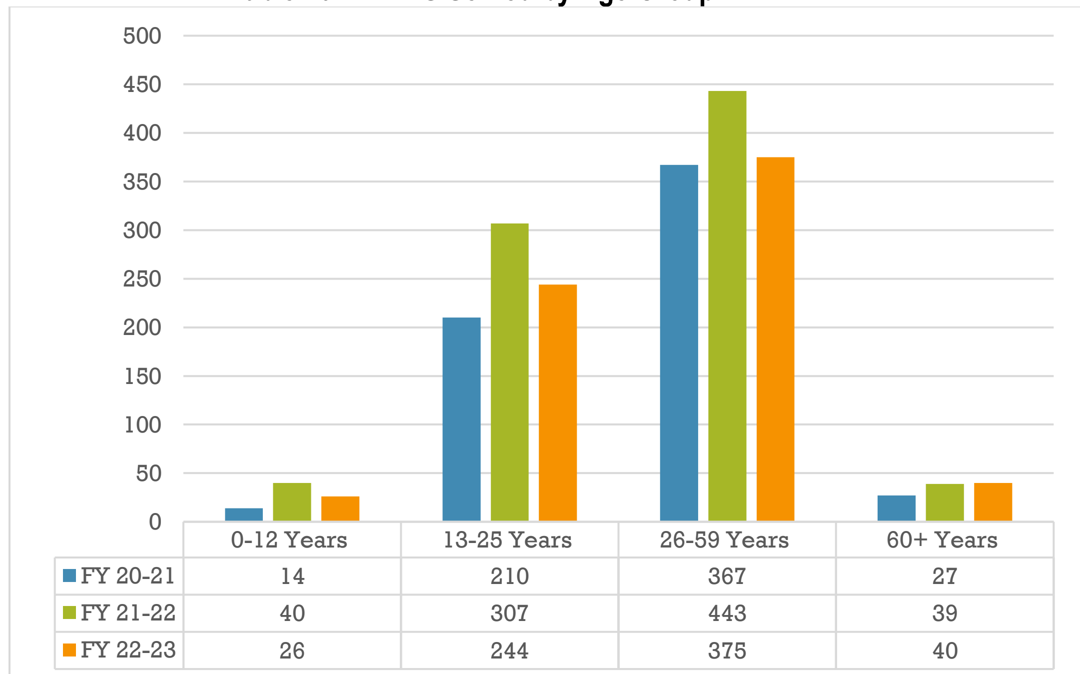


	ADHD	Anxiety Disorder	Adjustment Disorder	Depressive Mood Disorder	Disruptive Disorder	Other Diagnosis
FY 20-21	1,082	310	233	232	101	250
FY 21-22	1,058	340	268	268	103	316
FY 22-23	956	244	214	190	97	204

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

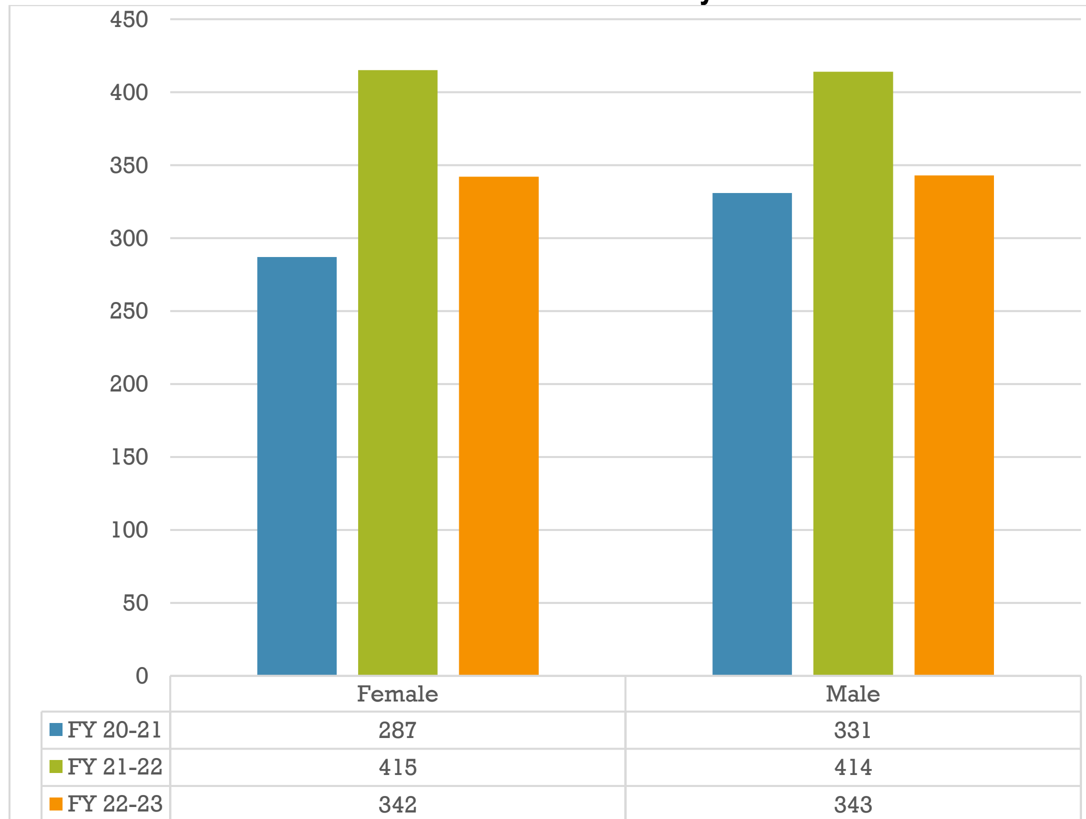
Table 20-25 indicate demographic information for beneficiaries served by MHTE Services.

Table 20. MHTES Served by Age Group



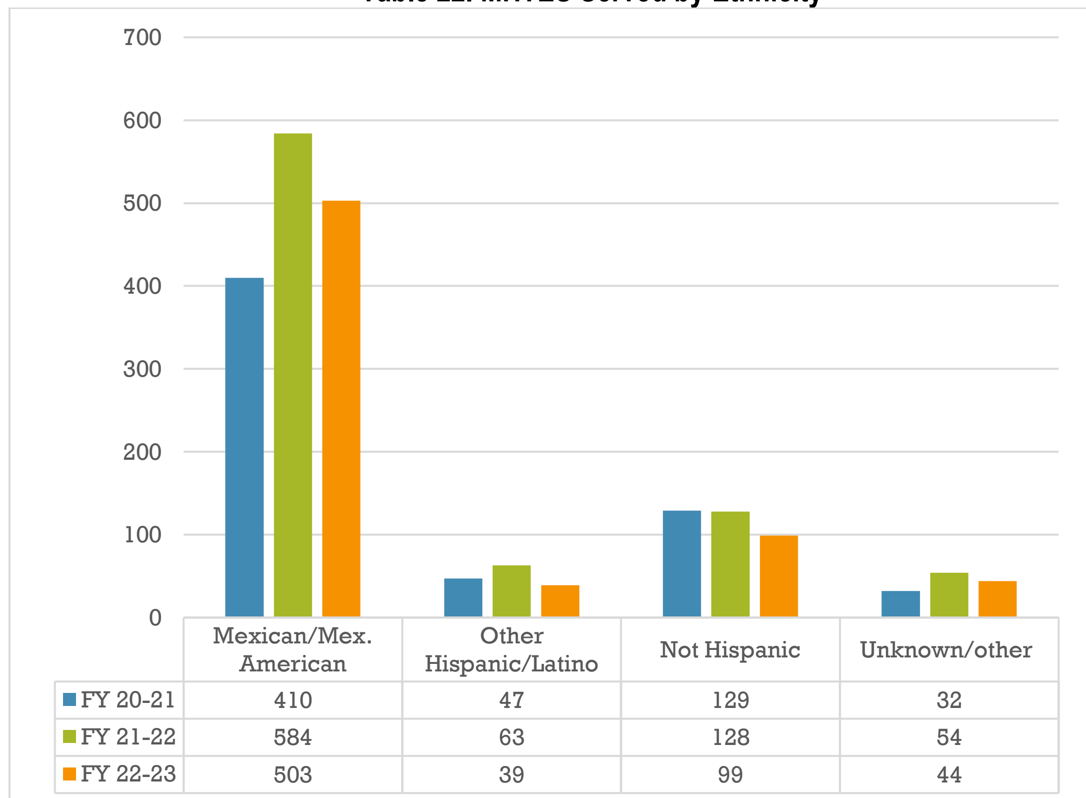
	0-12 Years	13-25 Years	26-59 Years	60+ Years
FY 20-21	14	210	367	27
FY 21-22	40	307	443	39
FY 22-23	26	244	375	40

Table 21. MHTES Served by Gender



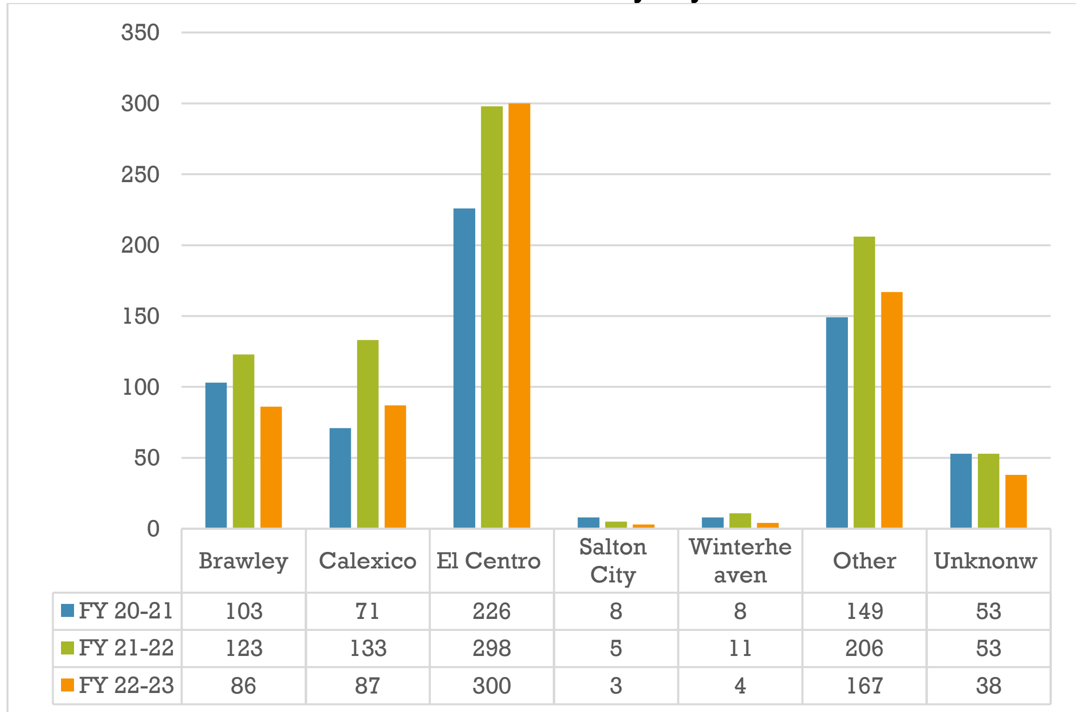
	Female	Male
FY 20-21	287	331
FY 21-22	415	414
FY 22-23	342	343

Table 22. MHTES Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 20-21	410	47	129	32
FY 21-22	584	63	128	54
FY 22-23	503	39	99	44

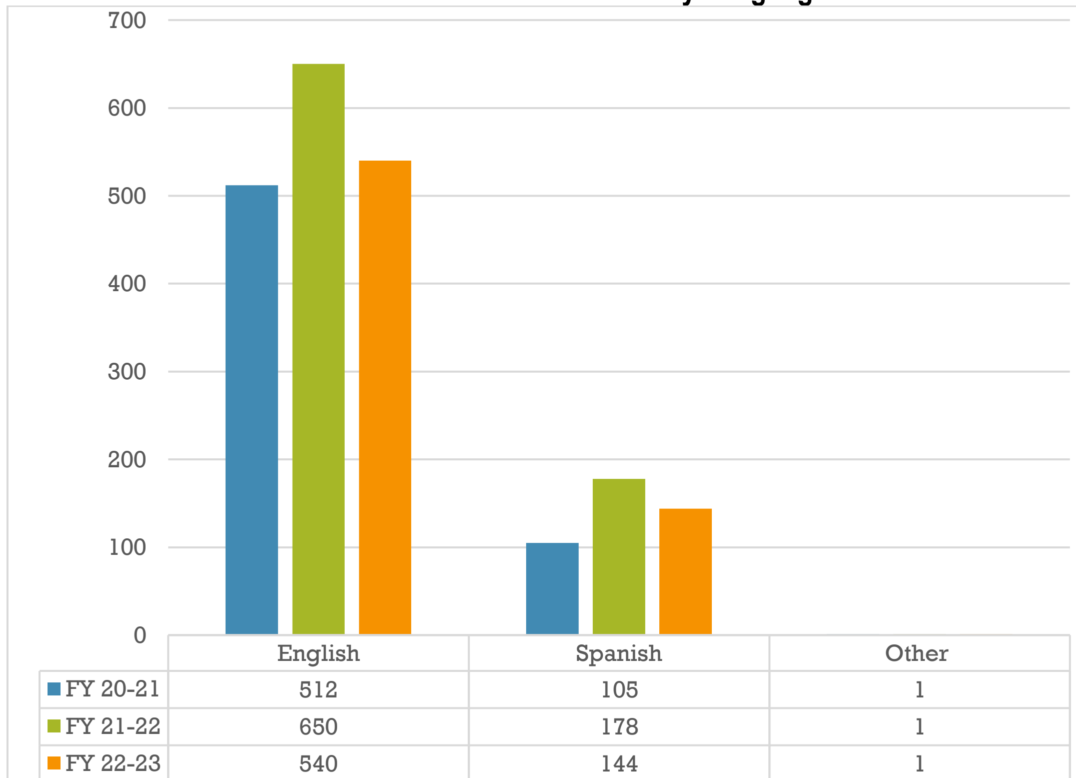
Table 23. MHTES Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 20-21	103	71	226	8	8	149	53
FY 21-22	123	133	298	5	11	206	53
FY 22-23	86	87	300	3	4	167	38

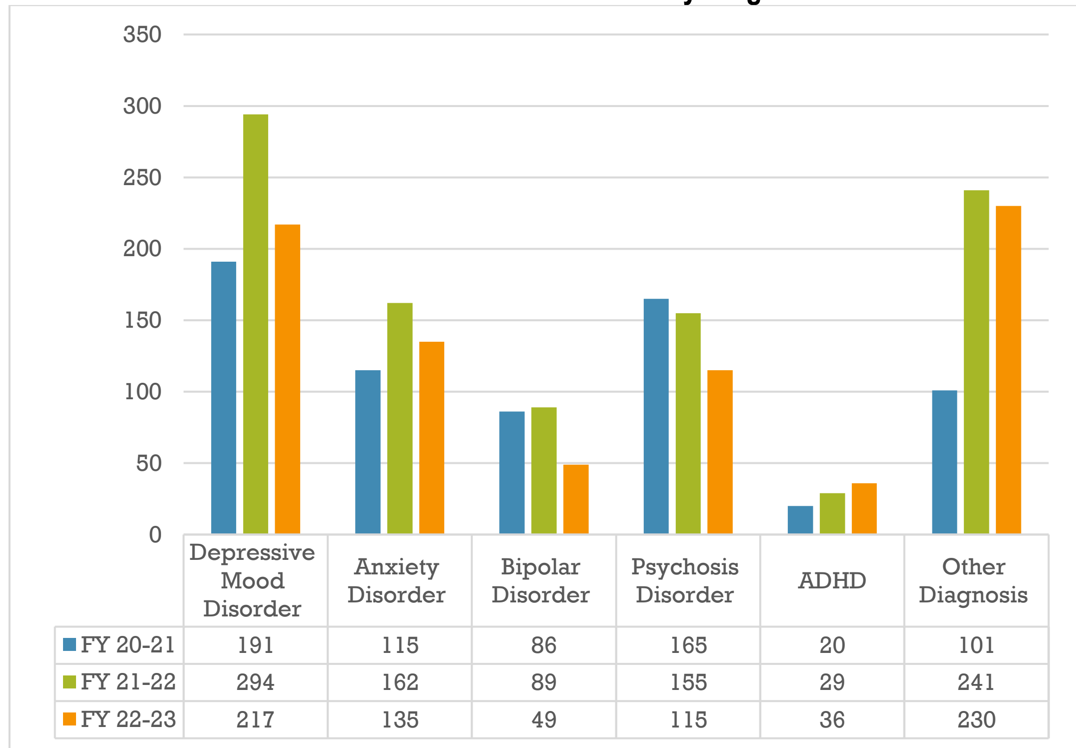
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Table 24. MHTES Served by Language



	English	Spanish	Other
FY 20-21	512	105	1
FY 21-22	650	178	1
FY 22-23	540	144	1

Table 25. MHTES Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 20-21	191	115	86	165	20	101
FY 21-22	294	162	89	155	29	241
FY 22-23	217	135	49	115	36	230

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Tables 26-29 indicate by type of service the number of contacts for July-December 2022 of FY 22-23. This information is provided for each of the MHP's four service divisions.

Table 26. Type of Services and Number of Contacts
Children Services

Division	Number of Contacts FY 20-21	Number of Contacts FY 21-22	Number of Contacts FY 22-23
Medication Education and Management	20,966	18,186	7,899
Mental Health Services	32,995	29,756	13,456
Targeted Case Management	193	154	145
Crisis Intervention	47	51	11
Intensive Care Coordination	31	41	67
Intensive Home Based Services	2,341	2,031	575

Table 27. Type of Services and Number of Contacts
YAYA Services

Division	Number of Contacts FY 20-21	Number of Contacts FY 21-22	Number of Contacts FY 22-23
Medication Education and Management	12,409	11,963	5,163
Mental Health Services	27,663	32,862	13,604
Targeted Case Management	297	292	175
Crisis Intervention	242	457	222
Intensive Care Coordination	8	15	28
Intensive Home Based Services	403	784	468

Table 28. Type of Services and Number of Contacts
Adult Services

Division	Number of Contacts FY 20-21	Number of Contacts FY 21-22	Number of Contacts FY 22-23
Medication Education and Management	37,782	29,970	13,742
Mental Health Services	29,394	25,178	9,442
Targeted Case Management	1,288	1,205	705
Crisis Intervention	563	502	220

Table 29. Type of Service and Number of Contacts
Mental Health Triage and Engagement Services

Type of Service	Number of Contacts FY 20-21	Number of Contacts FY 21-22	Number of Contacts FY 22-23
Medication Education and Management	4,479	4,795	2,625
Mental Health Services	6,383	5,803	3,357
Targeted Case Management	906	615	507
Crisis Intervention	4,015	3,825	2,159

The MHP also provides non-billable services to residents in Imperial County. These are summarized in Table 30.

Table 30. 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) MHP Contracted Providers

a) Geographic Location and Target Population

As part of the MHP's efforts to ensure mental health services are available to Imperial County residents, the MHP contracts with a variety of local and out-of-county providers:

i. *In-County*
During FY 22-23, the MHP had three contracted outpatient providers, one contracted adult crisis residential treatment services provider, and one contracted Short-Term Residential Therapeutic Program (STRTP) provider. The contracted outpatient providers are responsible for providing mental health services, targeted case management, medication support services, intensive care coordination, intensive home-based services, and therapeutic behavioral services.

Outpatient services are available to beneficiaries of all ages, while the adult crisis residential treatment services provider only serves adults age 18 and older, and the STRTP provider only serves youth placed in the facility. Contracted MHP services are available to beneficiaries throughout Imperial County.

ii. *Out-of-County*
During FY 22-23, the MHP had one contracted provider located outside of the county. This provider provides adult residential treatment services to adult beneficiaries who are referred by the MHP.

b) Services Provided

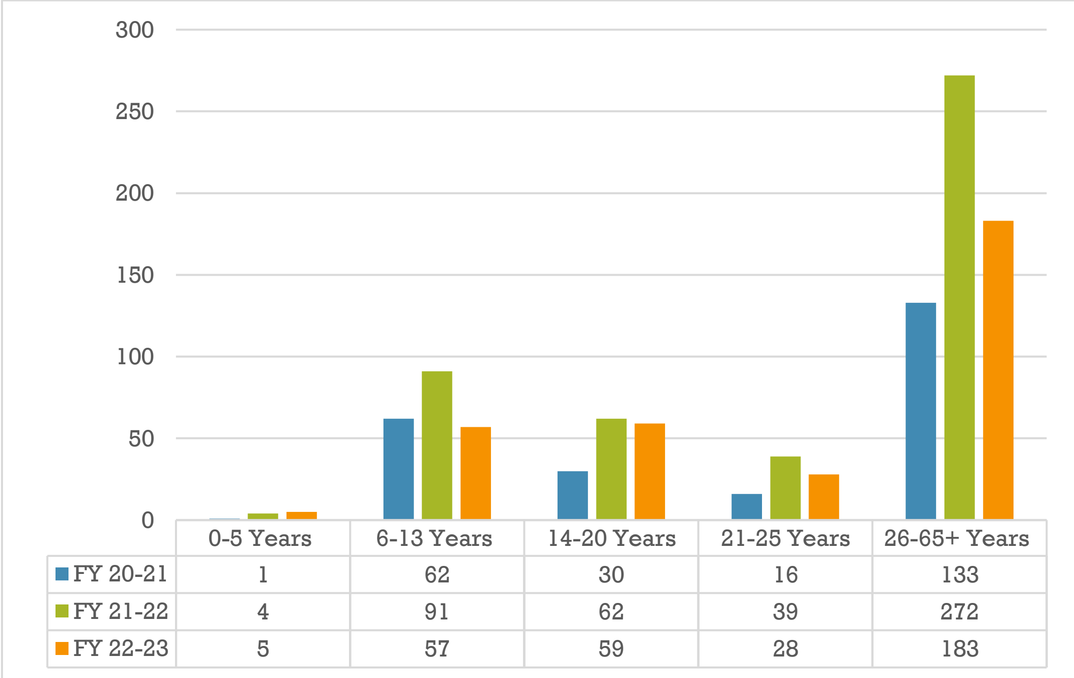
Table below indicate type of services and number of contacts provided by contracted providers during FY 22-23, in addition to a comparison for the past three years.

Table 31. Beneficiaries Served by Contract Providers

Fiscal Year	Number of Beneficiaries
FY 20-21	242
FY 21-22	468
FY 22-23*	332

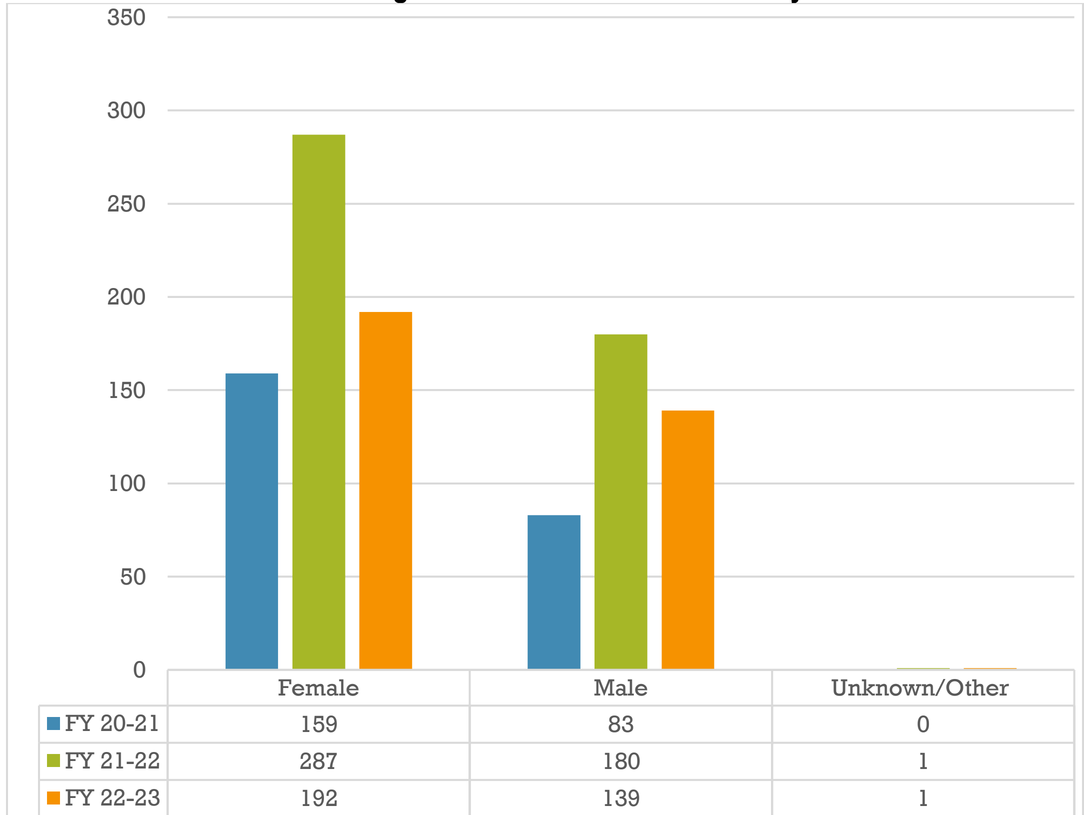
Table 32-38 indicate demographic information for beneficiaries served by the MHP Organizational Providers.

Table 32. Organizational Provider Served by Age Group



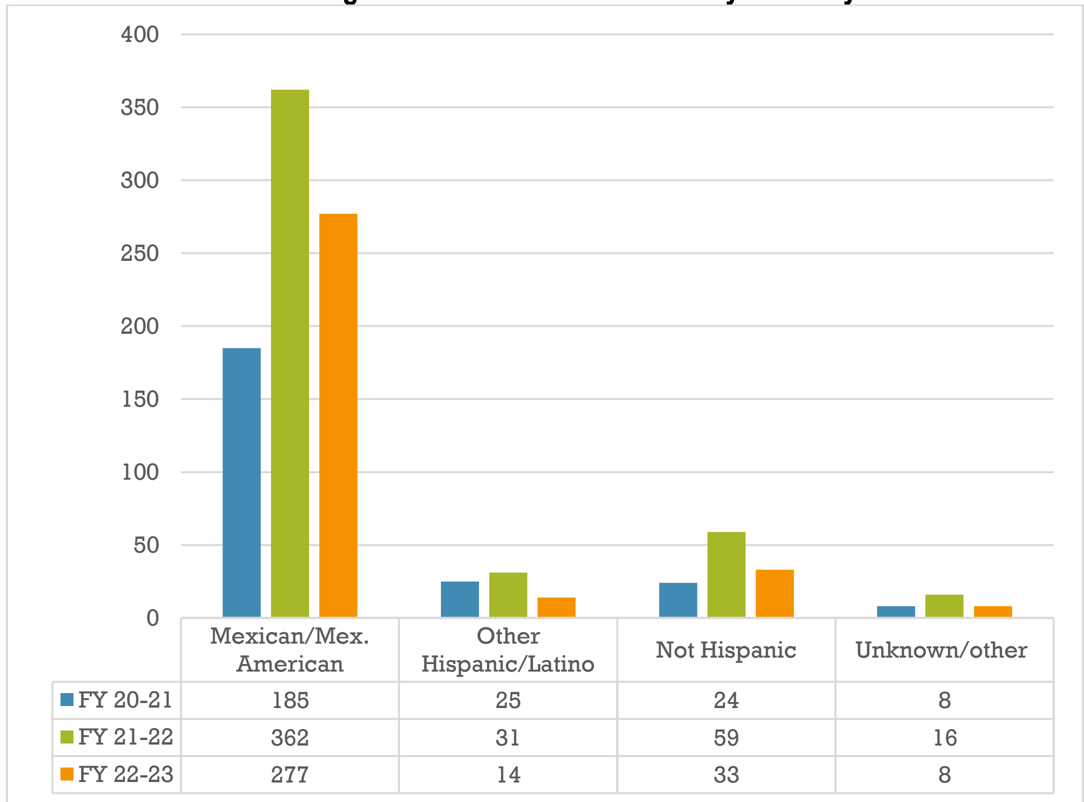
	0-5 Years	6-13 Years	14-20 Years	21-25 Years	26-65+ Years
FY 20-21	1	62	30	16	133
FY 21-22	4	91	62	39	272
FY 22-23	5	57	59	28	183

Table 33. Organizational Providers Served by Gender



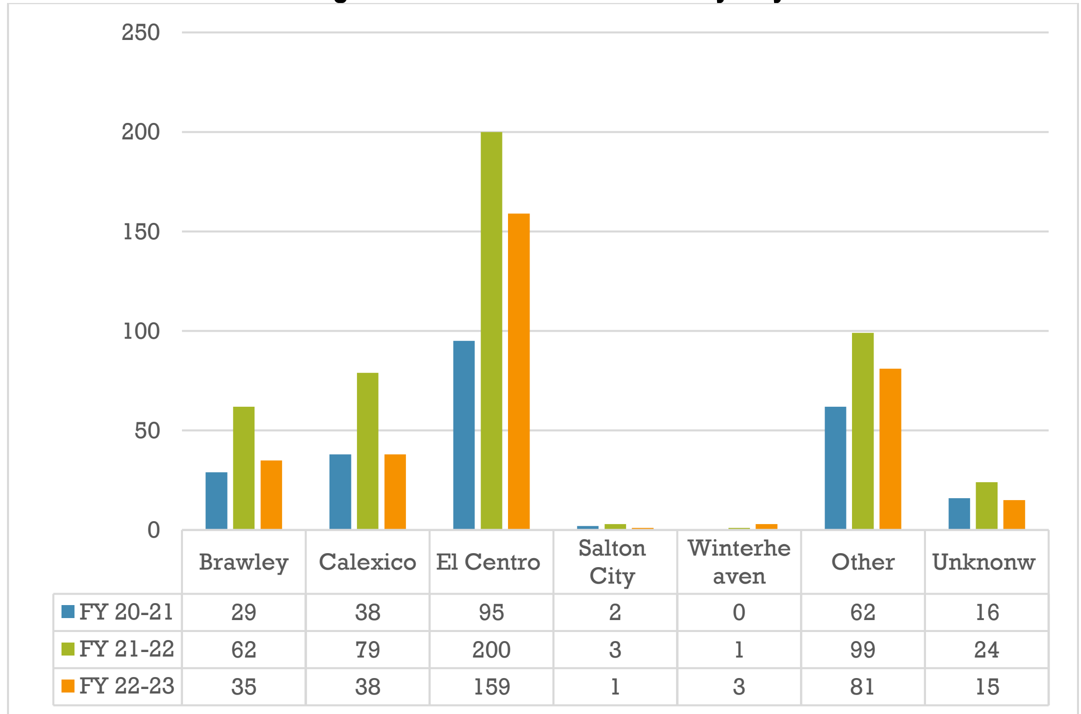
	Female	Male	Unknown/Other
FY 20-21	159	83	0
FY 21-22	287	180	1
FY 22-23	192	139	1

Table 34. Organizational Provider Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 20-21	185	25	24	8
FY 21-22	362	31	59	16
FY 22-23	277	14	33	8

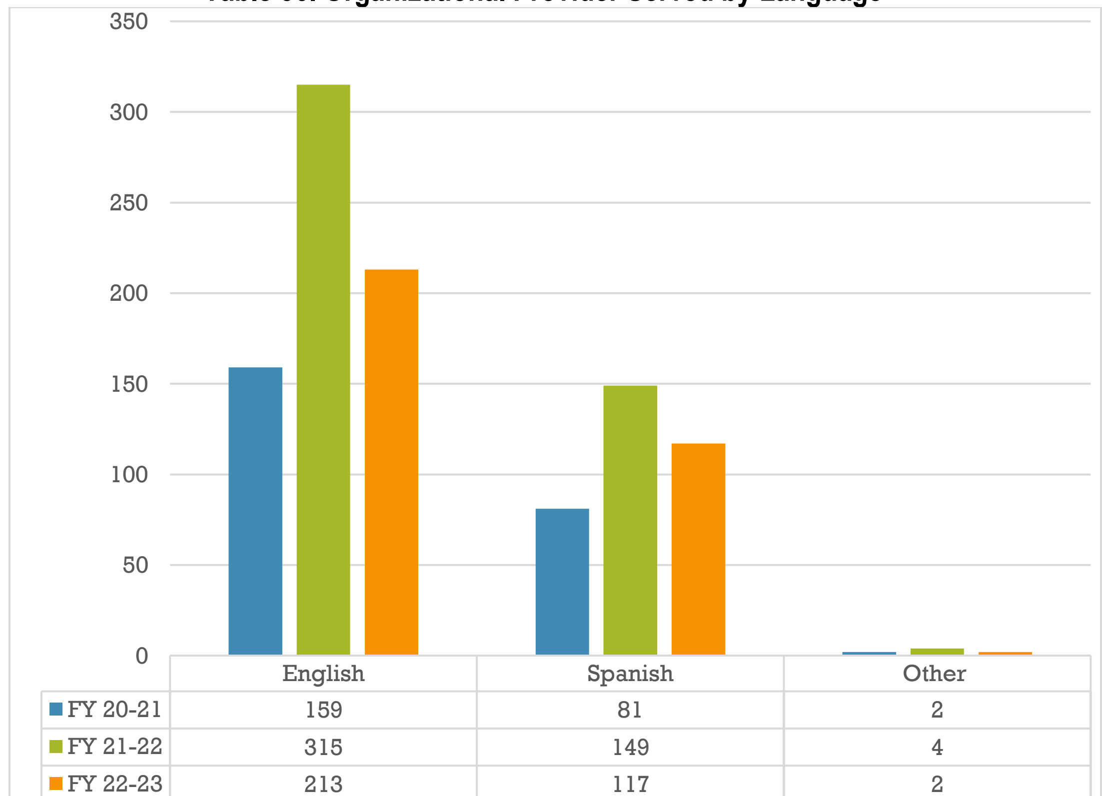
Table 35. Organizational Provider Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 20-21	29	38	95	2	0	62	16
FY 21-22	62	79	200	3	1	99	24
FY 22-23	35	38	159	1	3	81	15

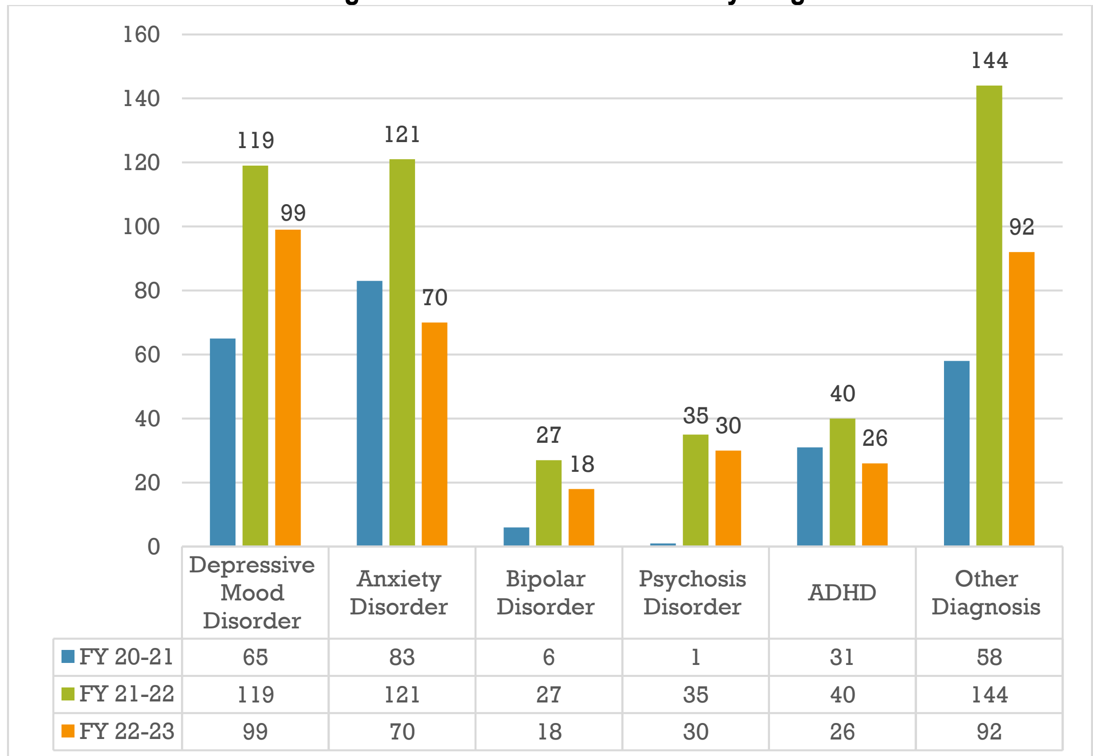
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Table 36. Organizational Provider Served by Language



	English	Spanish	Other
FY 20-21	159	81	2
FY 21-22	315	149	4
FY 22-23	213	117	2

Table 37. Organizational Provider Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 20-21	65	83	6	1	31	58
FY 21-22	119	121	27	35	40	144
FY 22-23	99	70	18	30	26	92

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Table 38. Type of Services and Number of Contacts Contracted Network Providers

Division	Number of Contacts FY 20-21	Number of Contacts FY 21-22	*Number of Contacts FY 22-23
Mental Health Services	1,635	3,021	2,582
Targeted Case Management	26	377	612
Therapeutic Behavioral Services	1,705	1,353	889
Crisis Intervention	6	12	19

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 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 39.

Table 39. 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
Urgent	Within 48-hours from the 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 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.

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 22-23, the monitoring process consisted of reviewing the Access Log report from the EHR to verify whether the MHP 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). Table 40 indicates timeliness of services for requested services.

Table 40. 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 22-23	8	7	1	88%
FY 21-22	1	1	0	100%
FY 20-21	0	N/A	N/A	N/A
Review Period	**Medi-Cal Urgent Requests**	**Appointments Offered within the 48-Hour Standard**	**Appointments Offered Over the 48-Hour Standard**	**Compliance Rate**
FY 22-23	17	15	2	88%

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 22-23	9	9	0	100%
FY 21-22	12	10	2	83%
FY 20-21	20	20	0	100%

The MHP uses the DHCS methodology for determining compliance, which is that 80 percent of beneficiaries must have been offered an appointment within the applicable time frames, depending on the type of request.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- 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 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.

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 to First Non-Urgent Services

The DHCS standard for first offered non-urgent appointment is 10 business days. The current intake process for the MHP allows for clients to be scheduled an appointment with a mental health professional if at the time of the screening the client reports an urgent request or be seen on a walk-in basis at any of the outpatient clinics. The first offered non-urgent mental health appointment is an intake assessment scheduled with a clinician.

Requests for appointments are recorded by the Access Unit. The QM Unit evaluates timeliness to services by reviewing the date of the request and determining the length of time to the first offered appointment. The QM Unit also reviews the data to determine the length of time from request to scheduled appointment, the length of time from request to completed appointment, and the percentage of appointments that were completed.

The QM Unit monitors the timeliness to first non-urgent services monthly to ensure beneficiaries are able to access services without delays. Findings are reported to the QIC at least annually.

During FY 22-23, the MHP met the 10-business day timeliness standard for 95 percent of requests for non-urgent services. The MHP has maintained a consistently high compliance rate over the last three years, as indicated in Table 41.

Table 41. 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 22-23	2,902	2,761	141	95%
FY 21-22	5,905	5,751	154	97%
FY 20-21	4,428	4,428	0	100%

During FY 22-23, 141 appointments were offered outside the 10-day timeliness standard, which is a decrease from the prior year. This decrease is due primarily to the lack of availability of clinician time as a result of many clinicians separating from the MHP within the last several years.

The MHP typically maintains consistency in requests for services throughout the year; however, historically the MHP sees a decrease year-over-year during the first quarter of the fiscal year. This is typically a result of decreases in requests for services for the children and adolescent population due to students being out of school for summer vacation.

2) *Timeliness to Urgent Services Not Requiring Prior Authorization*

The DHCS standard for urgent services not requiring prior authorization is 48 hours from the time of the initial request. Beneficiaries may request an urgent care appointment any time by contacting the 24-hour telephone line or by walking into one of the MHP's clinics. Urgent care means health care for a beneficiary whose "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit is responsible for monitoring the timeliness of urgent services and reporting findings to the QIC at least quarterly.

The QM Unit compares the time and date of initial requests for urgent care appointments to the time and date the urgent care appointment was scheduled on the EHR to determine if appointments are provided within 48 hours of initial request.

By evaluating the data gathered during July-December 2022, the MHP met the 48-hour timeliness standard for 88 percent of requests for urgent services as indicated in Table 42. The MHP's ability to meet the demand for urgent services is essential, as the risks associated with delayed treatment can be severe.

Table 42. Timeliness of Services for Urgent Conditions Not Requiring Prior Authorization

Review Period	Requests for Urgent Services	Requests Within 48-Hour Standard	Compliance Rate
FY 22-23*	17	15	88%

3) Timeliness to Urgent Services Requiring Prior Authorization

The MHP is responsible for the monitoring of requests to urgent services that require prior authorization. The MHP must review and make an authorization 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 services requiring prior authorization on a quarterly basis. The monitoring process entails a review of the Payment Authorization Unit Treatment Authorization Request Tracking Log to determine if any requests for urgent services were recorded and were authorized within the established timeframes, as required, to ensure clients receive timely interventions when presenting the need for an urgent service. There were no requests for urgent conditions requiring prior authorizations by providers, as indicated in Table 43.

Table 43. Timeliness of Services for Urgent Conditions Requiring Prior Authorization

Review Period	# of TARs Submitted	Requests for Urgent Services	Requests Within 96 Hour Standard	Compliance Rate
FY 22-23	196	0	N/A	N/A
FY 21-22	297	0	N/A	N/A
FY 20-21	253	0	N/A	N/A

4) Access to After-Hours Care

The MHP is responsible for ensuring beneficiaries have access to after-hours care. After-hours care is provided through the 24-hour toll-free telephone line, where callers are assessed for safety and urgency of need and referred to the ICBHS Triage Unit for immediate attention. ICBHS has established a one-hour standard from the time of the request to provide after-hours care.

The QM Unit compares the After-Hours Access Log call times from the EHR, which identifies the beneficiary's request for after-hours care (requests made after-hours, weekends, and holidays) to the times contacts are made to the

beneficiary by After-Hours Triage staff, to determine whether or not after-hours care was provided within one hour.

By evaluating the data gathered in FY 22-23, the QM Unit verified that access to after-hours care was provided within one hour for 98 percent of requests. This is a slight decrease when compared to last fiscal year, as indicated in Table 44.

Table 44. Access to After-Hours Care

Review Period	Requests	Within Standard	Compliance Rate
*FY 21-22	164	161	98%
FY 21-22	309	307	99%
FY 20-21	488	480	98%

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. The QM Unit's monitoring process entails conducting random test calls, during business hours and after hours, in English and Spanish, Imperial County's threshold language. Monitoring is conducted to verify that the 24-hour toll-free telephone line is available to beneficiaries 24/7.

Test calls determine the ability of the Access Unit staff to provide information related to 1) available specialty mental health services, 2) referrals for urgent services and medical emergencies, 3) information regarding beneficiary problem resolution and fair hearing process, and 4) interpreter and translation service information. Test callers also assess the Access Unit staff's ability to determine urgency of applicable test calls; ensure calls were answered within the standard of five rings; and if TTY/TDY 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 22-23, the QM Unit conducted a total of 49 test calls, 24 during business hours and 25 after hours. The Access Unit was 100 percent compliant in all the test call criteria evaluation, as indicated in Table 45.

Table 45. 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	100%	100%	100%
Access Log Criteria	**Percentage of Test Calls Where Log Requirement Was Met**		
	Business Hours	**After Hours**	**All Calls**
Name of the caller	64%	95%	82%
Date of the request	64%	100%	85%
Initial disposition of the request	57%	100%	82%

Additionally**,** the MHP determined that Access Unit staff logged 82 percent of calls, which is 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 94 percent of the calls made. Test callers requested various brochures for the MHP divisions, one Provider Directory, and two Grievance Forms.

During FY 22-23, the QM Unit determined that the 24-hour toll-free telephone line was available to beneficiaries 24/7, in both English and Spanish. Access staff were able to schedule mental health appointments for callers, provide information related to the availability of specialty mental health services, and screen for safety and urgency of need.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- The QM Unit will monitor the timeliness to non-urgent services, timeliness to urgent services, 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 QM Unit will continue to work collaboratively with Information Systems (IS) for the development of timeliness tracking within the new EHR.

3. Beneficiary/Family Satisfaction

The QM Unit monitors beneficiary/family satisfaction with the MHP through the 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 22-23:

1) *MHP Consumer/Family Satisfaction Survey*

During CY2022, the MHP administered the Statewide Consumer Perception Survey (CPS) during CY 2022 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.

To promote beneficiary/family participation, the QM Unit provided a specialized "Consumer Perception Survey Data Collection Training" to MHP staff, as well as contract provider staff. 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.

358 surveys were completed during the CY 2022 CPS period. Survey participation increased by 246 surveys from CY 2021.

82 youth surveys were completed during the CY 2022 CPS. Data shown in Table 46 indicates a significant decrease in the areas of "General Satisfaction", with a decrease of 10 percentage points; "Social Connectedness", with a decrease of 31 percentage points; and "Perception of Functioning", with a decrease of 24 percentage points. There was a notable increase in the area of "Participation in Treatment Planning", with an increase of 14 percentage points Survey findings for youths are summarized in Table 46, including a side-by-side comparison with CY 2021 findings:

Table 46. Satisfaction Rates - Youth MHSIP Consumer Perception Survey

Survey Area	CY 2020 (n=15)	CY 2021 (n=3)	CY 2022 (n=82)
General Satisfaction	91%	96%	86%
Perception of Access	90%	95%	95%
Participation in Treatment Planning	93%	80%	94%
Outcome of Services	87%	90%	94%
Social Connectedness	82%	100%	69%
Cultural Sensitivity	93%	90%	82%
Perception of Functioning	86%	90%	66%

138 youth family surveys were completed during the CY 2022 CPS. Although most areas either stayed the same or had slight improvements, there was a notable decrease in the areas of "Outcome of Services", with a 10 percentage point decrease, and "Perception of Functioning", with a 12 percentage point

decrease. Survey findings for youth families are summarized in Table 47, including a side-by-side comparison with CY 2021 findings:

Table 47. Satisfaction Rates - Youth for Families MHSIP Consumer Perception Survey

Survey Area	CY 2020 (n=17)	CY 2021 (n=27)	CY 2022 (n=138)
General Satisfaction	89%	88%	90%
Perception of Access	91%	89%	93%
Participation in Treatment Planning	91%	88%	90%
Outcome of Services	91%	80%	70%
Social Connectedness	83%	82%	87%
Cultural Sensitivity	86%	90%	96%
Perception of Functioning	88%	80%	68%

93 adult surveys were completed the during CY 2022 CPS, adult consumers reported high satisfaction perception (72 to 95 percent). Findings remained consistent from the previous year, excluding "Participation in Treatment Planning", which increased by 11 percentage points, and "Perception of Functioning", which decreased by 14 percentage points. Survey findings for adults are summarized in Table 48, including a side-by-side comparison with CY 2021 findings:

Table 48. Satisfaction Rates - Adult MHSIP Consumer Perception Survey

Survey Area	CY 2020 (n=41)	CY 2021 (n=66)	CY 2022 (n=93)
General Satisfaction	90%	86%	81%
Perception of Access	89%	88%	94%
Quality and Appropriateness	91%	87%	90%
Participation in Treatment Planning	93%	84%	95%
Outcome of Services	82%	83%	72%
Social Connectedness	86%	77%	83%
Perception of Functioning	82%	85%	71%

45 older adult surveys were completed during the CY 2022 CPS. Findings remained consistent from the previous year, excluding "Outcome of Services", which decreased by 20 percentage points, and "Social Connectedness", which decreased by 13 percentage points. Survey findings for older adults are summarized in Table 49, including a side-by-side comparison with CY 2021 findings:

Table 49. Satisfaction Rates - Older Adult MHSIP Consumer Perception Survey

Survey Area	Spring 2020 (n=2)	CY 2021 (n=16)	CY 2022 (n=45)
General Satisfaction	100%	85%	92%
Perception of Access	100%	86%	92%
Quality and Appropriateness	100%	87%	83%
Participation in Treatment Planning	100%	85%	91%
Outcome of Services	92%	90%	70%
Social Connectedness	100%	80%	67%
Perception of Functioning	98%	80%	76%

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

The QM Unit will conduct additional surveys to obtain beneficiary feedback regarding the areas identified with decreased satisfaction.

2) *Beneficiary Grievances and Appeals*

The QM Unit monitors beneficiary protection processes to ensure federal grievance and appeal system requirements are followed by the MHP and its providers. The QM Unit monitors the grievance and appeal logs to ensure grievances and appeals are investigated and resolved appropriately and that beneficiaries are informed of their rights during the grievance or appeal process.

During FY 22-23, the MHP received a total of 121 grievances (representing both Medi-Cal beneficiaries and non-Medi-Cal clients),17 standard appeals, and 12 expedited appeals. This is an increase in grievances, but a decrease in appeals when compared to FY 21-22. Table 50 summarizes the grievances and appeals by category:

Table 50. Grievances & Appeals by Category

Grievance Category	FY 20-21	FY 21-22	FY 22-23
Related to Costumer Service	0	0	0
Related to Case Management	0	0	0
Access to Care	0	2	20
Quality of Care	77	91	97
County (Plan) Communication	0	0	0
Payment/Billing Issues	1	0	0
Suspected Fraud	0	0	0
Abuse, Neglect or Exploitation	0	0	0
Lack of Timely Response	0	0	0

Denial of Expedited Appeal	0	0	0
Field for other reasons	26	7	4
Appeal Category	**FY 20-21**	**FY 21-22**	**FY22-23**
Denial or Limited Authorized or Service (s)	0	0	1
Reduction, Suspension, or Termination of a Previously Authorized Service	41	23	28
Payment Denial	0	0	0
Service Timeliness	0	0	0
Untimely Response to Appeal or Grievance	0	0	0
Denial of Beneficiary Request to Dispute Financial Liability	0	0	0

Of the grievances and appeals received during FY 22-23, acknowledgments for six grievances and two appeals were issued to the beneficiaries late; one grievance and four expedited appeals were resolved late; and four notices of appeal resolution were issued late. The QM Unit issued a corrective action plan to the applicable MHP providers to ensure grievance and appeal system requirements are followed.

The remaining grievances and appeals were resolved according to federal guidelines and to beneficiaries' satisfaction. No trends were identified in the grievances or appeals filed.

3) Requests to Change Persons Providing Services

The QM Unit monitors requests to change persons providing services to identify trends with providers or programs and to also ensure beneficiary concerns related to treatment providers are addressed.

During FY 22-23, the MHP received 232 requests to change persons providing services from Medi-Cal beneficiaries, which is an increase when compared to 187 requests received in FY 21-22. In addition, ICBHS received 23 requests to change person providing services from non-Medi-Cal clients. The clinical managers assigned to the MHP evaluated each request to change persons providing services and discussed the reason for the request with the client/authorized representative, unless unable to contact. When appropriate, clinical managers encouraged the beneficiary/authorized representative to discuss concerns with the provider. All beneficiaries/authorized representatives were notified of the decision by telephone, by mail, or in person within the requisite 14 business days.

The MHP approved 222 (96 percent) and denied 10 (4 percent) of the requests, representing both Medi-Cal beneficiaries and non-Medi-Cal clients. Six requests were withdrawn. Table 51 summarizes the requests to change persons providing services by category:

Table 51. Reason for Request for Change of Provider

Reason	FY 20-21	FY 21-22	FY 22-23
Quality of Care Treatment Concerns	0	18	57
Quality of Care-Staff Behavioral Concerns	0	7	20
Service Not Available	0	9	18
Request Transfer to Another Clinic	0	4	2
Language Barrier	0	13	10
Not Feeling Comfortable with Provider	0	5	10
No Therapeutic Alliance with Provider	0	10	5
Dissatisfaction with Provider	70	27	22
Disagreement with Course of Treatment	36	44	1
Confidentiality	0	2	0

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

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

- The QM Unit will conduct additional surveys to obtain youth beneficiary feedback regarding the areas identified with decreased satisfaction.

- The MHP will implement corrective action to ensure the grievance and appeal system requirements are implemented appropriately to ensure the protection of beneficiary rights when filing grievances and appeals.

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 medication monitoring and chart reviews.

During FY 22-23, as part of the CalAIM initiative, ICBHS trained all current providers on the new policies related to increasing access to MHP services for adults and children, documentation reform, and providing treatment during the assessment period prior to diagnosis. These policy changes were incorporated into the QM Unit's monitoring of the MHP service delivery.

a. **Overview of the MHP objectives, scope, and planned activities for FY 22-23:**
   1) ***Medication Monitoring***

      a) *Medication Monitoring Committee*
      The Medication Monitoring reviews are conducted monthly by nine MHP adult and child psychiatrists, a pharmacist, and the Medical Director. Utilizing a review tool, the Medication Monitoring Committee monitors the MHP's service delivery system, including telepsychiatry, 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 adults, and adults receiving medication support services; and address any quality of care concerns or outliers identified related to medication use.

      The charts are randomly selected from the EHR or through quality of care referral 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. The QM Unit also ensures that management receives a copy of reports and completed tools, as appropriate.

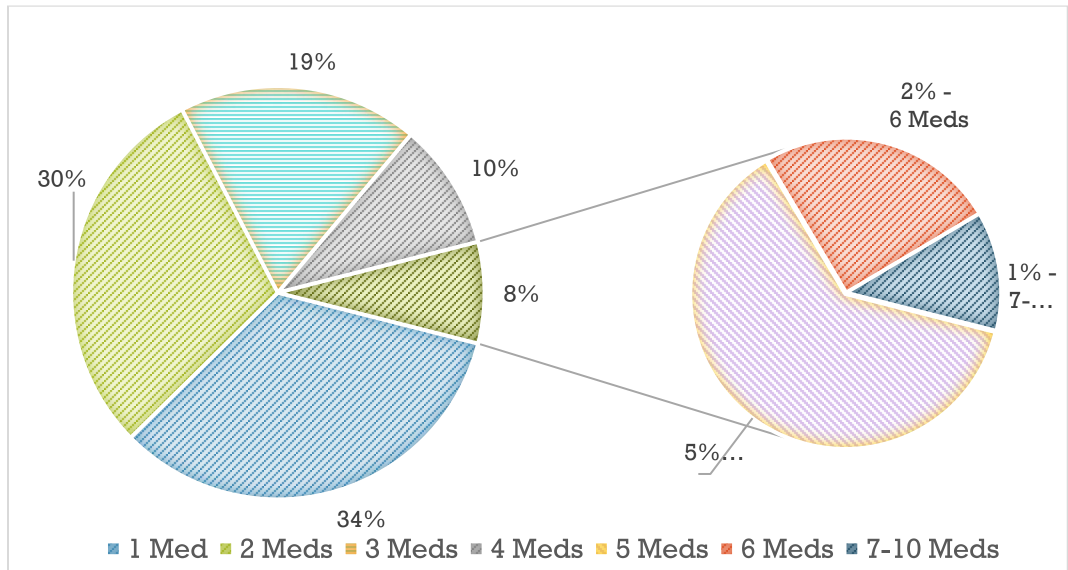
      Report findings, including areas of concern and areas identified as opportunities for improvement, are discussed with the MHP psychiatrists by the Medical Director at each monthly meeting.

      During FY 22-23, the medication monitoring committee reviewed 253 charts: 76 from Adults Services, 92 from Children Services, and 85 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 the fifteen areas evaluated, with the exception of "Are medication consent forms completed appropriately, up to date and signed by the physician/provider" at 66 percent compliance, and "Are AIMS completed in the last 12 months of treatment as required" at 80 percent compliance. No significant findings were otherwise identified, which indicates that MHP prescribers are following best practices in the implementation of medication support services.

      b) *Use of Psychotropic Medications*
      The QM Unit monitors the use of psychotropic medications to provide an overview of the utilization of all psychotropic medications by age. Knowledge of how and with whom psychotropic medications are utilized is a valuable tool for achieving optimum client care that reduces symptoms and in the clients' ability to attain a normal life.

      Sample data was collected from the *Psychotropic Medication* report in the EHR for Quarter 1 and Quarter 2 of FY 22-23 and analyzed by number of medications prescribed per individual by age group, number of medications by category and age group, and by diagnoses by age group.

Of the sample of 400 individuals prescribed psychotropic medications, a majority (62%) were prescribed one or two psychotropic medication(s). Those prescribed three, four, or five medications accounted for 19 percent, 11 percent, and 4 percent (total of 34 percent). Those prescribed 6 to 10 medications accounted for 4 percent. Most individuals prescribed psychotropic medications were between the ages of 13 and 65 years: 52 percent of those prescribed one or two medications were ages 13 to 45 years; however, 76 percent of those prescribed three to five medications were between the ages of 20 to 65 years. The chart below illustrates the distribution of individuals by number of medications prescribed.



An analysis of the number of medications by age group indicates individuals between the ages 20 to 65 years were most likely to be prescribed three or more medications. They account for 66 percent of the individuals prescribed three medications and 88 percent of individuals prescribed four medications – this is 59 percent of all individuals prescribed three or more medications. Table 52 below shows the number of medications prescribed per individual by age group.

Table 52. Concurrent Psychotropic Medications by Age Group

Age Group	1 Med	2 Meds	3 Meds	4 Meds	5 Meds	6 Meds	7-10 Meds	Total	
								#	%
0-12	24	22	9	2	-	1	-	58	15%
13-19	37	28	9	2	2	1	-	79	20%
20-45	38	34	28	23	7	1	3	134	34%
46-65	19	26	21	13	9	4	2	94	24%
65+	11	11	7	4	1	0	1	35	9%
Totals	129	121	74	44	19	7	6	400	100%
Percentage	32%	30%	19%	11%	5%	2%	2%	100%	

The analysis of psychotropic medications by number of prescriptions and medication category indicates antidepressants were the most frequently prescribed, accounting for 36 percent overall. The second and third most

frequently prescribed were antianxiety (19%) and antipsychotic (18%). Mood stabilizers and non-stimulants were the least prescribed with 9 percent and 5 percent, respectively. The utilization of these medications is shown by percentage of prescriptions by medication category and age in Table 53 below. Percentages are calculated based on the total number of prescriptions by medication category.

Table 53. Number of Prescriptions by Age Group

Medication Category	Number of Prescriptions by Age Group					
	0-12	13-19	20-45	46-65	65+	Total
Antianxiety	3	16	120	87	26	252
	1%	6%	48%	35%	10%	19%
Antipsychotic	17	25	95	75	20	232
	7%	11%	41%	32%	9%	18%
Antidepressant	23	76	191	130	47	467
	5%	16%	41%	28%	10%	36%
Mood Stabilizer	4	7	43	46	16	116
	3%	6%	37%	40%	14%	9%
Stimulants	82	58	18	1	-	159
	52%	36%	11%	1%		12%
Non-Stimulants	47	17	8	4	-	76
	62%	22%	11%	5%		6%
Other	-	-	9	3	1	13
			69%	23%	8%	1%
Total # Prescriptions	176	199	484	346	110	1315
Percent	13%	15%	37%	26%	8%	100%

Although a review of diagnoses indicates ADHD and MDD as the overall most frequent diagnoses with 24 percent and 23 percent, respectively, the ADHD diagnoses were found primarily in the ages 0-19 years, and Bipolar and Schizophrenia were found primarily in the ages 20–65 years. However, GAD and MDD were represented across all ages with smaller proportions in the 0-12 age group with 7 percent and 5 percent, respectively, whereas Schizoaffective (1%), Schizophrenia (1%), and PTSD (2%) had the smallest proportions in the 13-19 age group. Diagnoses are shown by age group in Table 54 below.

Table 54. Diagnosis Age Group

Diagnoses	Age Groups					Total	
	0-12	13-19	20-+45	46-65	65+	#	%
ADHD	46	31	7	-	-	84	21%
Adjustment	1	1	1	-	-	3	1%
Bipolar	-	4	27	26	6	63	16%
Conduct/Impulse	-	3	2	1	-	6	2%

DMDD	2	1	1	-	-	4	1%
GAD/Anxiety	5	13	23	9	10	60	15%
MDD	3	17	38	29	12	99	25%
Mood	-	2	-	1	1	4	1%
Panic	-	-	3	1	-	4	1%
PTSD	-	2	4	4	3	13	3%
Schizoaffective	-	1	10	2	1	14	4%
Schizophrenia	-	1	14	19	2	36	9%
Other	1	3	5	1	-	10	3%
Totals	58	79	135	93	35	400	100%

c) *Behavioral Health Medication Treatment – Healthcare Effectiveness Data and Information Set (HEDIS)*

The QM Unit evaluates the MHP's medication practices through the lens of several Healthcare Effectiveness Data and Information Set (HEDIS) measures. The purpose of reviewing the MHP's data against HEDIS measures is to ensure the quality of care for the beneficiaries receiving medication from the MHP and provide the best outcomes for the MHP's beneficiaries. Ensuring quality of care helps prevent over medication and encourages utilization of alternative interventions, while providing a means to see whether medications are needed and how well they are working. Providing the best outcomes helps in promoting recovery thereby reducing suffering and improving quality of life for consumers and contributes to determining what are best practices.

Findings are shared with the Medical Director and are also utilized to update the Medication Monitoring Committee's chart review tool as needed. Cases are also referred for a quality of care review when warranted.

i. *Antidepressant Medication Management (AMM)*
Monitoring the use of antidepressants plays an important role in mental health, particularly with the prevalence of depressive disorders in recent years. Based on best practices recommendations, individuals 18 years and older who are treated with antidepressants and diagnosed with major depression should remain on medication treatment. Data gathered in monitoring provides information that can assist in determining treatment strategies and protocols that may increase adherence and thus improve their outcomes for these individuals.

The QM Unit monitors the management of antidepressant medications in adults using the HEDIS criteria, which is to assess adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. Data is collected from the EHR and analyzed to determine adherence to prescribed medication treatment according to two rates:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).

Effective Acute Phase of Treatment
Of adult clients who began treatment during July-December 2022, 92 percent were prescribed an antidepressant medication and 67 percent remained on the medication for at least 84 days (12 weeks).

The average time for the 67 percent that remained the 84+ days was 139 days. Most of the individuals were between the ages of 21 and 45 years

Effective Continuation Phase Treatment
A total of 78 individuals who met the criteria for AMM were reviewed adherence for durations of 180 days or more. 49 (63%) met or exceeded the 180-day criteria. The average days ranged from 233 days to 321 days; ages ranged from 18 to 67 years of age; and the number of enrollments ranged from one admission to 21 admissions with the MHP.

ii. *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*
The APP HEDIS measure assesses percentage of children and adolescents newly started on antipsychotic medications without a clinical indication who had a documentation of a psychosocial intervention (PSI) as first-line treatment. The utilization of PSI as a first intervention for children and adolescents may prevent the need for medication and improve outcomes. Often the solution to mental health issues in this population is better addressed with therapy and/or case management to assist individuals with coping mechanisms, behavior modification, changing one's perspective of a situation or assisting parents with techniques that aide the client and relieve stress for the adult, all of which mean better outcomes for the client.

Data is collected from the EHR and analyzed to determine whether children and adolescents, without an indication for antipsychotic medication use, had documentation of psychosocial care as first-line treatment. A review of medications prescribed to children and adolescents during July-December 2022 revealed few individuals were prescribed antipsychotic medications. Antipsychotic medication was prescribed to 10 (5%) of the children and adolescents receiving concurrent PSI and medication interventions. Of these 10 individuals prescribed antipsychotic medication, 9 (90%) were adolescents and 1 (10%) was a child. In nine of the cases, the antipsychotic medication was prescribed prior to the PSI, on average 98 days prior.

Although the percentage of children and adolescents prescribed antipsychotic medication is relatively low, there are variables in the times medications are initiated in relation to the initiation of PSI, and which PSI are most or least utilized by age, as well as diagnoses. These may be considered in the future for further review.

iii. *Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*

The SAA HEDIS measure assesses adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80 percent of their treatment period. Lifelong treatment is required to manage these illnesses, whether or not symptoms are currently present. Antipsychotics are the medications most commonly prescribed and are often prescribed in combination with other medications. This requires monitoring to ensure both the best combination of medications are prescribed and that they are prescribed at the lowest effective dose. Monitoring allows both the prescriber and the individual to exchange information and determine adjustments to treatment.

Data is obtained from the EHR and analyzed for these criteria: 1) ages 19 through 64 years, 2) diagnosed with schizophrenia, 3) dispensed an antipsychotic medication, 4) remained on the antipsychotic medication at least 80 percent of their treatment period. A sample of individuals was reviewed during FY 22-23, 36 in Quarter 1 and 50 in Quarter 2, for a total of 86 individuals diagnosed with schizophrenia, 19 years or older and prescribed an antipsychotic medication; this was 25% of individuals that met the criteria for review.

Of these 86 individuals, the overall adherence rate was 67 percent for those who remained on antipsychotic medication at least 80 percent of their treatment time. Adherence measures ranged from 80 percent to 100 percent as shown below:

- 62 percent remained on medication 95 percent to 100 percent of treatment time,
  - Average adherence rate was 98 percent of treatment time
  - Ages ranged from 24 to 64 years
- 29 percent remained 85 percent to 94 percent of treatment time
  - Average adherence rate was 97 percent of treatment time
  - Ages ranged from 25 to 61 years
- 9 percent remained on medication 80 percent to 84 percent of treatment time
  - Average adherence rate was 82 percent of treatment time
  - Ages ranged from 26 to 50 years.

Although the overall adherence rate was 67 percent, there was little correlation between the length treatment time in treatment and time remaining on antipsychotic medication. Those with the longest

treatment times may have periods when antipsychotics are not prescribed, but the individual remains on other psychotropic medications, and may be prescribed an antipsychotic at a later time in treatment. These gaps can be attributed to non-adherence with treatment, or an individual's request to use only other psychotropic medications.

iv. *Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*

The APC HEDIS measure assesses the percentage of children and adolescents who were on two or more concurrent antipsychotic medications for an extended period during the year. The prescription of antipsychotics to this population has gained importance in recent years due to increased use which raises concerns of side effects and the risk of health complications as individuals mature. Monitoring the prescription of antipsychotics in children and adolescents helps in the development of best practices and improves outcomes for this population.

Data is collected from the EHR and selected by criteria of age and prescribed antipsychotic medication. This data is then analyzed by age groups: children 0-12 years and adolescents 13-19 years. The MHP's percentage of children and adolescents prescribed two or more antipsychotic medications is relatively low during Quarter 1 and Quarter 2 of FY 22-23, with 7 percent overall: 6 percent for children and 8 percent for adolescents; however, adolescents accounted for 74 percent of those prescribed two or more antipsychotic medications. The combined average time children and adolescents remained on the antipsychotic medication was 310 days: adolescents averaged 412 days compared with children 197 days.

There was difference of 37 percent in the overall time on antipsychotics between the age groups with adolescents remaining longer; however, this was influenced by a significant increase in adolescent time in Quarter 2 compared with Quarter 1. Most individuals had prior enrollments with the MHP (77%): 23 percent had one enrollment, while the multiple enrollments were 40 percent with triage admissions or hospitalizations, or SUD treatment admissions, accounting for 7 percent and 10 percent respectively.

v. *Follow-Up Care for Children Prescribed ADHD Medication (ADD)*

A timely first appointment following the prescription of medication is important to ensure consumers are tolerating and benefitting from the medication, and provides the prescriber an opportunity to assess the effectiveness and adjust dosage or change the medication. This leads to improved outcomes for patients.

For children prescribed ADHD medication, the QM Unit evaluates follow-up care through the ADD HEDIS measure. Data is collected from

the EHR and analyzed to assess follow-up care for children prescribed an ADHD medication according to two rates:

- Initiation Phase: Assesses children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.
- Continuation and Maintenance Phase: Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the nine months after the Initiation Phase.

Initiation Phase
During FY 22-23 Quarter 1 and Quarter 2, there were 142 children that met the criteria of age and diagnosis: 82 (58%) were prescribed medication, 31 (22%) were pending the prescription of medication, and 29 (20%) were provided only psychosocial interventions.

Of the 82 children prescribed ADHD medication, all were scheduled a first follow-up: 47 (57%) were scheduled within 30 days, 31 (38%) were scheduled within 31 to 60 days, and 4 (5%) were scheduled over 60 days.

Continuation and Maintenance Phase
During FY 22-23, the QM Unit reviewed data for children reported in the Initiation Phase during January-September 2022, which was a total of 97 children. There were 69 children who had a prescription for ADHD medication during this timeframe: 46 (75%) met the criteria for remaining on medication for at least 210 days. These children had at least two follow-up visits with a prescribing practitioner within 9 months after starting the medication.

2) *Chart Reviews*

a) *Quality of Care Reviews*

The MHP has the responsibility to detect and address concerns related to poor quality of care, including, but not limited to: inaccurate diagnosis, medication malpractice, treatment that is not medically necessary, clinical interventions that are outside the scope of the provider, underuse and overuse of treatment services, services that are unethical or culturally inappropriate, and treatment that jeopardizes the safety and well-being of the client. When quality of care concerns are identified by MHP staff or contracted providers, the QM Unit is notified by submitting a Quality of Care Referral Form. The QM Unit will assign the case for a second level review by the Medication Monitoring Committee or to an individual reviewer such as a Quality Improvement Specialist, Program Supervisor, Program Manager, licensed clinician, registered nurse, or the Medical Director. Findings are presented to the program supervisor and manager, as appropriate.

During FY 22-23, the QM Unit received quality of care referrals for 14 clients served by the MHP. There were no quality of care concerns identified; however, recommendations for improvements were made to the treatment team(s) assigned to each case. Two corrective action plans were also issued. A summary of findings were presented to the QIC.

The QM Unit made the following recommendations to the QIC as a result of the quality of care reviews conducted during FY 22-23:

- Ensure meaningful care coordination takes places between mental health providers, significant supports, and/or community agencies to support the client towards decreasing functional impairments and improving their overall mental health condition.
- 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.

b) *Quality Management Chart Reviews*

The QM Unit has the responsibility of monitoring the MHP's service delivery system to ensure beneficiaries receive quality mental health treatment. Based on the MHP's contract with DHCS, the Quality Management Unit reviewed documentation to assess the quality of services provided to beneficiaries.

The quality management chart reviews were conducted by the QM Unit for each service division of the MHP. The QM Unit utilized a chart review tool that evaluated the following areas: Access to Specialty Mental Health Services, Assessment/Reassessment, Problem List, Treatment Interventions, Care Coordination, and Other Areas of Review. The QM Unit compiled reports that identified opportunities for improvement and areas of concern, as appropriate. Division reports were provided to Deputy Directors and Behavioral Health Managers. Areas of concern required a corrective action plan. The QM Unit approved corrective action plans, prior to implementation, and followed up with each division to ensure all corrective actions were completed, as appropriate.

During FY 22-23, the QM Unit reviewed 90 clinical and case management charts for the MHP, of which 30 charts were for Children Services, 30 charts were for Youth and Young Adults Services, and 30 charts were for Adults Services. The below summary of findings were areas identified as needing correction.

Assessment/Re-Assessment

- No assessment of ICC/IHBS.
- No ongoing assessment of the presenting problem.
- No evidence of outcome measurement tools being administered, as required.
- No clinical interpretation of measurement outcome tools to evaluate progress throughout the course of treatment.

Problem List

- No evidence of client(s) participation and/or contribution in the development of the Problem List.
- Problems identified by the provider/treatment team were not included in the Problem List.

Treatment Interventions

- No clear description of the purpose of the intervention and how it addresses the presenting problem and/or mental health condition.
- Interventions provided were ineffective and there is no evidence of making treatment changes.
- Interventions provided don't match the presenting problem or the behaviors listed in the Problem List.
- No evidence of involving client's support system/person to assist client with mental health treatment, as appropriate.
- No attempt to facilitate home and/or school visits, as appropriate.
- No plan for follow up or future encounters for the provider and/or client and to evaluate effectiveness of the intervention.

Care Coordination

- No care coordination with outside resources and family support to coordinate care to support client with recovery.
- No care coordination with treatment team to discuss treatment approaches, as appropriate.
- No valid release of information with outside support that is being used for treatment.
- Releases of information not properly scanned in the client's EHR.
- No follow up/care coordination after a crisis admission.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

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

- The QM Unit will continue to evaluate data against HEDIS measures to ensure quality of care and positive outcomes for beneficiaries prescribed medication. The QM Unit will also seek to work with the QIC and the Medical Director to establish performance benchmarks for the relevant HEDIS measures.

- The MHP will implement performance improvement interventions, as required, according to the applicable HEDIS measures as mandated by DHCS.

- The MHP will implement appropriate interventions to ensure meaningful care coordination takes places, when appropriate, and that home visits are conducted, when appropriate.

- The MHP will implement interventions to ensure improvements are made in the areas of Assessment/Re-Assessment, Problem List, Treatment Interventions, and Care Coordination, as identified by the QM Unit.

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.

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

1) Care Coordination & Continuity of Care

During FY 22-23, 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.

The reviews are included as part of the quality management chart review process and entail assessing access to care, coordination of services, and referrals to community resources. The QM Unit reviewed 90 clinical charts and identified the following trends:

- No care coordination with outside resources and family support to coordinate care to support client with recovery.
- No care coordination with treatment team to discuss treatment approaches, as appropriate.

The QM Unit issued the corrective action plans and worked closely with clinical staff to monitor the implementation of the corrective action to ensure provider coordinate care for beneficiaries, as appropriate.

During FY 22-23, the MHP also began the implementation of the adult and youth screening and transition of care tools for Medi-Cal mental health services. The screening and transition of care tools guide referrals to the Medi-Cal mental health system that is expected to best support each beneficiary. Through the implementation of the screening tool, Medi-Cal beneficiaries are able to have their needs addressed more rapidly by connecting them to the appropriate level of care. The screening tool has also been useful in more clearly identifying urgency of need and connecting beneficiaries to a MHP staff person who can provide crisis intervention services when needed.

The transition tool allows for beneficiaries to more easily step-down to a lower level of care and link them to providers that can address their immediate needs.

Once the MHP is able to fully optimize the new EHR, SmartCare, it is anticipated that reporting will be available regarding the beneficiary outcomes of utilizing the screening and transition of care tools.

2) Memorandum of Understanding with Manage Care Plans

The MHP 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 22-23, 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. In CY 2024, Imperial County will have two new MCPs that the MHP will need to establish relationships with.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- 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 QM Unit will work with the Information Systems Unit to develop reporting mechanisms on the outcomes associated with implementing the Medi-Cal screening and transition of care tools.

- The MHP will partner with the two new MCPs assigned to Imperial County effective January 1, 2024, in order to coordinate care for Imperial County Medi-Cal beneficiaries.

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 22-23:

The QM Unit monitors provider complaints and appeals and reports the findings to the QIC at least annually.

During FY 22-23, 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 22-23, no complaints were reported to the QM Unit, as indicated in Table 55.

Table 55. Inpatient and Outpatient Provider Complaints

Period	Number of Complaints	Reason for Complaint	Resolved	
			Yes	No
FY 22-23	0	N/A	-	-
FY 21-22	0	N/A	-	-
FY 20-21	0	N/A	-	-

In FY 22-23, no appeals were reported to the QM Unit, as indicated in Table 56.

Table 56. Inpatient and Outpatient Provider Appeals

Period	Number of Appeals	Reason for Appeal	Appeals Denied	Appeals Approved
FY 22-23	0	N/A	-	-
FY 21-22	1	Denial of Payment	1	0
FY 20-21	0	N/A	N/A	N/A

During FY 22-23, 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 23-24:

- 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 MHP staff as needed to resolve complaints at the lowest possible level.

7. Timeliness of Services

Outside of the state-mandated timeliness monitoring, the QM Unit monitors additional areas for timeliness of services. These include timeliness of follow-up after hospitalization for mental illness and timeliness to initial psychiatric assessment for medication support services.

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

1) Follow-Up After Hospitalization for Mental Illness (FUH)

Follow-up after hospitalization for mental illness is a HEDIS measure that assesses the percentage of inpatient discharges for diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days and 30 days. Monitoring for timeliness of follow-up after hospitalization is essential as individuals hospitalized for mental health disorders often do not receive adequate follow-up care. By receiving appropriate and timely follow-up care, clients are more likely to have positive outcomes and have a reduced risk for readmission to a hospital.

During FY 22-23 the QM Unit monitored the timeliness to first *psychiatric* appointment after a hospitalization, as the MHP has established a standard of providing a psychiatric assessment within 7 business days of discharge for all clients who are hospitalized. Beginning FY 23-24, the QM Unit will begin measuring against all follow-up care appointment types, regardless of provider.

The monitoring process entails collecting data for all clients who are discharged from a psychiatric hospital. The data sources utilized are the Hospitalization Log, which identifies the clients who were hospitalized, their date of admission, and their date of discharge, and the EHR, which includes documentation regarding clients' treatment history, claims, and the date of the first psychiatric appointment and other appointments scheduled.

During FY 22-23, there were a total of 198 hospitalizations. Of those, 80 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 (5%); residing out of county (26%); being unable to make contact with (7%); or refusing services (3%).

Of the 118 clients that received follow-up psychiatric appointments, 86 (73%) were actively receiving services from the MHP and 32 (27%) were not. The average wait time to receive an appointment was 5 days for active clients and 10 days for inactive clients.

During FY 22-23, the MHP was 84 percent compliant in meeting the standard for scheduling a follow-up psychiatric appointment within 7 business days after a hospitalization, which is a decrease from the previous year. For inactive clients, the MHP scheduled follow-up psychiatric appointments within 7 business days after a hospitalization 69 percent of the time, which is also decrease from the previous year.

Of the 118 clients that received a follow-up psychiatric appointment, 97 percent received an appointment within 8 to 30 days after hospitalization.

A comparison to prior years is included in Table 57.

Table 57. Timeliness of First Psychiatric Appointment After a Hospitalization

Active Clients					
Review Period	Clients Hospitalized	Received F/U Appt. in 7 Days	Received F/U Appt. in 8-30 Days	Avg. Wait Time For Appt.	Complianc e Rate
FY 22-23	86	70	85	5 days	84%
FY 21-22	56	51	56	3 days	91%
FY 20-21	49	42	48	5 days	86%
Inactive Clients					
Review Period	Clients Hospitalized	Received F/U Appt. in 7 Days	Received F/U Appt. in 8-30 Days	Avg. Wait Time For Appt.	Complianc e Rate
FY 22-23	32	22	30	10 days	69%
FY 21-22	23	20	23	5 days	87%
FY 20-21	26	23	26	4 days	88%

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. The timeliness standard for the first offered appointment is 30 business days. This timeliness standard benefits beneficiaries by offering specialty mental health services timely without delays upon determination of need by the assessing clinician and obtaining the appropriate care to improve beneficiaries' quality of life.

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 business 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. Appointment wait times greater than 30 business days indicate opportunities for improvement.

The monitoring process consists of collecting data related to the initial intake assessment and the offered IPA appointments from the EHR and removing entries for clients that are screened out at the time of the intake assessment as well as those that had no scheduled IPA.

A summary of the data for each division and the MHP is included in Table 58. During FY 22-23, the QM Unit was only able to obtain data for Quarter 1 and Quarter 2. Currently, the new EHR doesn't allow for tracking of offered IPAs.

Table 58. Timeliness to Initial Psychiatric Assessment

Division	FY 21-22			FY 22-23		
	Scheduled IPAs	Compliance Rate	Avg. Wait Time	Scheduled IPAs	Compliance Rate	Avg. Wait Time
Children Services	353	32%	29 days	182	36%	32 days
YAYA Services	380	47%	30 days	189	52%	28 days
Adults Services	704	39%	20 days	386	32%	31 days
MHTES	369	38%	12 days	222	51%	20 days
MHP	**1,806**	**38%**	**24 days**	**979**	**41%**	**28 days**

Due to the limited data set for FY 22-23, the QM Unit is unable to compare the data to previous fiscal years. It is unknown at this time if the new EHR will have available a method for tracking offered IPAs.

a. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- 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 QM Unit will begin measuring timeliness of follow-up after hospitalization for mental illness against all types of follow-up appointments.
- The QM Unit will work with the Information Systems Unit to explore the feasibility of updating the new EHR to capture data related to offered IPAs.

5. No Show Rates

To maximize service delivery capacity and expand the service delivery to MHP consumers, the QM Unit monitors, tracks, and analyzes the no show rates for psychiatrist, clinician, and nurse appointments. 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. Data related to appointments by category was collected from the EHR for all clients receiving services from the MHP. This assists the MHP in evaluating client engagement in services and identifying possible barriers to treatment or causes of non-adherence. By effectively monitoring no show appointments, the MHP is able to implement interventions to increase client engagement and decrease wait times for services.

For FY 22-23, data collected is limited to Quarter 1 and Quarter 2.

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

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)

Report findings reflect that the MHP no show rate to IPA was 19 percent during FY 22-23, which is a decrease when compared to FY 21-22. The Children Services Division demonstrated a high no show rate of 23 percent for FY 22-23, which is above their benchmark. Trends for the Children Division were identified at the program-level and were shared with management. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 59:

Table 59. 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 22-23	63	23%	63	24%	71	19%	13	7%	210	19%
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%

b) No Show Rates to Medication Support Appointments

Report findings reflect that the MHP no show rate to medication support appointment was 15 percent during FY 22-23, which is a decrease when compared to FY 21-22. No trends were identified. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 60.

Table 60. 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 22-23	399	14%	380	18%	742	15%	1,521	15%
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%

2) *Clinician No Show Rates*

a) *No Show Rates to Intake Assessments*

Report findings reflect that the MHP no show rate to initial intake assessment was 26 percent during FY 22-23. This is consistent with the no show rate from FY 21-22. The Mental Health Triage and Engagement Services Division demonstrated a high no show rate at 31 percent, which is above their benchmark. Trends for the Mental Health Triage & Engagement Services Division were identified at the program-level and were shared with management. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 61.

Table 61. 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 22-23	170	20%	157	27%	230	29%	152	31%	709	26%
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%

b) *No Show Rates to Psychotherapy Appointments*

Report findings indicate that the MHP no show rate was 15 percent during FY 22-23, which is a decrease when compared to FY 21-22. No trends were identified. Trends for the Children Division were identified at the

program-level and were shared with management. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 62:

Table 62. 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 22-23	365	13%	282	24%	108	9%	755	15%
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%

3) *Nurse No Show Rates*

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

Report findings reflect that the MHP no show rate to INA was 17 percent during FY 22-23, which is a decrease when compared to FY 21-22. No trends were identified. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 63.

Table 63. 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 22-23	40	14%	75	23%	69	14%	39	15%	223	17%
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%

b) *No Show Rates to Medication Support Appointments*

Report findings reflect the MHP no show rate to nurse medication support appointments was 12 percent during FY 22-23, which is a decrease when compared to FY 21-22. No trends were. The current benchmarks by division are as follows:

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

The results by division are summarized in Table 64.

Table 64. 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 22-23	58	12%	76	27%	208	10%	342	12%
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%

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- 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 QIC will discuss establishing a lower no show benchmark for scheduled appointments and utilize interventions to make incremental improvements towards achieving that benchmark.
- The QM Unit will survey clients to obtain their feedback regarding their appointments and attendance to appointments.

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 21-22. During FY 21-22, there were a total of 73 Medi-Cal beneficiaries and 37 non-Medi-Cal clients hospitalized, for a total of 110 clients hospitalized, which is a decrease from the previous fiscal year. For the 110 clients hospitalized,

there were 91 Medi-Cal admissions and 41 non-Medi-Cal admissions for a total of 132 hospital admissions, which is a decrease from the previous fiscal year. A comparison to prior fiscal years is included in Table 65.

Table 65. Hospital Admissions

Review Period	# of Clients Hospitalized			# of Admissions		
	Medi-Cal	Non Medi-Cal	Total	Medi-Cal	Non Medi-Cal	Total
FY 21-22	73	37	110	91	41	132
FY 20-21	85	39	124	106	40	146
FY 19-20	89	65	154	119	65	184

Of the 132 client admissions during FY 21-22, 62 percent were for active clients receiving services from the MHP at the time of the hospitalization. The status by division is included in Table 66.

Table 66. FY 21-22 Client Hospitalization Status

Status	Children Services	Youth & Young Adult Services	Adult Services	Mental Health Triage & Engagement Services	MHP
Active	7	14	40	21	82
Inactive	0	1	0	49	50
Total	7	15	40	70	132

2) *Hospital Readmissions*

The QM Unit monitored the County's psychiatric hospital readmissions by conducting an assessment of all readmissions that occurred during FY 21-22. Of the 132 admissions during FY 21-22, 22 were readmissions. The MHP's overall readmission rate is 17 percent. This is an increase from FY 20-21 when the readmission rate was 15 percent.

A total of 12 readmissions occurred within 30 days of discharge, resulting in a 9 percent 30-day readmission rate. This is an increase from FY 20-21 when the 30-day readmission rate was 7 percent. Table 67 summarizes the MHP's readmissions.

Table 67. Hospital Readmissions

Review Period	FY 19-20	FY 20-21	FY 21-22
Total Readmissions	30	22	22
Total Admissions	184	146	132
Readmission Rate	**16%**	**15%**	**17%**

Readmissions Within 30 Days	21	10	12
Total Admissions	184	146	132
30-Day Readmission Rate	**11%**	**7%**	**9%**

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. This allows the QM Unit to determine whether or not clients are receiving the appropriate follow up care after a psychiatric hospitalization and implement corrective interventions if necessary.

During FY 22-23, the QM Unit reviewed 199 hospitalizations: 49 for Adults Services, 26 for YAYA Services, 17 for Children Services, 107 for Mental Health Triage and Engagement Services. A review tool with the following three categories was utilized: 1) Hospitalization Monitoring; 2) Hospitalization Discharge Planning; and 3) After Hospitalization Discharge Summary.

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:

During Hospitalization Monitoring

- Present case during treatment team meetings to care coordinate and receive treatment recommendations and/or changes after the inpatient psychiatric treatment.

Hospitalization Discharge Planning

- 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 a home visit/Zoom appointment within 3 business days of discharge and completes a thorough assessment (mental status, adherence to medication, and/or needed referrals).

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.

During FY 22-23, the QM Unit also issued corrective action plans to all four divisions of the MHP for deficiencies in the following areas:

- Presenting case weekly at team meetings for updates in treatment recommendations.
- Confirming medication supply (3-day and 30-day Rx).
- Conducting a home visit within 3 business days of discharge and completed a thorough assessment (mental status, adherence to medication, and/or needed referrals).

The QM Unit approved and monitored CAPs to support the MHP in strengthening the beneficiaries/clients experience good quality of care services after an inpatient psychiatric admission.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

- 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 MHP will implement interventions approved as part of a corrective action plan issued by the QM Unit to ensure clients who are discharged from an inpatient psychiatric hospital receive appropriate follow-up care in accordance with MHP policy.

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 22-23:

1) Clinical – Reducing Psychiatric Emergencies – Holistic Outreach Prevention and Engagement (HOPE)

As part of its ongoing monitoring activities, the QM Unit reviewed and analyzed the number of admissions to the Triage Unit during FY 21-22. During the review period, there were a total of 184 Triage admissions (5150 holds), ages 13 to 25 years old, and a total of 47 readmissions during this review period. Out of the 184 admissions, 18 youth were in foster care. Youth admitted to the Triage Unit accounted for 43 percent of the total admissions. Out of the 184 youth admissions, 111 were actively receiving mental health services with the MHP and 73 were inactive (not open to services with the MHP). Of the 184 youth admissions, 21 were admitted to a psychiatric hospital, 12 to Crisis Residential Facility and five to an Adult Residential Facility for continuation of care. The QM Unit identified an increase in youth

accessing emergency psychiatric care. A PIP was initiated to address this increase in emergency psychiatric care amongst the youth population.

This clinical PIP focused on decreasing the number of psychiatric emergencies for youth by coordinating care and providing support utilizing the Holistic Outreach Prevention Engagement (HOPE)Program as an intervention to focus on holistic specialized services focused on wellness activities to assist emotional, physical, spiritual, and mental health needs. The PIP monitored clients referred to the HOPE Program after a psychiatric emergency to evaluate outcomes.

The improvement strategy and interventions consisted of community service workers, peer supporters, and mental health professional staff from the YAYA Division providing supportive services to youth who have experienced a psychiatric emergency. The activity depended on the youth's interests regarding the available wellness activities. Staff provided ongoing outreach and engagement services to increase adherence toward services, decrease stigma and improve mental health functioning. The improvement strategy also considered the individual's cultural background, language, and sexual orientation.

The PIP initiated in July 2022 in efforts to decrease psychiatric emergency admissions for youth, 13 to 25 years old, by 5 percentage points by one year of the PIP. The data indicates a total of 189 (38%) youth were admitted to the Triage Unit (5150 holds) from July 2022 through June 2023. This is a decrease when compared to FY 21-22.

The interventions implemented are included in Table 68.

Table 68. PIP – Clinical Interventions

Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
HOPE Activity – wellness activities including mindfulness, fitness, and music /art and rehabilitation interventions.	-Mental Health Rehabilitation Technician (MHRT) Client contact for first two months is at minimum once a week in person and telephonic as needed. From month three until fully transitioned out of project, contact lessens, dependent upon each client's progress. -Community Service Worker (CSW) – Client contact for the first two months is at a minimum of twice per week. From month three until fully transitioned out of project, contact lessens, dependent upon each client's progress. -Wellness Activities- Contingent upon client and vendor availability	1.Wellness activities and case management/peer support services	July 2022

Out of the 91 clients enrolled in the HOPE Program, 11 (12%) had a psychiatric emergency between October 2022 through March 2023.

The PIP task force committee met monthly during the PIP to monitor the progress of the interventions and documented the MHP's work in the Clinical Roadmap.

2) *Follow-Up After Emergency Department Visit for Mental Illness (FUM)*

During FY 22-23, the MHP began implementing measures to address performance related to follow-up after emergency department (ED) visits for mental illness. The purpose of the PIP is to improve coordination and exchange of data between the Managed Care Plans and the MHP.

The data provided by DHCS indicated that only 66 percent of ED visits for a mental illness by MHP beneficiaries were followed up by MHP within seven days, and 73 percent within 30 days. The setting measure for this PIP is to meet the 50th percentile national benchmark and eventually exceed to the 90th percentile.

The improvement strategy was to initiate communication with the county's local EDs to implement the preliminary stage of data exchange capabilities. The MHP met with El Centro Regional Medical Center (ECRMC); however, after a few meetings, the MHP observed hospital staff changes that created communication barriers with ECRMC. During the start of the PIP, ECRMC was facing a possible closure and a new CEO implementing organizational restructuring.

Implementing the FUM PIP has proven challenging. The preexisting financial and systemic challenges faced by hospitals in Imperial County have been further aggravated by the economic strain brought by the COVID-19 pandemic. As a result, the MHP is encountering difficulties in establishing effective communication channels with both ECRMC and Pioneers Memorial Hospital (PMH) due to the existing challenges associated with healthcare. The MHP continues to make efforts to establish a collaborative working relationship with PMH, as well as enhance its current relationship with ECRMC.

After numerous attempts to engage local EDs, the MHP reached out to the MHP's two Medi-Cal managed care plans (Molina and California Health & Wellness) regarding data exchange capabilities to make some progress with the PIP. The MHP met with Molina on May 10, 2023, and California Health & Wellness on May 24, 2023, and continue to have discussions regarding data exchange processes.

As a result of the barriers and challenges faced, the MHP utilized supplemental data from the Mental Health Triage & Engagement Services Division, which implements the Care Coordination Model (CCM) at ECRMC. The CCM is designed to assess the level of risk of clients presenting at the ED for a mental health emergency using a screening tool to identify symptoms and behaviors. Additionally, the CCM allows staff to coordinate care for individuals after the

ED discharge to ensure follow up care. The MHP has had a mental health professional stationed at the ECRMC ED since February 2022.

The QM Unit is tracking the number of referrals made to the MHP by ECRMC and monitors the timeliness of follow-up care with the MHP after the ED visit. The MHP is also tracking an email distribution list to serve as a centralized receiving point for incoming referrals from ECRMC due to the MHP being unable to secure direct messaging via EHR.

Table 69 illustrates the count of ED visits, same-day crisis interventions, newly referred clients to the MHP, scheduled and kept mental health follow-up appointments from the MHP's internal tracking log.

Table 69 Timeliness of Services after ED Visit

Period	# of clients who met criteria and attended ED for MH Illness	# of clients who received a same-day crisis intervention		# of clients who were referred to the MHP		# of clients who were scheduled a follow-up apt.		# of clients who kept follow-up apt.	
		#	%	#	%	#	%	#	%
January 2023-June 2023	71	71	100%	31	44%	46	65%	42	91%

The interventions implemented to date are included in Table 70.

Table 70. PIP Clinical Interventions

Intervention	Barriers/Causes Intervention Designed to Target	Corresponding Indicator	Date Applied
• A care coordination model (CCM), to include screening in the EDs to identify symptoms and behaviors for the appropriate designation of individual's requiring mental health treatment and provide discharge after-care coordination to ensure ongoing engagement efforts are made and appointments scheduled. (Avoid gaps in referral process) • Develop bi-directional data exchange protocols for the MHP and local EDs to identify frequent utilizers of the ED that are not accessing services through the MHP. • Implement a centralized referral tracking process for local EDs and the MHP, which generates automated timelines and tracks key data indicators relating to clients ED visits for mental health conditions and follow-up appointments.	• Improve care coordination with the Managed Care Plans and Specialty Mental Health Plans that will leverage data exchange capabilities to improve follow-up appointments after an emergency department visit for a mental illness.	• Number of clients assessed by Care Response Team at emergency department. • Number of client's referred to the MHP after emergency department visit for mental illness. • Number of clients who were scheduled a follow-up appointment after emergency department visit.	01/01/2023

• The MHP will assign a referral liaison, to monitor and provide care coordination for referrals received through local EDs. Referral liaison to provide reminders, scheduling and rescheduling follow-up appointments and update clinical teams regarding status of case.		• Number of clients who kept follow-up appointment after emergency department visit.	

The PIP Taskforce has met regularly since the inception of this PIP to discuss information exchange and to monitor the progress of the interventions which are tracked in the Imperial PIP Progress Tracker and the DHCS PIP Template.

b. Overview of the MHP objectives, scope, and planned activities for FY 23-24:

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

- ICBHS will continue to participate in the CalAIM Behavioral Health Quality Improvement Program (BHQIP). With the support of the Information Systems Unit and the DMC-ODS 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 Mental Illness (FUM).

- The QM Unit will submit as required the BHQIP PIP Progress Tracker Tool and DHCS PIP Template.

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

A. State Mandated Areas

1. Service Delivery Capacity

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 22-23.

a. Overview of ICBHS objectives, scope, and activities for FY 22-23:

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 22-23. The types and number of services provided between July 1, 2022 and January 31, 2023 were retrieved from ICBHS electronic information system, AVATAR while the types and number of services provided from February 1, 2023 to June 30, 2023 were retrieved from the new ICBHS EHR, SmartCare.

ICBHS ensures that regardless of where a beneficiary enters the ICBHS system for outpatient DMC-ODS services, that beneficiary receives an initial screening at one of the SUD clinics closest to the individual's place of residence within 10 business days from the date of request. If the beneficiary meets access and medical necessity criteria for DMC-ODS services, ICBHS will conduct an ASAM assessment to determine the level of care appropriate to meet the beneficiary's needs. ICBHS provides clinically appropriate DMC-ODS services for up to 30 days (or up to 60 days for beneficiaries under the age of 21 or if there is evidence that the beneficiary is experiencing homelessness and requires additional time to complete the assessment) following the initial screening, including when the beneficiary's diagnosis and/or level of care have yet to be established.

With the implementation of the screening tools by the MHP, beneficiaries are also screened for the need for SUD services when requesting mental health services through ICBHS. Once reporting through SmartCare is fully operational, ICBHS will be able to determine if the screening tools utilized by the MHP are increasing beneficiary access to DMC-ODS services.

ICBHS is also responsible for authorizing beneficiary requests for residential treatment. Beneficiaries who are determined to need residential treatment are referred to one of ICBHS' out-of-county contracted residential treatment facilities. ICBHS provides transportation and care coordination services to beneficiaries receiving residential treatment services in order to ease the transition to a facility located outside of the county.

Requests for NTP services are made directly to ICBHS' contracted NTP provider. Beneficiaries requesting NTP services are offered an assessment within 3 business days from the date of request.

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.

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. During FY 22-23, a total of four DMC certified sites provided services to Imperial County residents. The treatment sites include two Adult Outpatient Clinics one in El Centro and one in Calexico and two Adolescent Outpatient Clinics also located in El Centro and Calexico.

ICBHS provides outpatient DMC-ODS 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

ICBHS provides quality professional DMC-ODS services for individuals suffering from substance use. DMC-ODS services provided include Outpatient Treatment, Intensive Outpatient Treatment, Medications for Addiction Treatment (MAT), Withdrawal Management, Care Coordination, 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. 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. Services received by the individual beneficiary may exceed the maximum based on individual medical necessity.

The components of outpatient treatment services and Intensive Outpatient Treatment (IOT) include: Assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for opioid use disorder (OUD), MAT for alcohol use disorder (AUD), and non-opioid SUDs, patient education, recovery services, SUD crisis intervention services. Services may be provided in person, by telehealth, or by telephone.

ICBHS integrated the use of additional 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);
- Opiate withdrawal management/symptomatic relief-Clonidine for anxiety, Ibuprofen for aches, Dicyclomine for stomach cramping, Loperamide for diarrhea, and Trazodone for insomnia;
- Reduction of alcohol craving - Naltrexone, extended release injectable (Vivitrol), and Acamprosate (Campral);
- Alcohol withdrawal management - Librium (chlordiaxepoxide), Gabapentin, Clonidine (Catapres), Diazepam, Lorazepam, and Trazadone for sleep disturbances; 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.

Withdrawal Management (Level 2) consists of ambulatory withdrawal management with extended on-site monitoring. This service is provided to beneficiaries at the Adult El Centro SUD Program based on clinical need and the beneficiary’s consent.

Care Coordination services are provided to beneficiaries enrolled at an ICBHS SUD clinic (ASAM 1 or 2.1). Care Coordination services assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community resources. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.

Recovery Services may be provided to beneficiaries based on a self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services.

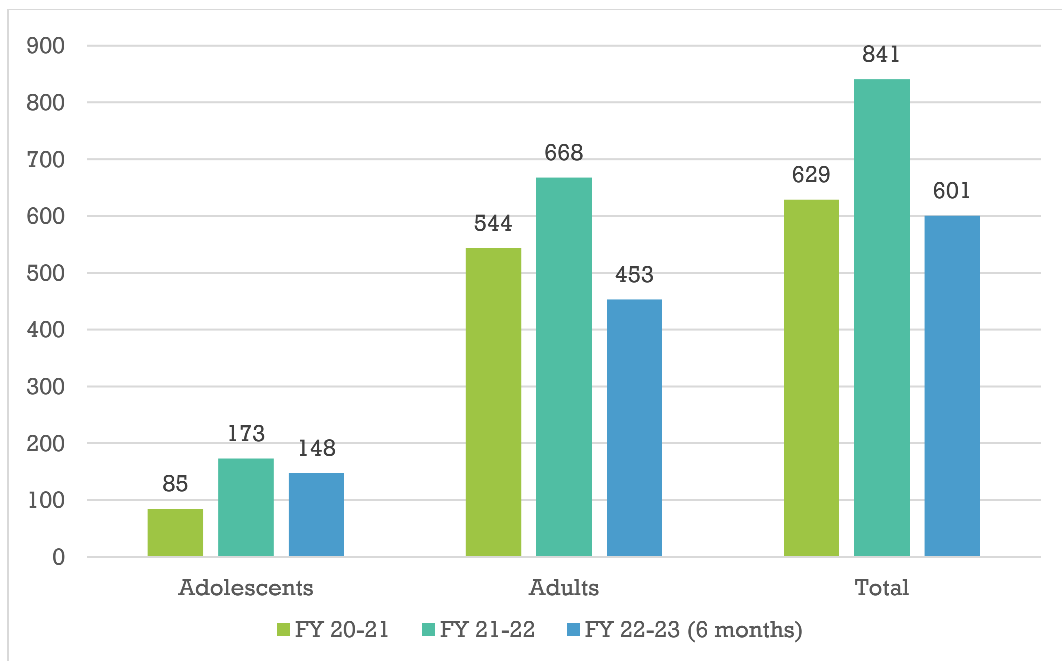
Beneficiaries receiving MAT, including NTP services, may receive recovery services. Beneficiaries may receive recovery services immediately after incarceration with a prior diagnosis of SUD. The service components of recovery services are individual and/or group counseling, assessment, care coordination, family therapy, recovery monitoring, and relapse prevention 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 following data is a three-year snapshot of unduplicated Medi-Cal beneficiaries served by ICBHS during FY 19-20, FY 20-21, and FY 22-23. Data for FY 22-23 is only for six months covering July 1, 2022 through December 31, 2022. Table 71 depicts the overall data for Medi-Cal beneficiaries served by SUD programs and Table 72 is a graphic visual of the total beneficiaries served by SUD programs.

Table 71. Medi-Cal Beneficiaries Served

SUD Programs	FY 20-21	FY 21-22	FY 22-23
Adolescent SUD Services	85	173	148
Adult SUD Services	544	668	453
Total Beneficiaries	**629**	**841**	**601**

Table 72. Beneficiaries Served by SUD Programs



FY 22-23 SUD Medi-Cal Population

The total number of unduplicated clients served in the first six months of FY 22-23 was 837. The number of unduplicated Medi-Cal beneficiaries

accessing outpatient DMC-ODS services through ICBHS in FY 22-23 was 601 or 72 percent of the individuals served. The distribution of the Medi-Cal population receiving DMC-ODS services from ICBHS is shown by age, gender, ethnicity, city of residence, language, and diagnosis. Table 73 through 78 provides data for beneficiaries served in the Adolescent SUD treatment programs and Tables 79 through 84 for the Adult SUD treatment programs.

Table 73. Adolescent Beneficiaries Age Group

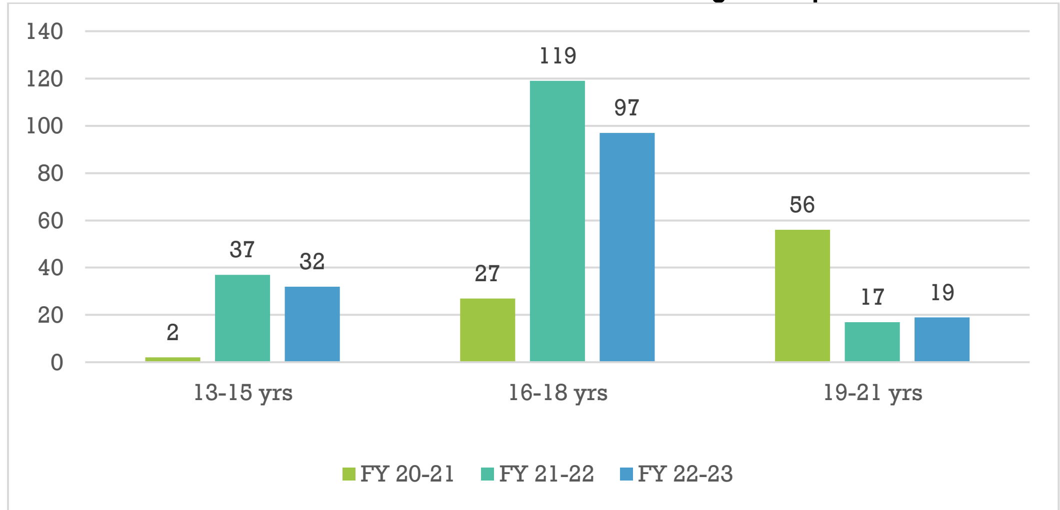


Table 74. Adolescent Beneficiaries Gender

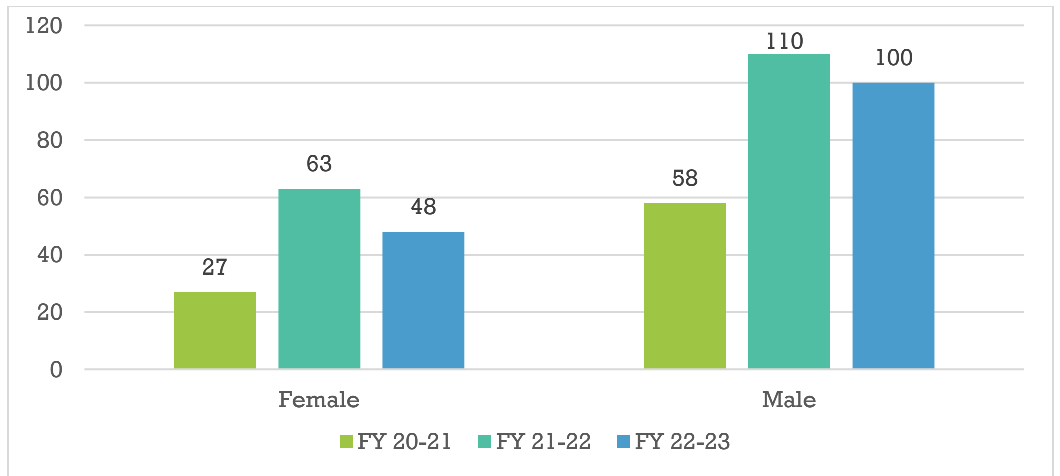


Table 75. Adolescent Beneficiaries Ethnicity

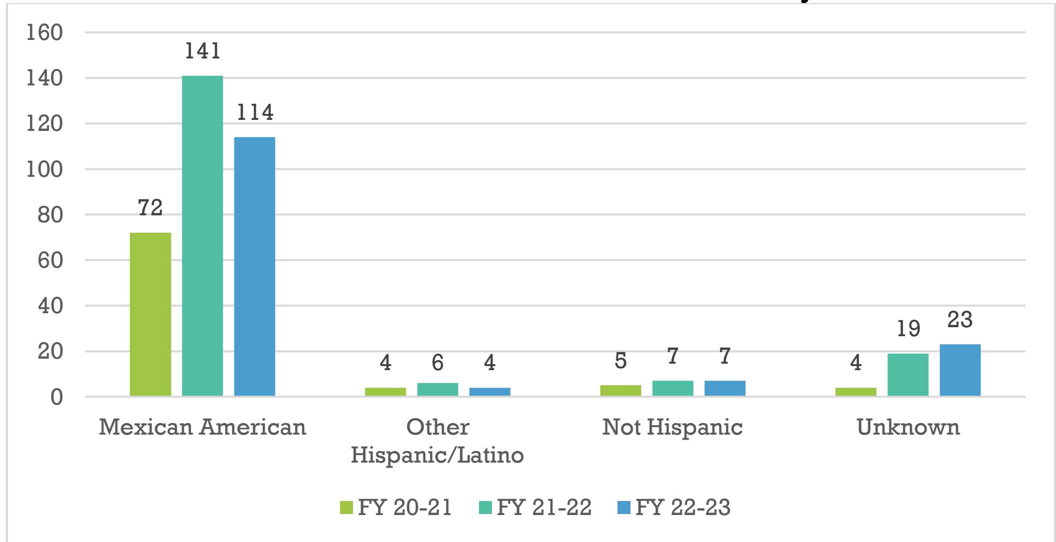


Table 76. Adolescent Beneficiaries City of Residence

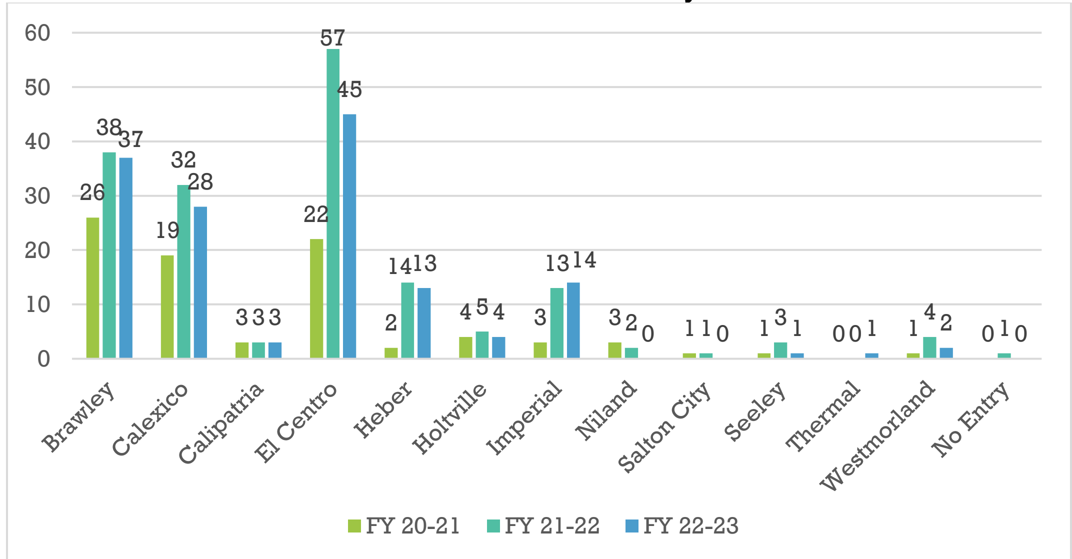


Table 77. Adolescent Beneficiaries Language

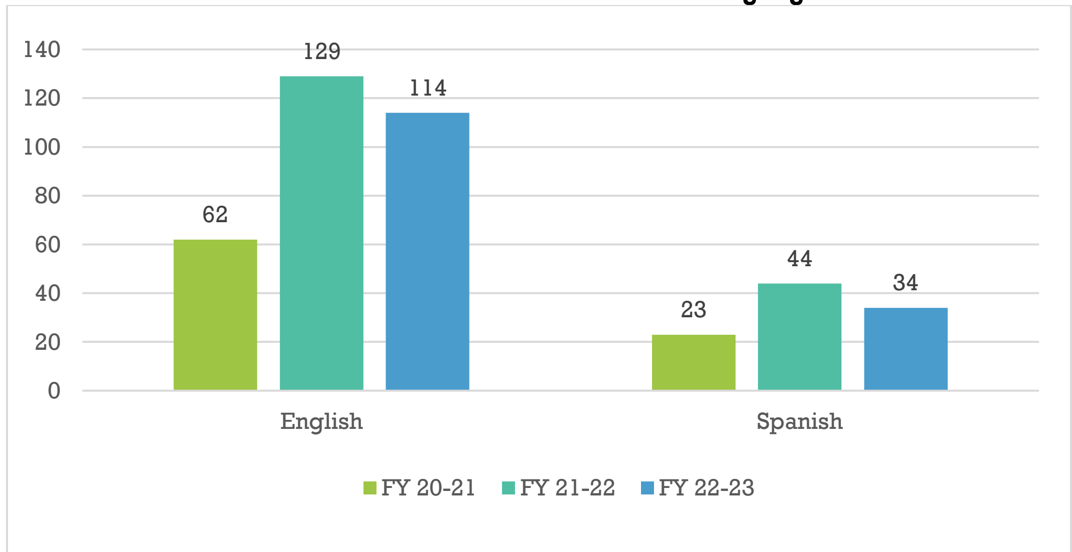
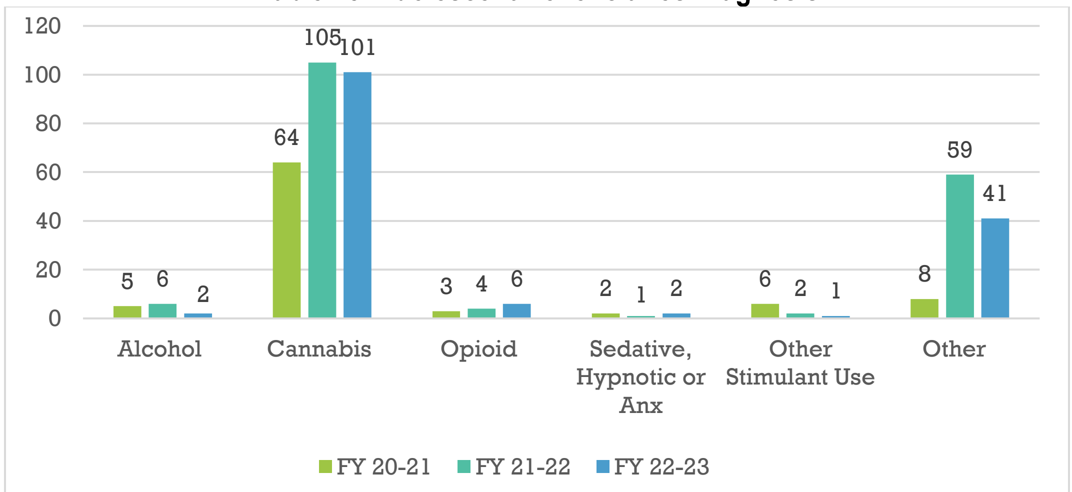


Table 78. Adolescent Beneficiaries Diagnosis



*Data may not total the number of beneficiaries served as some have more than one diagnosis.

Table 79. Adult Beneficiaries Age Group

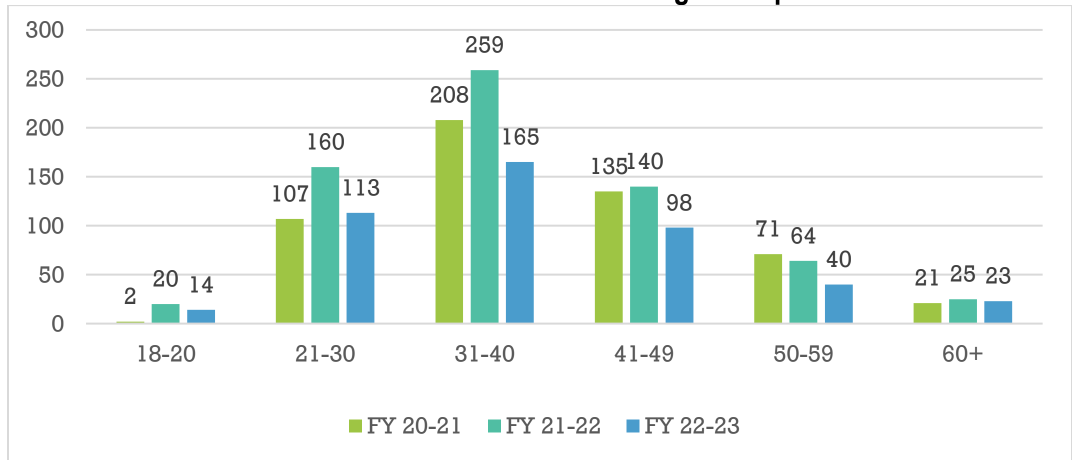


Table 80. Adult Beneficiaries Gender

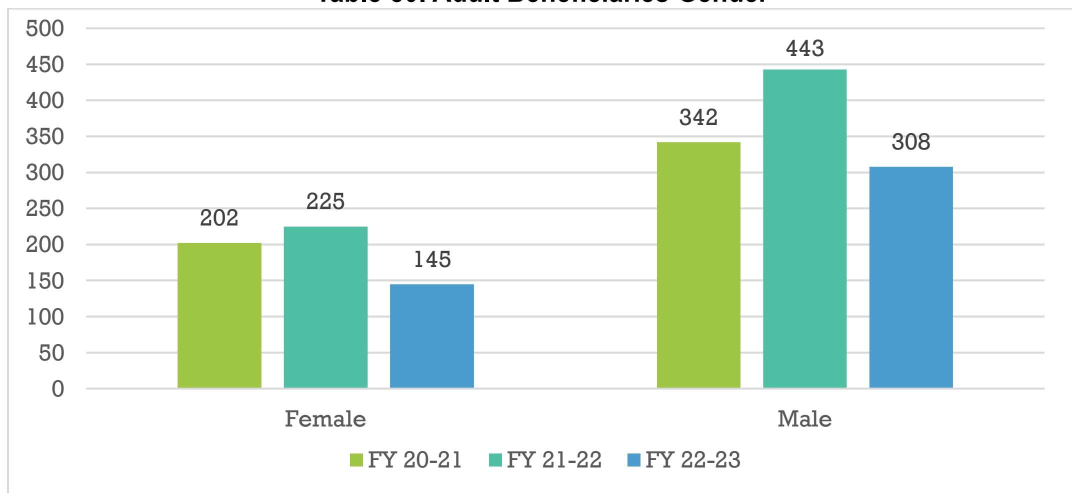
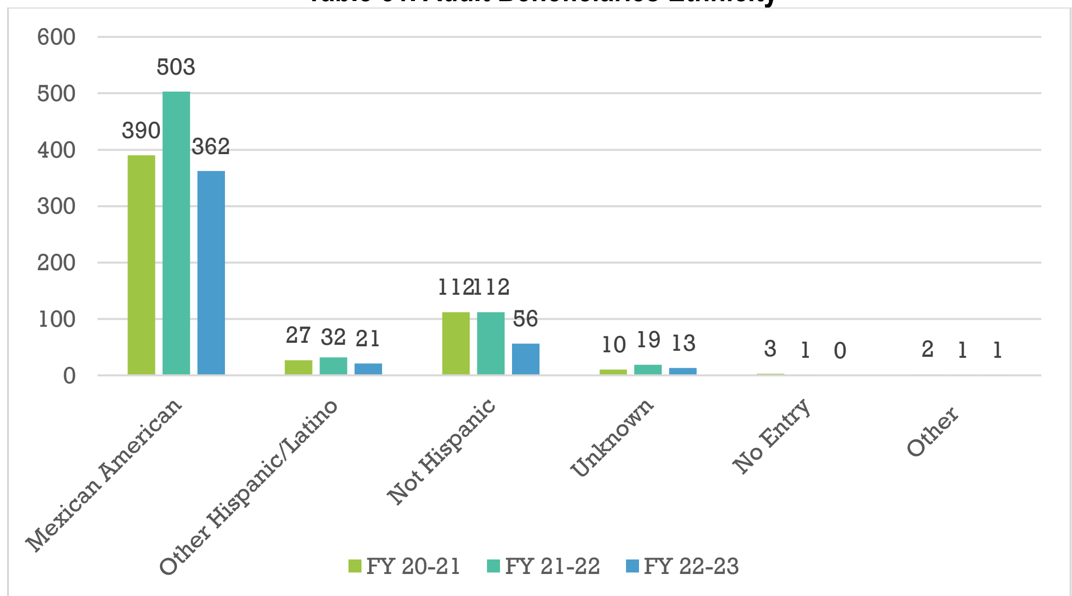
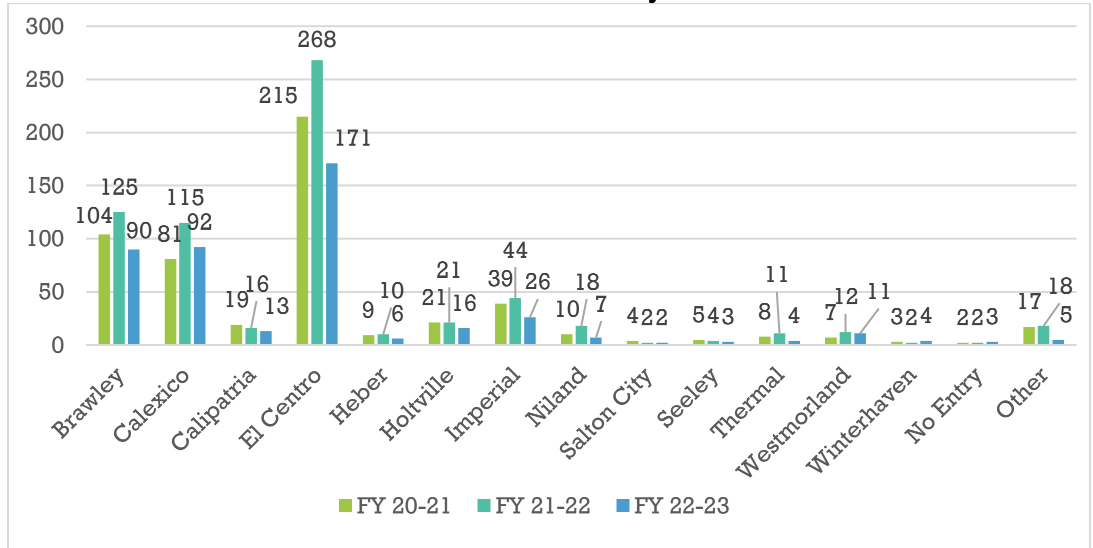


Table 81. Adult Beneficiaries Ethnicity



*Other – Includes 1 Puerto Rican and 1 Cuban (FY 20-21); 1 Puerto Rican (FY 21-22); and 1 Puerto Rican (FY 22-23)

Table 82. Adult Beneficiaries City of Residence



*Other includes: FY 20-21 (4-National City; 5-Ocotillo; 2-Yuma; 2-Santa Ana; 1-Santa Monica; 1-Lakeside; 1-Ontario; 1-Palo Verde). FY 21-22 (1-National City; 3-Santa Monica; 2-Ocotillo; 1-Bell; 1-Bombay Beach; 1-Coachella; 1-Merced; 1-Palo Verde; 1-Panorama City; 1-Phoenix; 1-Santa Ana; 1-Victorville; 1-Yuma). FY 22-23 (1-Bell; 1-Lakeside; 1-Niland/Slab City; 1-Ontario; 1-Santa Ana).

Table 83. Adult Beneficiaries Language

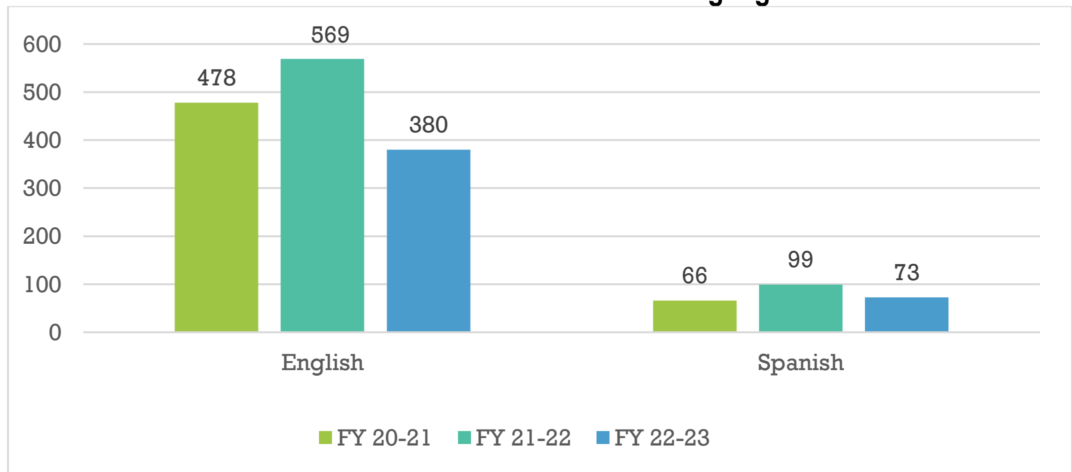
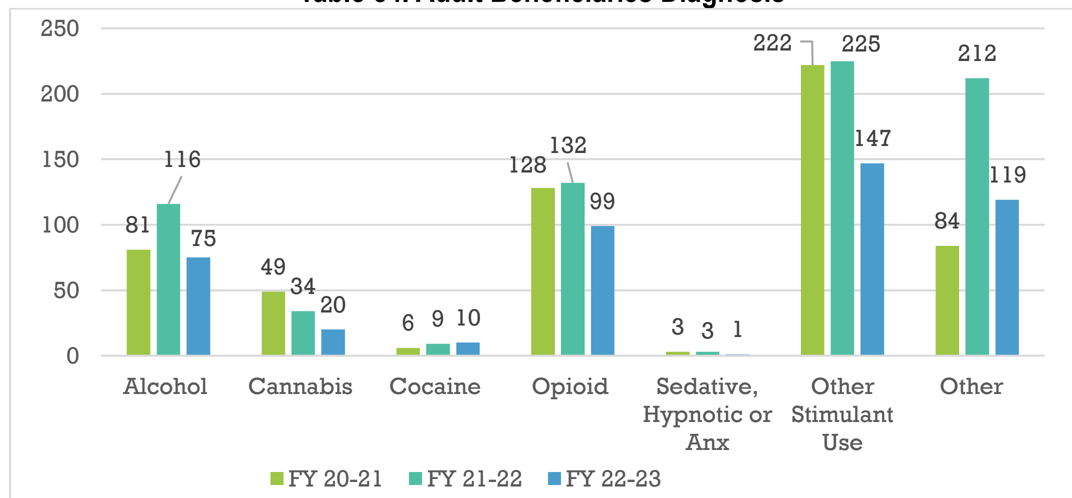


Table 84. Adult Beneficiaries Diagnosis



*Data may not total the number of beneficiaries served as some have more than one diagnosis.

Utilization of Services for FY 22-23

During FY 22-23, individual counseling was the most utilized service by beneficiaries in both the Adolescent and Adult SUD programs. The least utilized services by beneficiaries were crisis intervention, MAT, family therapy, and recovery services for the Adolescent SUD Program, while crisis intervention, family therapy, and withdrawal management 2.0 were the least utilized services by beneficiaries and the Adult SUD Program.

DMC-ODS treatment services provided by the Adolescent SUD Program and the Adult SUD Program in the first six months of FY 22-23 along with a comparison from FY 20-21 and FY 21-22 are shown in Table 85 and Table 86.

Table 85. Type of Service and Number of Beneficiaries
Adolescent SUD Services

Type of Service	Number of Clients FY 20-21		Number of Clients FY 21-22		Number of Clients FY 22-23 *6 months*	
	ODF	IOT	ODF	IOT	ODF	IOT
Assessment	102	2	171	7	97	9
Group Counseling	3	0	95	2	86	8
Individual Counseling	95	6	187	8	175	12
Case Management	46	4	134	7	77	7
Crisis Intervention	0	0	7	3	2	0
Medication Assisted Treatment	2	2	5	2	3	2
Family Therapy	0	0	2	0	0	0
Recovery Services	21	1	24	0	10	0

Table 86. Type of Service and Number of Beneficiaries
Adult SUD Services

Type of Service	Number of Clients FY 20-21		Number of Clients FY 21-22		Number of Clients FY 22-23 *6 months*	
	ODF	IOT	ODF	IOT	ODF	IOT
Assessment	474	276	157	581	174	115
Group Counseling	78	40	44	117	68	67
Individual Counseling	472	274	196	717	450	151
Case Management	256	235	120	525	193	163
Crisis Intervention	10	9	10	6	0	4
Medication Assisted Treatment	121	122	87	301	110	90
Family Therapy	2	3	0	1	1	0
Recovery Services	127	9	24	87	71	1

Withdrawal Management 2.0	1	1	2	0	0	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 22-23 through in-county and out-of-county contracted providers.

i. *In-County*
During FY 22-23, 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 22-23, 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. ABC Recovery provided level of care 3.2 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.

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 types of services provided by contracted providers to Imperial County residents in FY 22-23 is displayed in Table 87 & Table 88 along with the total number of admissions. Table 87 reflects FY 22-23 data for the first half of the fiscal year covering July 1, 2022, through December 31, 2022, for beneficiaries served by the NTP provider. Table 88 reflects data for FY 22-23 for beneficiaries served by out-of-county residential treatment providers.

Table 87. Contracted Providers
Type of Service and Number of Admissions

Contracted Provider	Type of Service	FY 20-21 Admissions	FY 21-22 Admissions	FY 22-23 Admissions
Narcotic Treatment Program	Buprenorphine/Naloxone	14	13	7
	NTP – Dose Methadone	364	306	218
	Individual Counseling	357	301	217
	Group Counseling	311	283	203
NTP Total		**1,046**	**903**	**462**

Table 88. Contracted Providers
Type of Service and Number of Admissions

Contracted Provider	Type of Service	FY 20-21 Admissions	FY 21-22 Admissions	FY 22-23 Admissions
Residential Treatment Services	ASAM Level 3.1	18	28	27
	ASAM Level 3.2	33	27	12
	ASAM Level 3.3	0	2	0
	ASAM Level 3.5	30	22	62
	ASAM Level 3.7	0	0	0
	ASAM Level 4.0	0	0	0
	OTP – Level 1	0	0	0
Residential Treatment Services Total		**81**	**79**	**101**

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 89.

Table 89. 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
Urgent	Within 48-hours from the 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 will continue to submit the Network Adequacy Certification Tool (NACT) to DHCS annually, 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 23-24:

- The QM Unit will monitor the number, type, and geographic distribution of SUD services and will report to the QIC at least annually.
- 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 to first non-urgent services, the timeliness to urgent services, and access to after-hours care.

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

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. The QM Unit's monitoring process entails conducting random test calls, during business hours and after hours, in English and Spanish, Imperial County's threshold language. Monitoring is conducted to verify that the BAL is available to beneficiaries 24/7.

Test calls determine the ability of the Access Unit staff to provide information related to 1) available SUD services and referrals to DMC-ODS providers, 2) referrals for urgent services and medical emergencies, 3) information regarding beneficiary problem resolution and fair hearing process, and 4) interpreter and translation service information. Test callers also assess the Access Unit staff's ability to determine urgency of applicable test calls; ensure calls were answered within the standard of five rings; and if TTY/TDY 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 22-23, the QM Unit conducted a total of 48 test calls, 24 during business hours and 24 after hours. The Access Unit was 100 percent compliant in four of the test calls criteria and 89 percent compliant for the Urgent Conditions criteria. When it came to logging the calls, the Access Unit was 97 percent compliant with a 90 percent compliance rate in logging name of the caller, as indicated in Table 90. Findings were compiled into quarterly reports and presented to QIC.

Table 90. 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%
SUD Access Information	100%	100%	100%
Urgent Condition Information	86%	100%	89%
Beneficiary Resolution and Fair Hearing Process	100%	100%	100%
Access Log Criteria	**Percentage of Test Calls That Met Log Requirements**		
	Business Hours	**After Hours**	**All Calls**
Name of the caller	89%	90%	90%
Date of the request	94%	100%	97%
Initial disposition of the request	94%	100%	97%

Additionally**,** the Access Unit's ring standard, of five rings for both business hours and after-hours calls, was met for 100 percent for three quarters and 92 percent for quarter 2. The test callers requested two (2) SUD Program Brochures, two (2) provider directories, three (3) grievance forms and two (2) Beneficiary Handbooks. All written information was received as requested.

During FY 22-23, the QM Unit determined that the BAL was available to beneficiaries 24/7, in both English and Spanish. Access staff were able to schedule DMC-ODS appointments for callers, provide information related to the availability of DMC-ODS services, and screen for safety and urgency of need, although some improvement could be made in assessing the need for urgent services.

2) *Timeliness to First Non-Urgent Services and First Delivered Service*

SUD County-Operated Programs

ICBHS is required by DHCS to offer an appointment within 10 business days from the request for outpatient DMC-ODS services, other than NTP services. Beneficiaries may request outpatient DMC-ODS by contacting the 24-hour BAL, by walking into one of the ICBHS SUD clinics, or through referral from another provider or agency. The QM Unit is responsible for monitoring the timeliness of first non-urgent services and reporting findings to the QIC at least quarterly.

During FY 22-23, 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 business days between the date of initial request and the date of the first offered intake appointment.

By evaluating the data gathered for the first six months of FY 22-23 (July-December 2022), the QM Unit verified that ICBHS offered outpatient DMC-ODS services within 10 business days 99 percent of the time, as indicated in Table 91. The average wait time to receive an appointment was five business days from the date of the request, which is an increase of one day from the previous year.

During FY 22-23, timely appointments were available to beneficiaries when outpatient SUD services were requested, with the average wait time being well below the 10 business days timeliness standard. The low percentage of clients attending the first appointment (62%) may need to be evaluated, should the completion rate drop further, to determine what barriers may exist that are preventing beneficiaries from following through with their scheduled appointment.

Table 91. Timeliness to First Non-Urgent Services and First Delivered Service – SUD County-Operated Programs

Review Period	Requests for Routine Apt.	Apts Offered Within Timeliness Standard	Apts Offered Over Timeliness Standard	Compliance Rate	% of Completed Appts*
FY 22-23	525	519	6	99%	62%
FY 21-22	1,163	1,162	1	99%	82%
FY 20-21	808	740	68	92%	61%

*When the percentage of completed appointments is less than 50%, the QM Unit conducts an analysis to determine the case for the low attendance rate.

Narcotic Treatment Programs

ICBHS is required by DHCS to ensure an appointment is offered within 3 business days from the request for opioid treatment services. Opioid treatment services are provided by ICBHS' contracted NTP provider. Beneficiaries may request opioid treatment services by contacting the 24-hour BAL, by contacting the NTP provider directly, or through referral from another provider or agency. The QM Unit is responsible for monitoring the timeliness of first non-urgent NTP services and reporting findings to the QIC as needed.

During FY 22-23, the source document utilized by NTP clinics was the Access Log and Timely Access Log, which identify the date of initial contact, the date of the first offered intake appointment and the first day of the completed appointment.

By evaluating the data gathered in FY 22-23, the QM Unit verified that NTP offered services within the timeliness standard 100 percent of the time, as indicated in Table 92. The average wait time to receive an

appointment was one day, which is consistent with the findings from the previous fiscal year. The low percentage of clients attending the first appointment (57%) may need to be evaluated, should the completion rate drop further, to determine what barriers may exist that are preventing beneficiaries from following through with their scheduled appointment.

Table 92. Timeliness to First Non-Urgent Services and First Delivered Service – Narcotic Treatment Programs

Review Period (FY)	Requests for Routine Apt.	Apts Offered Within Timeliness Standard	Apts Offered Over Timeliness Standard	Compliance Rate	% of Completed Apts
22-23	200	200	0	100%	57%

*When the percentage of completed appointments is less than 50%, the QM Unit conducts an analysis to determine the case for the low attendance rate.

3) *Timeliness to Urgent Services*

ICBHS is required by DHCS to offer an urgent care appointment within 48 hours of the request. Beneficiaries may request an urgent care appointment any time by contacting the 24-hour BAL or by walking into one of the ICBHS SUD clinics. Urgent care means health care for a beneficiary whose "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit is responsible for monitoring the timeliness of urgent services and reporting findings to the QIC at least quarterly.

The QM Unit compares the time and date of initial requests for urgent care appointments to the time and date the urgent care appointment was scheduled on the Electronic Health Record to determine if appointments are provided within 48 hours of initial request.

By evaluating the data gathered in FY 22-23, the QM Unit verified that ICBHS provided appointments for urgent services within 48 hours of initial beneficiary request 50 percent of the time, which reflects a decreasing trend, as seen in Table 93. Additionally, the QM Unit identified requests that possibly should have been screened as urgent, but were not assessed or documented as such, which may be a contributing factor in the number of requests for urgent services identified during FY 22-23 as compared to previous years. The QM Unit will need to closely monitor requests for urgent services to ensure beneficiaries are being screened appropriately, and that services are being provided within 48 hours when needed or requested, in order to minimize the risks associated with delayed treatment.

Table 93. Timeliness of Services for Urgent Conditions

Review Period	Requests for Urgent Conditions	Requests Within 1 Hour Standard	Compliance Rate
FY 22-23	4	2	50%
FY 21-22	14	8	57%
FY 20-21	12	8	67%

4) Access to After-Hours Care

ICBHS is responsible for ensuring beneficiaries have access to after-hours care. After-hours care is provided through the 24/7 BAL, where callers are assessed for safety and urgency of need and referred to the ICBHS Triage Unit for immediate attention. ICBHS has established a one-hour standard from the time of the request to provide after-hours care.

The QM Unit compares the After-Hours Access Log call times from the EHR, which identifies the beneficiary's request for after-hours care (requests made after-hours, weekends, and holidays) to the times contacts are made to the beneficiary by After-Hours Triage staff, to determine whether or not after-hours care was provided within one hour.

By evaluating the data gathered in FY 22-23, the QM Unit verified that access to after-hours care was provided within one hour for 40 percent of requests, which reflects a decrease from FY 21-22, as seen in Table 94. The decrease in FY 22-23 can be attributed to the change in the EHR, which resulted in staff being unable to log after-hours requests appropriately. The 40 percent rate may not be indicative of reduced access to after-hours care and will need to be monitored closely during FY 23-24 to ensure beneficiaries are able to receive after-hours care within ICBHS' one-hour standard.

Table 94. Access to After-Hours Care

Review Period	After-Hours Requests	Verified	Compliance Rate
FY 22-23	5	2	40%
FY 21-22	7	6	86%
FY 20-21	7	7	100%

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24

- The QM Unit will monitor the 24-hour beneficiary line, timeliness to first non-urgent services, timeliness to urgent services, and access to after-hour care and report findings and identified trends to the QIC at least quarterly.

- The Access Unit will conduct trainings twice a year to ensure staff assigned to the BAL screen for safety and assess the need for urgent services when appropriate.

- The QM Unit will closely monitor requests for urgent care to ensure beneficiaries are screened appropriately and receive timely services, reducing the risks associated with delayed SUD treatment.

- The QM Unit will closely monitor access to after-hours care to ensure beneficiaries have their needs addressed by ICBHS providers within one-hour of determining that an immediate need exists.

- The QM Unit will continue to work collaboratively with Information Systems (IS) for the development of timeliness tracking within the new EHR.

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 22-23:

1) Beneficiary/Family Satisfaction Survey

During CY 2022, ICBHS administered the Statewide Treatment Perception Survey (TPS) during fall 2022 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.

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.

21 youth surveys were completed during the CY 2022 TPS period. Surveys were collected from beneficiaries receiving services from the two Adolescent SUD Programs operating within the county. Participation in the CY 2022 survey was consistent with the previous year.

Data shown in Table 95 indicates a significant decrease between CY 2021 and CY 2022 in the areas of "Positive/Trusting Relationship with Counselor", with a decrease of 11.7 percentage points, and "Recommend Services", with a decrease of 14.7 percentage points. There was, however, a 13.9 percentage point improvement in "Cultural Sensitivity". Survey findings for youths are

summarized in Table 95, including a side-by-side comparison with CY 2021 findings.

Table 95. Satisfaction Rates - Youth Treatment Perception Survey

Survey Area	CY 2020	CY 2021	CY 2022
Convenient Location	100%	82.6%	81.0%
Convenient Time	100%	83.3%	90.5%
Good Enrollment Experience	100%	87.0%	81.0%
Worked with Counselor on Goals	100%	91.3%	95.2%
Received the Right Services	100%	87.5%	80.0%
Treated with Respect	100%	95.8%	100%
Counselor Listened	100%	95.7%	95.2%
Positive/Trusting Relationship with Counselor	100%	91.7%	80.0%
Cultural Sensitivity	91.7%	54.5%	68.4%
Counselor Interested in Me	100%	87.5%	90.5%
Liked Counselor	100%	95.8%	90.5%
Counselor Capable of Helping	100%	100%	100%
Health/Emotional Needs Being Met	100%	95.8%	100%
Helped with Other Issues/Concerns	100%	91.3%	90.0%
Provided Family Services	100%	90.0%	80.0%
Better Able to Do Things	100%	82.6%	85.7%
Overall Satisfied with Services	100%	91.7%	100%
Recommend Services	100%	95.7%	81.0%

A total of 192 adult consumers surveys were completed during the CY 2022 TPS period, which includes 164 surveys from two in-county NTP clinics, 25 surveys from the two in-county Adult SUD Programs, two surveys from two contracted out-of-county residential treatment providers, and one survey from a contracted out-of-county detoxification/withdrawal management program. Adult survey participation decreased by 61 surveys compared to CY 2021 when 253 surveys were completed.

The data shown in Table 96 indicates relatively consistent responses between CY 2021 and CY 2022. Survey findings for adults are summarized in Table 96, including a side-by-side comparison with CY 2022 findings.

Table 96. Adult Treatment Perception Survey Results

Survey Area	CY 2020	CY 2021	CY 2022
Convenient Location	80.6%	88.8%	85.3%
Convenient Time	86.0%	91.6%	90.5%
I Chose my Treatment Goals	89.0%	92.8%	88.7%
Staff Gave Me Enough Time	92.9%	93.6%	93.7%
Treated with Respect	89.5%	93.2%	91.0%
Understood Communication	90.6%	96.0%	90.5%
Cultural Sensitivity	87.0%	93.7%	90.5%
Work with Physical Health Care Providers	85.5%	90.8%	88.2%
Work with Mental Health Providers	81.5%	89.1%	87.2%
Better Able to Do Things	88.3%	94.4%	89.9%
Felt Welcomed	90.5%	94.0%	92.6%
Overall Satisfied with Services	88.3%	91.4%	94.2%
Got the Help I Needed	88.9%	91.2%	91.1%
Recommend Agency	89.0%	92.4%	92.3%

The results of the CY 2022 TPS were provided to management and an overview of the survey results were presented to SUD staff.

During FY 22-23, as a result of the EQRO's recommendation during its FY 21-22 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.

The QM Unit will evaluate the CY 2023 TPS responses to determine if additional actions need to be taken to increase adult beneficiary participation in the TPS, particularly from the outpatient programs. Additionally, the QM Unit will conduct additional surveys to obtain youth beneficiary feedback regarding the areas identified with decreased satisfaction.

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

The QM Unit monitors beneficiary protection processes to ensure federal grievance and appeal system requirements are followed by ICBHS and its providers. The QM Unit monitors the grievance and appeal logs to ensure

grievances and appeals are investigated and resolved appropriately and that beneficiaries are informed of their rights during the grievance or appeal process.

During FY 22-23, ICBHS received seven grievances. There were no appeals submitted. The number of grievances increased from FY 21-22 when only two were submitted, as seen in Table 97, which summarizes the grievances by category.

Table 97. Grievances & Appeals by Category

Grievance Category	CY 2020	CY 2021	CY 2022
Related to Customer Service	0	0	0
Related to Case Management	0	0	0
Access to Care	0	0	0
Quality of Care	0	1	7
County (Plan) Communication	0	0	0
Payment/Billing Issues	0	0	0
Suspected Fraud	0	0	0
Abuse, Neglect or Exploitation	0	0	0
Lack of Timely Response	0	0	0
Denial of Expedited Appeal	0	0	0
Field for other reasons	2	1	0

All grievances received during FY 22-23 were resolved according to federal guidelines and to beneficiaries' satisfaction. No trends were identified in the grievances filed.

3) Requests to Change Persons Providing Services

The QM Unit monitors requests to change persons providing services to identify trends with providers or programs and to also ensure beneficiary concerns related to treatment providers are addressed.

During FY 22-23, ICBHS received 14 requests to change persons providing services from beneficiaries. All 14 were related to quality of care concerns, language barrier, not feeling comfortable with the provider, or having no therapeutic alliance. The clinical managers 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. A total of 12 beneficiaries/authorized representatives were approved and notified of the decision by telephone, by mail, or in person within the requisite 14 business days. One request to change providers was withdrawn by the client and one was denied; all other requests were approved.

The number of requests to change persons providing services received has gradually increased since FY 20-21. This is likely related to the overall increase in individuals being served by ICBHS.

The reasons for the requests received in FY 22-23 are summarized in Table 98. No trends were identified in the requests submitted during FY 22-23.

Table 98: Reasons for Request to Change Persons Providing Services

Reason	FY 20-21	FY 21-22	FY 22-23
Quality of Care Treatment Concerns	1	N/A	N/A
Prefer a Spanish Speaking Provider	N/A	N/A	1
Not feeling comfortable with Male/Female Provider	N/A	1	3
No therapeutic Alliance with Provider	1	1	5
Dissatisfaction with Provider	3	4	N/A
Disagreement with Course of Treatment	N/A	1	1
Uncomfortable with Provider	2	3	4

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

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

- The QM Unit will evaluate the CY 2023 TPS responses to determine if additional actions need to be taken to increase adult beneficiary participation in the TPS, particularly from the outpatient programs.

- The QM Unit will conduct additional surveys to obtain youth beneficiary feedback regarding the areas identified with decreased satisfaction.

4. Service Delivery System and Meaningful Clinical Issues Affecting Beneficiaries

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 chart reviews, medication monitoring, and evaluating wait times for the provision of certain levels of care and/or follow-up treatment.

During FY 22-23, as part of the CalAIM initiative, ICBHS trained all current providers on the new policies related to increasing access to DMC-ODS services for adults and children, documentation reform, and providing treatment during the assessment

period prior to diagnosis. These policy changes were incorporated into the QM Unit's monitoring of the DMC-ODS service delivery.

a) Overview of DMC-ODS objectives, scope, and planned activities for FY 22-23:

1) Medication Monitoring

The Medical Director and a pharmacist conducted the medication monitoring reviews monthly. Utilizing a review tool, the Medical Director and pharmacist monitored 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 QM Unit monitors the medication monitoring reviews and reports findings to the QIC at least annually.

The charts are randomly selected from the EHR 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. 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.

During FY 22-23, the Medical Director reviewed 48 charts from the NTP provider. The NTP was 100 percent compliant in all the 19 areas evaluated. For the SUD county-operated programs, the pharmacist reviewed 29 charts with 100 percent compliance in all eight areas evaluated. The Medical Director and pharmacist did not identify any issues that would suggest quality of care concerns for any of the beneficiaries receiving MAT. This is consistent with the reviews conducted during FY 21-22 when no findings were identified. The lack of findings identified during the medication monitoring reviews indicate that ICBHS and its providers are following best practices in the implementation of MAT.

Due to the addition of medical doctors to ICBHS during FY 22-23, a committee consisting of three medical doctors has been established and will be responsible for reviewing the implementation of MAT for the SUD county-operated programs.

2) Chart Reviews

The QM Unit is responsible for conducting chart reviews to monitor if ICBHS is following documentation standards as set forth in the DMC-ODS contract and

ICBHS policies and procedures. This process is instrumental in identifying billing issues, quality of care concerns, as well as opportunities for improvement.

The QM Unit conducted charts reviews on an ongoing basis, with charts randomly selected from the EHR. A review tool with the following sixteen categories is utilized: 1) Access Criteria; 2) Assessment; 3) Physical Examination; 4) Beneficiary Record; 5) Problem List; 6) Continuation of Services; 7) Outpatient Services; 8) Intensive Outpatient Services; 9) Care Coordination; 10) Clinician Consultation; 11) Perinatal Services 12) Recovery Services; 13) Quality of Care; 14) Family Counseling; 15) Adolescent SUD Best Practices Guide; and 16) Other Areas of Review. The QM Unit compiles findings and presents a report to the QIC at least annually.

The QM Unit compiled the data by program identifying opportunities for improvement and areas of concern, as appropriate. Reports were provided to the individual program supervisors and managers, as appropriate. Supervisors were responsible for responding to areas identified as needing corrective action. The QM Unit would approve the Corrective Action Plan (CAP), prior to implementation, and followed up with each program to ensure the Corrective Action Plan was completed.

During FY 22-23, the QM Unit reviewed a total of 40 clinical charts for ICBHS, of which 20 charts were for the Adolescent SUD Program and 20 charts were for the Adult SUD Program. The QM Unit also reviewed 20 charts from the contracted NTP provider and 18 charts from the contracted residential providers. Below are the identified deficiencies for ICBHS SUD county-operated programs:

Physical Examination
If the provider is unable to obtain documentation of the beneficiary's most recent physical examination, does documentation indicate the efforts made to obtain this documentation in the beneficiary's record?
-Out of 39 applicable charts, 77% compliance (Adults-3, Adolescents-6)

Continuation of Services
Documentation of the beneficiary's most recent physical examination
-Out of 18 applicable charts, 56% compliance (Adults-7, Adolescents-1)

Outpatient Services
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?
-Out of 33 applicable charts, 58% compliance (Adults-11, Adolescents-3)

Intensive Outpatient Services
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?
-Out of 8 applicable charts, 38% compliance (Adults-5)

<u>Quality of Care</u>
Are referrals and follow-up provided if there is a presenting need of medical care, mental health care and/or other services?
-Out of 14 applicable charts, 79% compliance (Adults-1, Adolescents-2)

<u>Adolescent SUD Best Practices Guide</u>
Was the treatment and recovery plan developed in collaboration with the adolescent and his or her family or other supportive adults based on his or her unique strengths, assets, and needs?
-Out of 20 applicable charts, 75% compliance (Adolescents-5)

Is the individual treatment and recovery plan assessed and reviewed by the adolescent and provider on a scheduled basis, and, additionally as requested by the adolescent or family?
-Out of 9 applicable charts, 67% compliance (Adolescents-3)

For the NTP contracted providers, areas of concern were identified in the areas of Assessment, and Other Areas of Review. Findings were presented to NTP treatment programs on December 2, 2022, and June 29, 2023.

In addition, residential contracted providers' areas of concern were identified in the areas of Beneficiary Records Quality of Care, and Other Areas of Review. Findings were presented to Clare Matrix on January 12, 2023, ABC Recovery on March 2, 2023, and Tarzana on June 1, 2023.

The QM Unit issued CAPs to each contracted provider to ensure that the appropriate corrections were made, as applicable, and that processes were established to ensure future compliance with treatment and documentation requirements. All evidence of correction for deficiencies for NTP and residential treatment providers were resolved and submitted on time.

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.

3) *Length of Time from Determination of Need to Residential Treatment Admission*

The QM Unit monitors the length of time from determining the need for residential treatment to admission to a residential facility monthly and reports findings to the QIC at least annually. The QIC reviewed a report on December 8, 2022, and June 8, 2023, and agreed to setting a 14-business day

benchmark on determining the need of residential treatment to residential treatment admission.

The monitoring process entails reviewing the Residential Treatment Services Log compiled by ICBHS, 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 22-23, there were a total of 101 ASAM assessments determining residential treatment level of care. Two adolescents placed at the residential level of care were admitted into a residential treatment program in an average of 36 days while the 99 adults were admitted in an average of 21 days. In some instances, the wait time was considerable; however, these delays were due to clients experiencing mental health concerns, being non-adherent to SUD treatment, or becoming incarcerated. For those individuals who experienced a delay in residential admission, ICBHS continued to provide care coordination, individual counseling, and group counseling in the interim.

The total number of residential admissions during FY 22-23 increased by 28 admissions. This is notable as clients have previously reported they were hesitant to agree to residential services due to all facilities being located outside of the county.

A summary of the data for length of time to residential treatment admission is included in Table 99.

Table 99. Residential Admissions

Adolescents	FY 20-21	FY 21-22	FY 22-23
ASAM Assessments Determining Residential Treatment	2	2	2
Total # of Residential Admissions	2	2	2
Average Time for Determination of Need to Residential Treatment Admission	36 days	18 days	36 days
Range (work-days)	27 days	17 days	3 days
Adults	**FY 20-21**	**FY 21-22**	**FY 22-23**
ASAM Assessments determining Residential Treatment	60	63	99
Total # of Residential Admissions	60	63	99
Average Time for Determination of Need to Residential Treatment Admission	29 days	28 days	22 days
Range (work-days)	32 days	4 days	96 days

4) Timeliness of Follow-Up After Residential Treatment

The QM Unit monitors the timeliness of follow-up after residential treatment to ensure beneficiaries are provided with timely treatment as they step down the continuum of care. 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 7-business day timeliness standard.

During FY 22-23, there were a total of 85 clients that were discharged from a residential treatment facility. Of the 85 clients that returned to Imperial County after discharge, 43 (51 percent) received a follow-up service within the 7-business day standard. A summary of the data for follow-up services after residential treatment is included in Table 100:

Table 100. Follow-Up Services After Residential Treatment

Follow-up Services after Residential Treatment	FY 20-21	FY 21-22	FY 22-23
Total number of residential discharges	49	51	85
Total number of follow-up services delivered within 7-days of discharge	37	30	43
Percent of services delivered within 7-days of discharge	76%	59%	51%
Total number of follow-up services delivered within 30-days of discharge	7	40	10
Percent of services delivered within 30-days of discharge	14%	78%	12%

Data shows a decrease in the percentage of clients receiving follow-up services within 7 business days of discharge from residential treatment. The percentage of clients receiving follow-up services within 30 days also decreased significantly.

5) Withdrawal Management Admissions and 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 22-23, there were a total of 12 admissions into withdrawal management, for a total of one unduplicated client admissions. Of those 12 admissions, one readmission occurred within 30 days of discharge, resulting in an 8 percent readmission rate. The annual residential withdrawal management admission and readmission findings are included in Table 101.

Table 101. Withdrawal Management Admission and Readmissions

WM Readmission Rates within 30 days	FY 22-23	FY 21-22	FY 20-21
Total number of WM admissions	12	27	35
Total number of readmissions *within 30 days*	1	1	1

Percent of readmission rate *within 30 days*	8%	4%	3%

Data reflects that the admissions into withdrawal management over the last three fiscal years have been decreasing considerably, although the number of withdrawal management readmissions within 30 days has remained relatively consistent.

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

The QM Unit monitors the utilization of methadone and non-methadone medication treatment for the Narcotic Treatment Program (NTP) and reports findings to management and the NTP, as appropriate.

The monitoring process entails collecting data related to the different medications used in the NTP programs. Data was collected from the EHR, using the "Services Report". This report tracks all clients who were prescribed methadone and non-methadone treatment during a specific review period.

During FY 22-23, there were a total of 411 clients receiving medication used in the NTP programs. The majority of clients received Methadone as seen in Table 102.

Table 102. NTP Utilization of Methadone and non-Methadone (MAT)

NTP - Medications	FY 21-22	FY 22-23
Methadone	301	398
Buprenorphine-Mono	1	0
Buprenorphine-Naloxone Combination	8	13
Disulfiram	0	0
Naloxone- Nasal Spray	0	0
Total	**310**	**411**

Data reflects an increase in the overall total of clients that received medication from FY 21-22 to FY 22-23. Methadone continues to be the number one medication used in the NTP setting although there has been a slow increase in FY 22-23 for clients that are receiving Buprenorphine-Naloxone combination. Feedback from the NTP program indicates beneficiaries are becoming more open to using non-methadone MAT medications.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

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

- ICBHS will implement interventions to ensure providers obtain beneficiaries' most recent physical examination and use it to help inform treatment decisions.

- ICBHS will implement interventions to ensure the requisite outpatient and intensive outpatient hours are made available to beneficiaries and are documented accordingly in each beneficiary's record.

- ICBHS will implement interventions to ensure treatment plans are developed and implemented in accordance with Adolescent SUD Best Practices Guidelines.

- The QM Unit will monitor the length of time from determination of need to residential admission, timeliness of follow-up after residential treatment, and withdrawal management admissions and readmissions and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QM Unit will evaluate length of time from determination of need to residential admission against the 14-business day benchmark established by the QIC.

- 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.

- The QM Unit will begin identifying the factors that may be resulting in clients not receiving follow-up services within 7 business days of discharge from a residential treatment facility.

- The QM Unit will evaluate why the admissions to withdrawal management services have decreased.

- The Narcotic Treatment Programs (NTPs) will continue to offer, when medically necessary, the required non-Methadone MAT medications of Buprenorphine, Disulfiram, and Naloxone.

5. 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 22-23:

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

Training & Education
During FY 22-23, SUD staff were assigned to participate in training on Seeking Safety therapy, an evidence-based treatment that helps those with trauma, posttraumatic stress disorder, and substance misuse. The purpose of this training was to acquire Seeking Safety techniques to educate clients with coping skills to attain safety in their lives.
SUD staff also participated in CalAIM training webinars to ensure staff have an understanding of and meet the requirements of CalAIM. The components included in these training were CalAIM overview, access to services, assessment, diagnosis and problem list, progress notes, and care coordination.

Outreach and Engagement
Adult and Adolescent SUD Programs continue to build strong partnerships with agencies such as school districts, mental health, justice system, medical providers, local hospitals, and community agencies. The outcome of these partnerships has resulted in an increase of incoming referrals. ICBHS conducts outreach and engagement activities in all areas of Imperial County to address accessibility of services, referral process, and identification of treatment needs. Some of the outreach activities included the following: outreach/resource events, presentations, information dissemination, and advertisements.

Recovery Incentives Program
Since ICBHS was approved to participate in the DHCS Recovery Incentives Program: California's Contingency Management Benefit on April 28, 2022, ICBHS has been diligently preparing to implement the Recovery Incentives Program. It required extensive training for staff to complete such as two-part four self-pace CM Overview Trainings, two live trainings with UCLA CM Implementation Specialists, and substance use disorder (SUD) counselors, behavioral health therapists (BHTs) and program supervisor has to prepare and complete role scenarios assessments and practice cases. Also, SUD Counselors and BHTs had to learn to use Incentive Manage Portal to execute recovery incentives to beneficiaries. Furthermore, ICBHS developed specific policies and procedures to ensure adherence to the recovery incentives program and to comply with the state and federal requirements to conduct substance use testing. ICBHS applied and received four Clinical and Public Health Laboratory Licenses from California Department of Public Health (CDPH) and four Clinical Laboratory Improvement Amendments (CLIA) certificates of waiver from the Centers of Medicare and Medicaid Services (CMS) on April 5, 2023.

Harm Reduction
In the efforts to prevent overdoses, ICBHS relies on a strategy of harm reduction that centers on prevention, treatment and recovery. ICBHS is proactive in providing education and information to schools and communities with the idea that such outreach remains one of the most effective strategies to prevent substance use. Outreach is conducted in partnership with schools, law enforcement, hospitals, and other community agencies. As part of the

prevention and treatment efforts, ICBHS provides clients and the community with naloxone, a life-saving medication used to prevent an opioid overdose from drugs such as heroin, fentanyl, and prescription opioid medications. ICBHS also provides fentanyl test strips that detect the presence of fentanyl in other drugs.

ICBHS continues to participate in 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. ICBHS implemented and followed the developed distribution plan, policies, and procedures. Trainings were provided regarding the administration of naloxone, client and employee distribution including storage and disposal. In January 2022, ICBHS received 252 units of Naloxone, 252 units in October 2022, and 744 units in April 2023, which were distributed to staff, clients and their families and support system. ICBHS will submit future applications to continue with this project with the goal of preventing opioid overdoses throughout the county.

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, for clients in need of pre-screening for SUD Treatment to linked them to outpatient treatment for MAT and other SUD related services. This collaboration allows ICBHS to provide MAT to those individuals who enter the emergency room and follow established protocol with ECRMC in which individuals who are treated with buprenorphine at the emergency room are bridged to the ICBHS outpatient clinic for continuity of care. For FY 22-23, ICBHS received 56 Bridge referrals. This partnership has allowed for timely access to services as clients can walk into the emergency room 24/7 and begin treatment immediately. ICBHS has designated appointments for ECRMC clients to ensure accessibility to services with an outpatient clinic within seven days from their release from the hospital.

ICBHS and Pioneers Memorial Hospital (PMH) discussed the process of implementing SUD navigation in the hospital to ensure patients in need of SUD and MAT services are linked to SUD Treatment Programs. ICBHS will provide assistance in educating PMH staff on SUD referral process.

Criminal Justice System
Adult SUD Treatment Programs continues to collaborate with Imperial County Sheriff’s Office (ICSO) and its medical provider, Naphcare, to expand access to MAT in the county’s criminal justice setting. ICBHS and ICSO hold monthly meetings to ensure clients receiving MAT at the County Jail are successfully linked to outpatient SUD treatment upon

release from incarceration. ICBHS continues to work closely with the Imperial County Superior Court, Probation Department, and County Jail to coordinate court ordered SUD evaluations. Through this partnership, for FY 22-23, SUD completed 203 court ordered in-custody assessments and care coordination to clients who are incarcerated. Adult SUD provided treatment services and, whenever necessary, linked to residential facilities, mental health services, recovery housing and other community services upon their release from jail.

School Partnerships
Adolescent SUD Programs continue to see an increase of referrals from the local school districts. School districts have demonstrated significant support toward the provision of SUD treatment services at the school sites, by providing referrals, requesting presentations to educate the students and parents in the harm of substance use as well as accessing SUD treatment services. The Adolescent SUD Program continues to provide outpatient (ASAM level of care 1.0), intensive outpatient (ASAM level of care 2.1), care coordination, Medication for Addiction Treatment (MAT), Crisis Intervention Services, Recovery Services and Residential Treatment Services.

Health Management Associates – Systems of Care Learning Collaborative – Optimizing Programs and Systems to Meet the Needs of Populations with Opioid and Other Substance Use Disorder (OUD/SUD)
On February 15, 2023, ICBHS entered into an agreement with Health Management Associates (HMA) to work in collaboration as part of the State Opioid Response Grant awarded by SAHMSA to DHCS. ICBHS received an amount of $25,000.00 for the purpose of implementing specific and approved strategies to expand access to MAT, residential treatment and/or improved care for individuals with co-occurring mental health and substance use disorders. Additionally, ICBHS aims to improve and expand SUD and MH services, enhance the knowledge and awareness of working with individuals with co-occurring disorders, improve community collaboration, and obtain collaboration for the implementation of harm and stigma reduction. ICBHS and HMA have been working in collaboration to implement processes and systems to identify, address, monitor disparities in access, utilization and outcomes of SUD and related treatment. As of today, ICBHS continues to receive customized coaching calls and mentoring activities.

Youth Opioid Response Grant 3
On April 1, 2023, ICBHS was awarded $500,000 from the Youth Opioid Response (YOR) grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response (SOR). The YOR grant will assist ICBHS to support prevention, treatment, and recovery services for youths (ages 12-24) with or at risk of opioid use disorder (OUD) and/or stimulant use disorder (StUD). As a result of this funding, ICBHS-SUD Treatment Program will be able to expand and provide enhanced services for youth and young adults with

or at risk of developing OUD and/or other StUD by expanding MAT and other SUD treatment services.

Round 5 Crisis and Behavioral Health Continuum
ICBHS was conditionally awarded $17,285,302 million in grant funding for county-based projects that support behavioral health infrastructure, giving the county new opportunities to address gaps in care and create sustainable improvements that better serve Imperial County residents. The award is delivered through the Department of Health Care Services' (DHCS) Behavioral Health Continuum Infrastructure Program (BHCIP) Round 5: Crisis and Behavioral Health Continuum grants. Funds will be used for the establishment and development of a 16 bed Residential SUD treatment facility in Imperial County that will provide ASAM Level 3.2 Withdrawal Management and Level 3.5 High Intensity Residential Treatment.

2) Memorandum of Understanding with Manage Care Plans

ICBHS continues to maintain Memorandums of Understanding (MOU) with two Medi-Cal Managed Care Plans (MCPs), California Health and Wellness and Molina. The MCP's 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 22-23, ICBHS upper management team and MCP representatives met in quarterly meetings to aid ICBHS in working collaboratively with the MCPs to ensure that processes affecting client continuity of care are appropriate and effective. In CY 2024, Imperial County will have two new MCPs that ICBHS will need to establish relationships with.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

- 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.

- ICBHS, in collaboration with Imperial County Sheriff's Office and Imperial County Probation Department, will develop an implementation plan that will outline processes to ensure the assessment, referral, and care coordination of incarcerated individuals who are identified as meeting criteria for Specialty Mental Health Services (SMHS) and substance use disorder treatment. ICBHS will ensure that these individuals are linked and have access to these services once released by providing care coordination services and ensuring adequate placement into treatment, which may include residential treatment services.

- ICBHS will increase community outreach and engagement activities in all areas of the county and amongst key community agencies to educate on the risks associated with substance use among the youth and young adult population. These outreach activities addressed accessibility of services, the referral processes, developing collaborative relationships to address the needs of youth misusing OUD, StUD or other SUD with the purpose of increasing community awareness and decreasing stigma associated with OUD, StUD and other SUDs.

- To expand access to evidence-based treatment for stimulant use disorder SUD programs will implement Recovery Incentives Program utilizing contingency management an evidence-based practice that recognizes and reinforces individual positive behavior change consistent with meeting individualized goals, including reduction or cessation of stimulant use and longer retention in treatment.

- ICBHS will increase efforts to integrate, as much as possible, the provision of mental health and SUD treatment services. ICBHS will follow policies to ensure confidentiality and obtain consents for release of information from clients to facilitate the exchange of information between treatment providers and coordination of care to address both mental health and SUD needs of clients. SUD providers consistently identify potential mental health issues and referred them to mental health to ensure clients are successfully linked. Both SUD and MH treatment providers take a team approach to address crisis and emergency situations and provide linkage to other ancillary services to prevent homelessness, incarcerations, isolation, and hospitalizations.

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

- ICBHS will partner with the two new MCPs assigned to Imperial County effective January 1, 2024, in order to coordinate care for Imperial County Medi-Cal beneficiaries.

6. 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 22-23:

During FY 22-23, 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 22-23, no complaints were reported to the QM Unit, as indicated in Table 103.

Table 103. DMC-ODS Provider Complaints

Period	Number of Complaints	Reason for Complaint	Resolved	
			Yes	No
FY 22-23	0	N/A	N/A	N/A
FY 21-22	0	N/A	N/A	N/A
FY 20-21	0	N/A	N/A	N/A

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.

7. 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.

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

The QM Unit monitoring process consisted of collecting data related to hospitalizations from ICBHS' 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 number of days the client was hospitalized, the number of ICBHS program episodes prior to the hospitalization as well as ASAM level of care, and the timeliness of follow-up care after hospital discharge. If any hospitalizations are reported, the QM Unit will also document ICBHS' efforts to prevent the hospitalization.

During FY 22-23, there were 14 hospitalizations made by SUD treatment programs, as indicated in Table 104.

Table 104. Hospitalization Admissions and Readmissions

Review Period	Admissions	Readmissions
FY 20-21	4	3

FY 21-22	11	4
FY 22-23	14	1

The Adult SUD Program (71%) experienced a higher number of hospital admissions compared to the Adolescent SUD Program (29%) during the fiscal year. During FY 22-23 the Adolescent SUD Program had one client that had a hospital readmission.

Overall, the average hospitalization time frame for both Adult and Adolescent SUD Programs was 0-3 days. After hospitalization, the average timeframe for follow-up care aftercare was within 0-3 days (57%). Data shows that most of the clients received timely follow-up care within the first week after leaving the hospital.

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 23-24:

- 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.

8. 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 22-23:

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.

For the purpose of this review, the monitoring process entailed collecting data on ASAM Assessments, MAT appointments, and individual counseling appointments from the AVATAR System, using the "SUD No Show Report" for the first two

quarters within the FY 22-23. Although the QM Unit was able to retrieve data for quarters three and four, it was identified that data was inaccurate due to the miscoding of appointments entered in the new EHR. For this reason this section will only apply to quarters one and two of FY 22-23..

During FY 22-23, the county-operated SUD treatment programs implemented strategies to decrease the no show rates to their ASAM Assessment appointments, MAT services, and individual counseling appointments, including, but not limited to, the following: conducting retention calls and arranging transportation, when needed, to ensure clients attend their scheduled appointments.

In an attempt to decrease the no show rates, the county-operated SUD treatment programs implemented as part of one of their Performance Improvement Project (PIP) the Positive Engagement Team (PET) within the SUD clinics. The goal of this PIP was to reduce stigma, negative feelings, attitudes, beliefs, stereotypes, perceptions, and/or discrimination associated with substance use disorder which can ultimately make the client less resistant to treatment and may increase their commitment to engage in treatment.

During the last two quarters of FY 22-23, the county-operated SUD treatment programs implemented PET to increase attendance to scheduled ASAM assessments and individual counseling appointments. Prior to beginning the PET intervention, the county-operated SUD treatment programs conducted a survey to obtain feedback from clients on the idea of having dogs present at the clinics during their scheduled appointments. Most clients reported they were looking forward to their appointment and requested their appointment(s) during the day/time the dog would be available at the SUD clinics. A brochure and a flyer were created by the county-operated SUD treatment programs to advertise the PET at the SUD clinics along with the days/times the dogs would be on-site.

The QM Unit measured a decrease in the percentage of no-shows when the PET was visiting the clinic on their particular date and time. Despite the conclusion of the PIP, the dogs will continue to visit the SUD clinics to increase client engagement during their scheduled appointment at the SUD Clinics.

1) ASAM Assessment Appointments

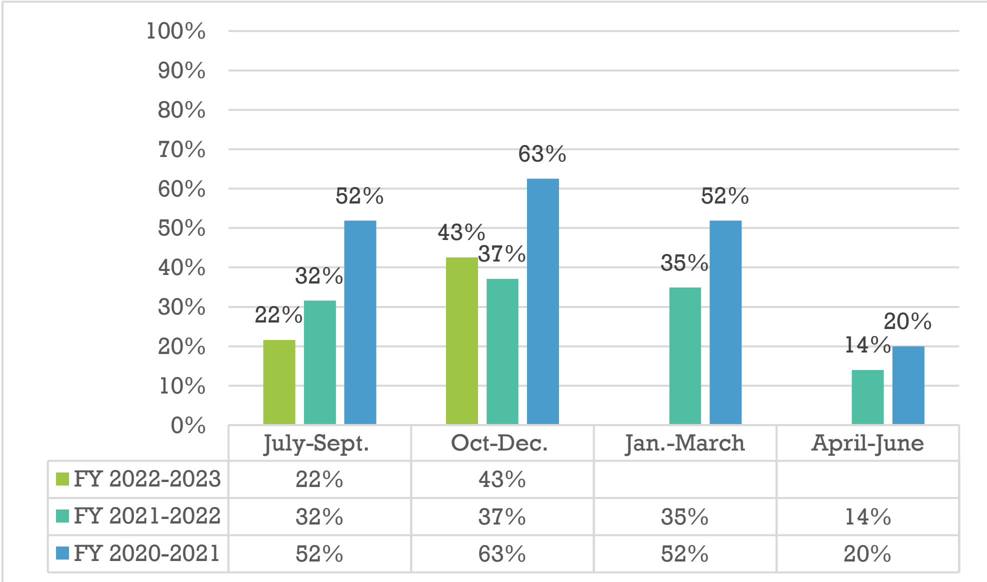
On February 13, 2020, the QIC program established the following benchmarks for the no show rates to ASAM assessment appointments:

- Adolescent SUD Program – 40 percent
- Adult SUD Program – 55 percent

During the first two quarters of FY 22-23, there was a total of 101 unduplicated clients with history of missed appointments. Of those, 37 (37%) had multiple appointments (2+ appointments), with the majority attending to one of their scheduled appointments and 64 (63%) had a rescheduled or canceled their appointment and did not return to receive

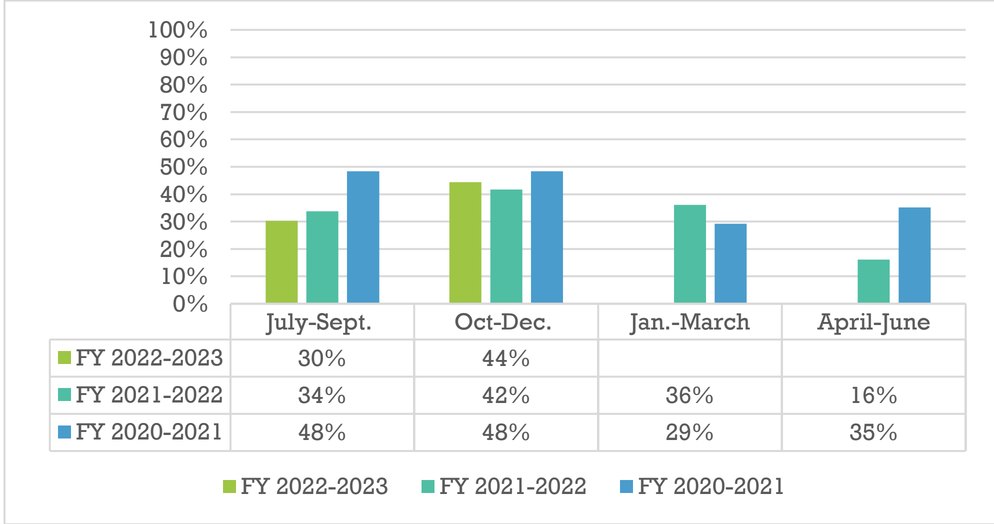
treatment services. Table 105 & 106 provides the total percentage of no-show for the ASAM assessment amongst the adolescent and adult programs for the first two quarters of FY 22-23 along with a comparison of the previous two fiscal years.

Table 105. ASAM Assessment: Adolescent Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	22%	43%		
FY 2021-2022	32%	37%	35%	14%
FY 2020-2021	52%	63%	52%	20%

Table 106. ASAM Assessment: Adult Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	30%	44%		
FY 2021-2022	34%	42%	36%	16%
FY 2020-2021	48%	48%	29%	35%

FY 2022-2023 FY 2021-2022 FY 2020-2021

During the reporting period, the Adolescent SUD Program met their 40 percent benchmark in both FY 21-22 and FY 22-23; however, in the second quarter of FY 22-23, the percentage increased almost twice from quarter one. A potential contribution to the no-show rates identified in this quarter could be attributed to the discrepancies identified in the AVATAR SUD No Show Report as the staff entries for no shows were identified differently from quarter one. For the Adult SUD Program, data reflects that they stayed below the 55 percent benchmark for both quarters.

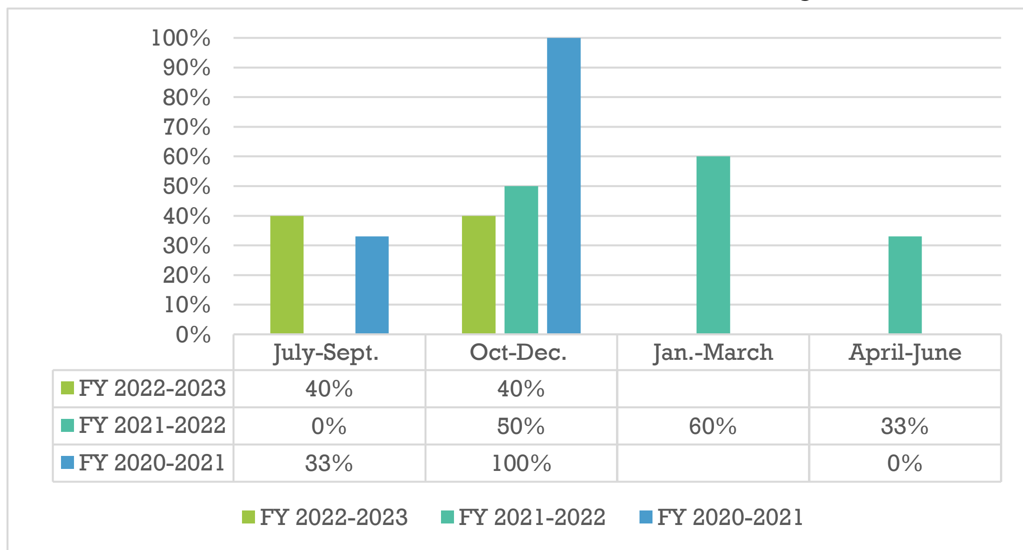
2) Medication Assisted Treatment (MAT)

The QIC established the no-show benchmark for the Adolescent SUD Program on April 14, 2022, and the benchmark for the Adult SUD Program on January 21, 2021, for MAT appointments:

- Adolescent SUD Program – 50 percent
- Adult Sud Program – 30 percent

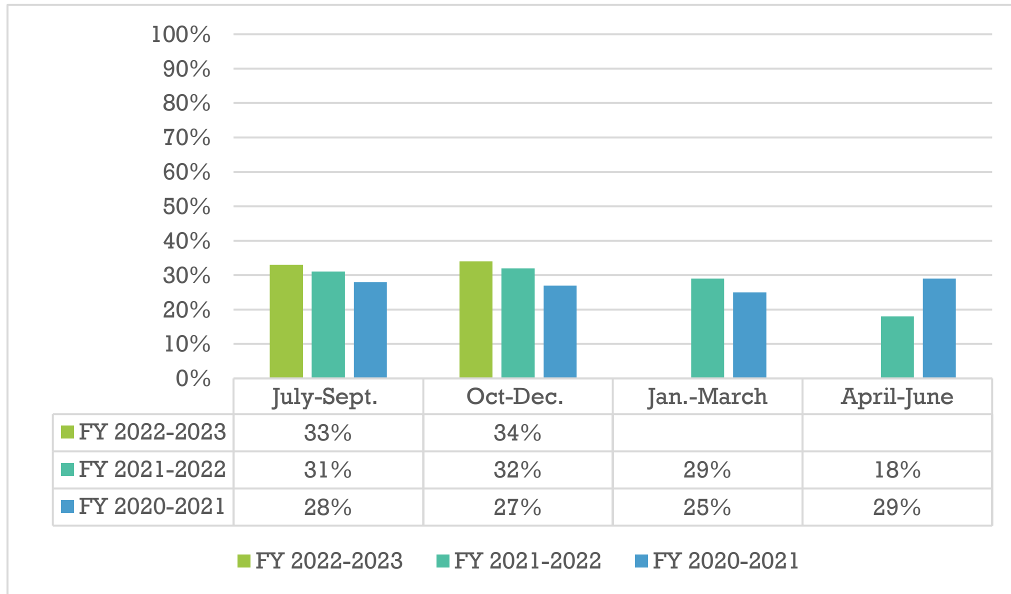
During the reporting period, the Adolescent SUD Program met their 50 percent benchmark in both FY 21-22 and FY 22-23;however, the Adult SUD Program experienced a slight increase in their no show rate, increasing from 32 percent the first quarter to 34 percent the second quarter. The rise in no show rates could be attributed to the discrepancies identified in the AVATAR SUD No Show Report as the staff entries for no shows were identified differently from quarter one. No trends were identified by provider, hours of operation, or days of the week. The results by program are summarized in Table 107 & 108.

Table 107. MAT Services: Adolescent Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	40%	40%		
FY 2021-2022	0%	50%	60%	33%
FY 2020-2021	33%	100%		0%

Table 108. MAT Services: Adult Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	33%	34%		
FY 2021-2022	31%	32%	29%	18%
FY 2020-2021	28%	27%	25%	29%

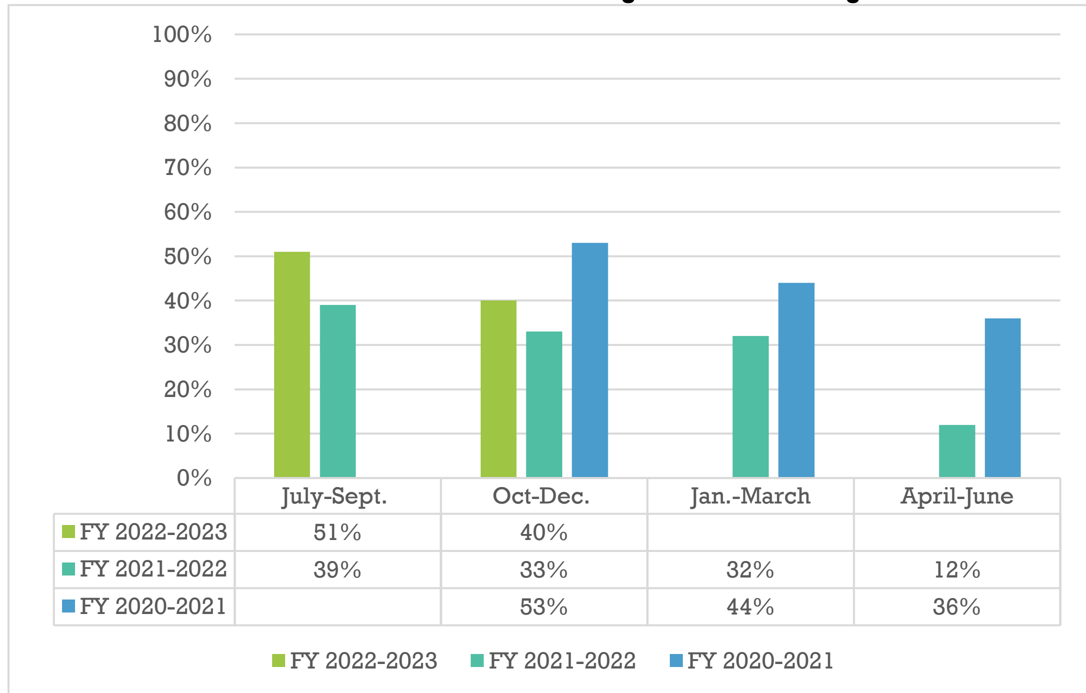
3) Individual Counseling Appointments

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

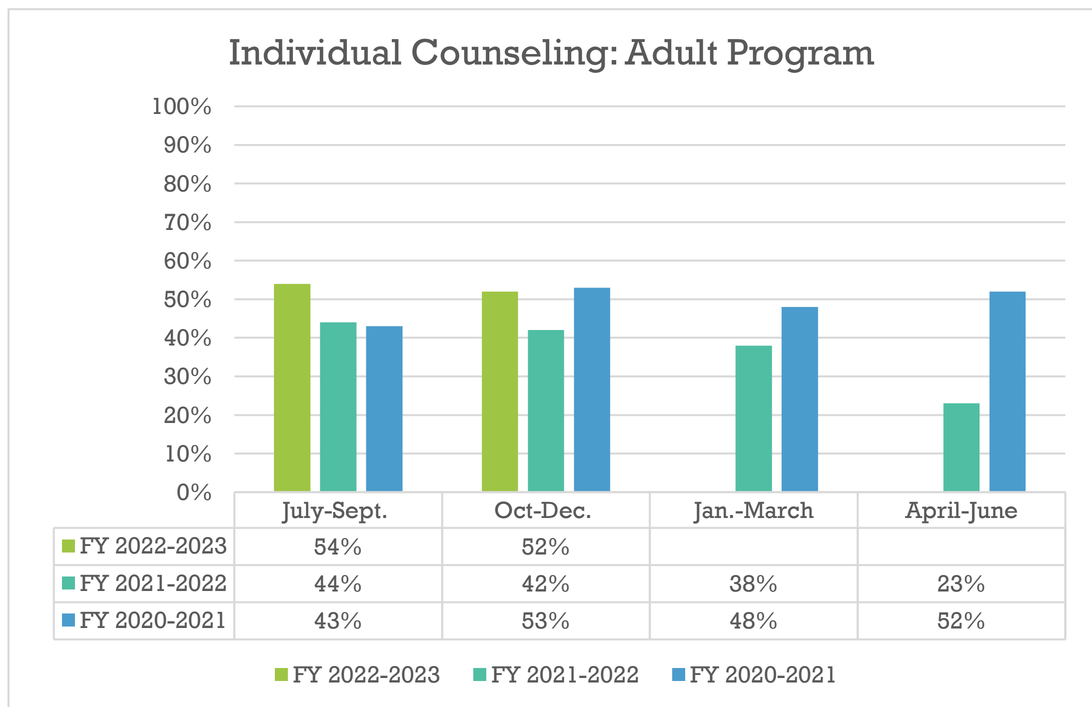
Report findings reflect that the no show rate to individual counseling appointments for the Adolescent SUD Program in the first quarter was higher than the established benchmark of 41 percent and slowly decreased to 40 percent in the second quarter. For the Adult SUD Program, data reflects a higher no show rate than the established benchmark for both quarters one and two. No trends were identified by provider, hours of operation, or days of the week. The results by program are summarized in Table 109 & 110.

Table 109. Individual Counseling: Adolescent Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	51%	40%		
FY 2021-2022	39%	33%	32%	12%
FY 2020-2021		53%	44%	36%

Table 110. Individual Counseling: Adult Programs



	July-Sept.	Oct-Dec.	Jan.-March	April-June
FY 2022-2023	54%	52%		
FY 2021-2022	44%	42%	38%	23%
FY 2020-2021	43%	53%	48%	52%

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

- The QM Unit will monitor the no show rates to ASAM assessment appointments, MAT appointments, and individual counseling appointments and report findings, including identified trends and recommendations, to the QIC at least annually.

- The QIC will discuss standardizing no show benchmarks across service types and establishing lower benchmarks for scheduled appointments, utilizing interventions to make incremental improvements towards achieving those benchmarks.

9. 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 and the timeliness of the First Dose of NTP Services.

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

1) Timeliness of Initial Medication Assisted Treatment (MAT) Request to First Medication Assisted Treatment Appointment

The QM Unit monitors all clients who have been referred to MAT services. The source document utilized is the MAT Timeliness Report 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.

MAT services are offered to clients via El Centro Regional Medical Center (ECRMC) and through the ICBHS county-operated SUD Treatment Programs. It is possible that clients may receive a MAT service prior to establishing access and medical necessity criteria for DMC-ODS services.

Findings indicate that the average MAT appointment provided by the ICBHS county-operated SUD Treatment Programs ranged from 16 to 36 days. No documentation was found to indicate no shows or other factors prior to attending the first MAT appointment.

Table 111 summarizes the findings for measuring the length of time from initial MAT request to first MAT appointment. The timeframe covers quarters one and two of FY 22-23 – the data for quarters three and four was not able to be captured due to the new EHR.

Table 111. 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 22-23	35	26	74%	16 days	36 days
FY 21-22	229	150	71%	13 days	56 days
FY 20-21	163	84	52%	10 days	53 days

2) **Timeliness of the First Dose of NTP Services**

The current timeliness standard for providing a NTP appointment from the date of request is 3 business 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.

During FY 22-23, the source document utilized in the quarterly reviews 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, the QM Unit measures the number of business 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 22-23, the QM Unit verified that the NTP clinics were able to offer the first dose of NTP services within 3 business days of the initial request for all clients. The NTP clinic maintained a consistent compliance rate over the last two years as indicated in Table 112:

Table 112. 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 22-23	98	98	0	100%	0 days
FY 21-22	97	96	1	99%	0 days
FY 20-21	90	90	0	100%	0 days

b) Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

- The QM Unit will monitor the Timeliness of Initial MAT Request to First MAT Appointment and Timeliness of First Dose of NTP Services and report findings, including identified trends and recommendations, to the QIC, as appropriate.

- The QM unit will work collaboratively with Information Systems (IS) for the development of tracking of the Timeliness of Initial MAT Request to First MAT Appointment in the new EHR system.

- 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.

10. 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 that are required by EQRO. The task force works together to identify areas of improvement

along with goals, interventions, data collection, and measured outcomes. On a monthly basis the QIC is informed on what the taskforce has been working on. Membership of the taskforce varies depending on the focus of each project.

During FY 22-23, ICBHS began participating in the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Quality Improvement Program (BHQIP), an incentive payment program to support Mental Health Plans (MHP), Drug Medi-Cal State Plans (DMC) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). As part of the BHQIP, the county is expected to deliver three milestones, of which one is focused on three PIPs that will leverage improved data exchange capabilities to improve quality and coordination of care. It is expected for ICBHS to submit these BHQIP PIPs by September 29, 2023, and March 20, 2024. Of the three BHQIP PIPs, two are related to the DMC-ODS:

1) Pharmacotherapy for opioid use disorder (POD); and,

2) Follow-up after emergency department visits for alcohol and drug abuse and dependence (FUA).

The Centers for Medicaid Services (CMS) requires DMC-ODS plans to have one active and ongoing clinical PIP and one active and ongoing non-clinical PIP each year as a part of the plan's quality assessment and performance improvement (QAPI) program, which are graded annually by CalEQRO. CalEQRO is currently allowing only one BHQIP PIP to count towards each county's PIP submissions, so for FY 22-23, ICBHS implemented three PIPs total.

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

1) Decreasing the no show rates for ASAM and Individual Appointments (EQRO: Non-Clinical)

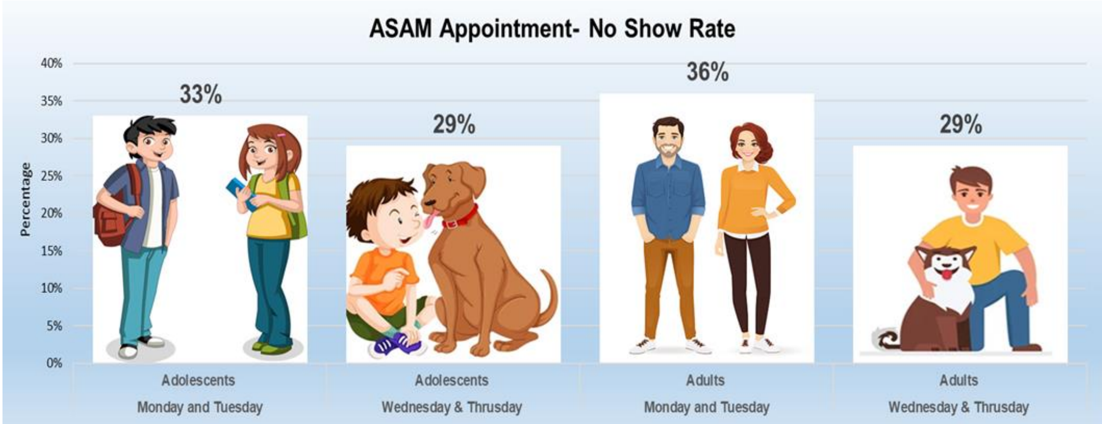
During the FY 20-21 EQRO review, it was recommended for ICBHS to evaluate the ASAM no-show rate as it was identified that the average monthly no-show rate of 40.4 percent.. Upon further review, the QM Unit determined that ASAM appointments had an overall no show rate of 42 percent, with the highest percentage being 50 percent during the second quarter of FY 20-21: the Adult SUD Program had the highest no show rate from the first to the third quarter ranging from 52 to 63 percent and the Adolescent SUD Program had the highest no show rate in the first and second quarters with 48 percent each. For individual counseling appointments, the analysis showed an overall no show rate of 49 percent, with the highest percentage being 53 percent during the second quarter. The Adult SUD Program had the highest no show rate in the second and third quarters ranging from 43 to 53 percent, while the Adolescent Sud program had the highest no show rate in the first and fourth quarters, ranging from 36 to 53 percent.
One of the potential causes of the high no show rate is low client engagement to attend ASAM and individual counseling appointments. Although appointments are available via telehealth and telephone, and retention calls are conducted a day before to remind clients of appointments, clients continue to miss appointments.

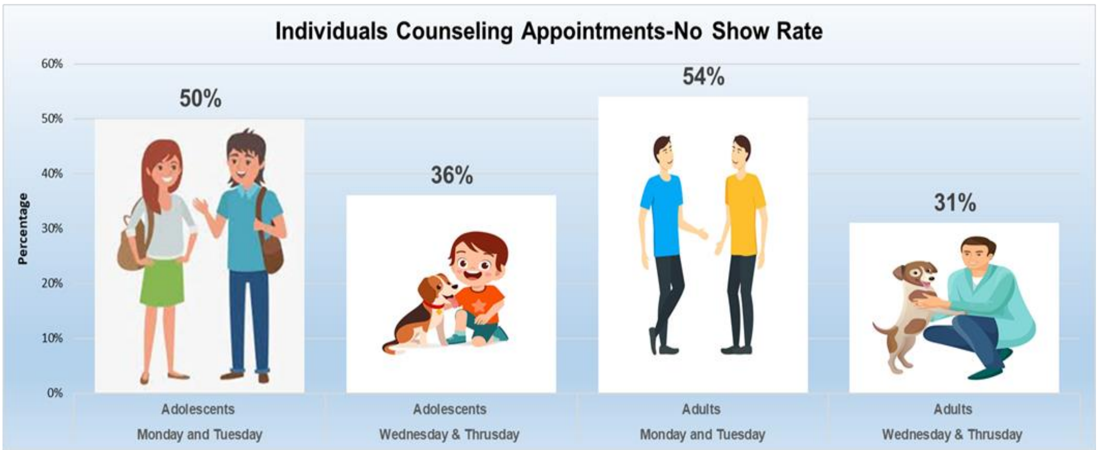
The ICBHS county-operated SUD Treatment Programs implemented the Positive Engagement Team (PET) intervention in January 2023 to increase attendance to scheduled ASAM assessments and individual counseling appointments (these include evaluations to establish medical necessity, ASAM updates, treatment planning for adolescent clients, continuing services justification, discharge planning, and evidence based therapy sessions).

The components of PET are to promote trust and increase client engagement in treatment with the presence of trained dogs. Additionally, the PET will assist in creating a positive, welcoming, and engaging experience during scheduled appointments which can make the client less resistant to treatment and may increase their commitment to engage in treatment.

The study question for this PIP is as follows*: If the SUD Treatment Programs have the PET program during the clients' scheduled appointments, will the ASAM and individual counseling appointments no-show decrease by 5% from the baseline and improve the clients' outcomes?*

The PIP concluded as of June 2023. During the review period, despite not reaching the goal of this PIP, the SUD Treatment Program was able to decrease the percentage of no shows when the PET was visiting the clinic on their particular date and time. The following graphs provide an overview of the findings.





2) Pharmacotherapy for Opioid Use Disorder (POD) (BHQIP)

During FY 22-23, ICBHS began implementing measures to address performance related to the HEDIS measure Pharmacotherapy for Opioid Use Disorder (POD). The PIP taskforce held several meetings with the County's NTP provider, first meeting in November 2022 to discuss information exchange in support of the POD measures. The PIP Taskforce and NTP have continued to meet regularly to monitor the progress of the interventions which are tracked in the Imperial PIP Progress Tracker and the DHCS PIP Template.

Due to the transition to the new EHR on February 1, 2023, ICBHS faced a challenge during the initial stages of the process regarding data exchange. This transition has presented difficulties in obtaining data from ICBHS' internal and external providers resulting in delays in the data exchange process and in the monitoring and tracking of clients. After resolving these difficulties, the QM Unit has been successful in extracting data from the new EHR regarding NTP's submitted claims.

The AIM Statement for this PIP is as follows: To increase the percentage of individuals in Imperial County maintaining Pharmacotherapy for Opioid Use Disorder (POD) for 180+ days without gaps from 13% to 25% within one year by reducing barriers to access and enhancing support services for individuals with opioid use disorder.

As part of the analysis of the intervention performance of NTP, ICBHS measured the percentage of missed consecutive doses flagged for follow-up engagement.

Out of the 281 beneficiaries that received MOUD at NTP Clinics, 45 patients were flagged for follow-up engagement of 3 missed days or more.

Numerator: Number of missed consecutive doses flagged for follow-up engagement (45)

Denominator: Total number of clients receiving medication during a specific period (281)
Calculation: Percentage = (45 / 281) x 100 = 16.01%

The measure for successful transition to follow-up care is approximately 16.01%.

A milestone deliverable will be submitted on September 29, 2023 and a second on March 20, 2024. The intended outcome of this PIP is to improve coordination and planning for addressing the underlying causes related to POD and enhance data access and exchange between NTP and ICBHS. The goal is to enhance treatment adherence, improve clients' outcomes, and increase the overall effectiveness of the program.

3) *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (BHQIP & EQRO-Clinical)*

During FY 22-23, ICBHS began implementing measures to address performance related to follow-up after emergency department visits for alcohol and other drugs or dependence. ICBHS held a meeting with El Centro Regional Medical Center (ECRMC) in October 2022 to discuss exchanging information in support of the FUA measures. ICBHS was unable to leverage secure direct messaging via the EHR with ECRMC due to technological constraints with ECRMC's current EHR in their Emergency Department (ED). ECRMC was in process of transitioning EHRs and there was potential to explore secure direct messaging in the future. As an interim solution, ICBHS used SUD staff from the California Bridge Program stationed at the ECRMC Emergency Room (ER) and created a designated email to serve as a centralized receiving point for incoming referrals from ECRMC. The SUD staff from the California Bridge Program are stationed at ECRMC from 8:00 am to 5:00 pm, Monday to Friday, and their job is to link and complete a referral to ICBHS for those individuals that were in the ER due to a SUD related condition. If the assigned SUD staff is unavailable, the ED Case Manager from ECRMC will be responsible to streamline the referral process by sending the referral via the designated email. Following this protocol ensures that beneficiaries are more likely to be transitioned to follow-up care.

Implementing the FUA PIP has proven challenging. The preexisting financial and systemic challenges faced by hospitals in Imperial County have been further aggravated by the economic strain brought by the COVID-19 pandemic. As a result, ICBHS is encountering difficulties in establishing effective communication channels with both ECRMC and Pioneers Memorial Hospital (PMH) due to the existing challenges associated with healthcare. ICBHS continues to make efforts to establish a collaborative working relationship with PMH, as well as enhance its current relationship with ECRMC.

Aside from the continued efforts with the local EDs, ICBHS Information Systems Unit reached out to the local Medi-Cal Managed Care Plans (Molina and California Health & Wellness) regarding data exchange capabilities to make some progress on this project. ICBHS met with Molina on May 10, 2023, and California Health & Wellness on May 24, 2023, and continue to have discussions regarding data exchange processes.
The PIP Taskforce has met regularly since the inception of this PIP to discuss information exchange and to monitor the progress of the interventions which are tracked in the Imperial PIP Progress Tracker and the DHCS PIP Template.

The AIM Statement for this PIP is as follows*: For Medi-Cal beneficiaries with ED visits for SUD, implemented interventions will increase the percentage of follow-up SUD services with the Plan within 7 and 30 days by 5% by June 30, 2023.*

As part of the analysis of the intervention performance of SUD, ICBHS measured the percentage of clients who successfully transitioned to follow-up care.

Out of the 110 clients at the emergency room, 52 clients were successfully transitioned to follow-up care with the SUD Treatment Programs. Among the remaining clients, 58 declined to receive services from the program.

Out of these, 17 clients followed up with their primary care physician (PCP) and/or mental health services, one client went to residential care, two were incarcerated, and the outcomes for 38 clients were unknown after discharge. Among the 52 clients who successfully transitioned to follow-up care, 32 attended their scheduled appointments with ICBHS.

Numerator: Number of clients who successfully transitioned (referral) to follow-up care (52)

Denominator: Total number of clients assessed by SUD staff (110)

Calculation: Percentage = (52 / 110) x 100 = 47.27%
The measure for successful transition to follow-up care is approximately 47.27%.

Numerator: Number of clients who kept their appointment after ED visit (32)

Denominator: Total number of clients who were scheduled with an appointment after ED visit (52)

Calculation: Percentage = (32/ 52) x 100 = 61.54%

The measure for appointments kept after ED visit is approximately 61.54%.

A milestone deliverable will be submitted to DHCS on September 29, 2023, and a second on March 20, 2024. The intended outcome of this PIP is to improve the continuity of care for individuals with alcohol and substance use disorder by implementing effective coordination and referral processes between ICBHS and EDs, with the goal of ensuring that individuals receive the necessary follow-up after emergency department visit due to an alcohol and other drug abuse or dependence.

b. Overview of the DMC-ODS objectives, scope, and planned activities for FY 23-24:

- The SUD PIP Task Force will continue to meet regularly to monitor the progress of EQRO Clinical and Non-Clinical PIPs goals and objectives.

- ICBHS will continue to participate in the CalAIM Behavioral Health Quality Improvement Program (BHQIP). With the support of the Information Systems Unit and the DMC-ODS 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 the EQRO Road Maps.

- The QM Unit will submit as required the BHQIP PIP Progress Tracker Tool and DHCS PIP Template.

CULTURAL AND LINGUSITIC COMPETENCE

In an effort to provide services with sensitivity to the linguistic and cultural background of ICBHS beneficiaries in FY 22-23, 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 22-23:

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 22-23. 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

Cultural Competence Training Plan
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.

Cultural Competence Training Report
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 22-23, the QM Unit monitored ICBHS compliance with the requirement of attending at least one cultural competence training per year. Out of 583 ICBHS employees, 100 percent completed a cultural competence training as required, although it should be noted that 3 percent of the staff were unable to complete their training due to being out on medical leave and/or new hires. 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 135 mental health and SUD program staff during FY 22-23. 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 22-23, the Access Unit supervisor provided two trainings to approximately 16 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 22-23, one interpreter training took place via Zoom on March 20-23, for 18 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 22-23, 70 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 147 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 22-23, the CCTF continued its work toward achieving its CY 2023 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 2023 Annual Cultural Competence Plan. Some of the CCTF achievements include:

- As part of CLAS standard Goal 5, 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 22-23 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.

- 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 FY 22-23 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 22-23 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 22-23, 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;
  - **Crisis Care Mobile Unit:** The CCTF reviewed the brochure on March 23, 2023, and recommendations were provided to the appropriate program.
  - **Positive Engagement Team (P.E.T):** The CCTF reviewed the brochure on March 27, 2023, and recommendations were provided to the appropriate program.
  - **Soaring Hawks:** The CCTF reviewed the brochure on March 27, 2023, and recommendations were provided to the appropriate program.

During FY 22-23, 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 22-23, the QM Unit prepared a CCP Update, which included the activities conducted by ICBHS CCTF. The CCP will be updated during FY 23-24 as required.

e) *Other Activities*
<u>Informing Clients of Their Right to Language Assistance Services</u>
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 84 percent of the workforce is bilingual and 90 percent is proficient in the Spanish language.

During FY 22-23, 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.

<u>Interpreter Services Contracts</u>
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.

<u>Quality Improvement Committee</u>
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.

<u>Mental Health Service Act Steering Committee</u>
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 22-23, 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 86.1 percent of the population and 74.86 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					
Service Region	**Average of full-time equivalent staff**		**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Southern Services	0.89% 3.64% 1.41% 6.25%	Full-time equivalent psychiatrists Full-time equivalent clinicians Full-time equivalent nurses Full-time equivalent mental health rehabilitation specialist/technicians	100% Hispanic	100% Spanish	90% Hispanic
Central Services	1.52% 8.41% 2.75% 15.83%	Full-time equivalent psychiatrists Full-time equivalent clinicians Full-time equivalent nurses Full-time equivalent mental health rehabilitation specialist/technicians	100% Hispanic	85% Spanish	100% Hispanic
Northern Services	78.00%	Full-time equivalent psychiatrists	83% Hispanic	83% Spanish	100% Hispanic

	2.91%	Full-time equivalent clinicians			
	1.62%	Full-time equivalent nurses			
	5.19%	Full-time equivalent mental health rehabilitation specialist/technicians			
Eastern Services	0.05%	Full-time equivalent psychiatrists	100% Hispanic	100% Spanish	100% Hispanic
	0.22%	Full-time equivalent clinicians			
	0.06%	Full-time equivalent nurses			
	0.60%	Full-time equivalent mental health rehabilitation specialist/technicians			

Youth and Young Adult Services					
Service Region	**Average of full-time equivalent staff**		**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Southern Services	0.53%	Full-time equivalent psychiatrists	100% Hispanic	100% Spanish	50% Hispanic
	1.42%	Full-time equivalent clinicians			
	1.11%	Full-time equivalent nurses			
	3.93%	Full-time equivalent mental health rehabilitation specialist/technicians			
Central Services	1.25%	Full-time equivalent psychiatrists	100% Hispanic	95% Spanish	76% Hispanic
	2.60%	Full-time equivalent clinicians			
	2.47%	Full-time equivalent nurses			
	13.00%	Full-time equivalent mental health rehabilitation specialist/technicians			
Northern Services	0.48%	Full-time equivalent psychiatrists	100% Hispanic	100% Spanish	60% Hispanic
	2.00%	Full-time equivalent clinicians			
	1.00%	Full-time equivalent nurses			
	4.90%	Full-time equivalent mental health rehabilitation specialist/technicians			

Adult Services					
Service Region	**Average of full-time equivalent staff**		**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Southern Services	1.17%	Full-time equivalent psychiatrists	100% Hispanic	92% Spanish	77% Hispanic
	1.92%	Full-time equivalent clinicians			
	1.90%	Full-time equivalent nurses			
	2.75%	Full-time equivalent mental health rehabilitation specialist/technicians			
Central Services	2.43%	full-time equivalent psychiatrists	100% Hispanic	83% Spanish	83% Hispanic
	3.92%	full-time equivalent clinicians			
	4.04%	full-time equivalent nurses			
	8.00%	full-time equivalent mental health rehabilitation specialist/technicians			
Northern Services	1.48%	Full-time equivalent psychiatrists	100% Hispanic	63% Spanish	75% Hispanic
	1.58%	Full-time equivalent clinicians			
	2.00%	Full-time equivalent nurses			
	4.50%	Full-time equivalent mental health rehabilitation specialist/technicians			
Eastern Services	0.11%	Full-time equivalent psychiatrists	100% Hispanic	100% Spanish	100% Hispanic
	0.00%	Full-time equivalent clinicians			
	0.10%	Full-time equivalent nurses			
	0.75%	Full-time equivalent mental health rehabilitation specialist/technicians			

Mental Health Triage and Engagement Services					
Service Region	**Average of full-time equivalent staff**		**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Central Services	2.64%	Full-time equivalent psychiatrists	100% Hispanic	94% Spanish	77% Hispanic
	3.17%	Full-time equivalent clinicians			
	3.00%	Full-time equivalent nurses			
	20.08%	Full-time equivalent mental health rehabilitation specialist/technicians			

ii. *Substance Use Disorder Services*

Adolescent SUD Services				
Region	**Average of full-time equivalent staff**	**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Southern Services	2.00% Full-time equivalent SUD counselor 2.51% Full-time Licensed Practitioner of the Healing Arts (LPHA)	100% Hispanic	60% Spanish	100% Hispanic
Central Services	5.00% Full-time equivalent SUD counselor 5.95% Full-time Licensed Practitioner of the Healing Arts (LPHA)	50% Hispanic	50% Spanish	83% Hispanic

Adult SUD Services				
Region	**Average of full-time equivalent staff**	**Ethnicity**	**Language Capabilities**	**Cultural Awareness**
Southern Services	2.00% Full-time equivalent SUD counselor 1.60% Full-time Licensed Practitioner of the Healing Arts (LPHA)	60% Hispanic	60% Spanish	60% Hispanic
Central Services	0.85% Full-time equivalent SUD counselor 1.60% Full-time Licensed Practitioner of the Healing Arts (LPHA)	100% Hispanic	100% Spanish	60% Hispanic

During FY 22-23, ICBHS direct service staff is 95 percent Hispanic with 90 percent fluent in Spanish. In addition, 84 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 22-23, the MHP provided services to 6,029 beneficiaries during the first two quarters of the fiscal year, unduplicated by division. Of these, 85 percent were Hispanic and 34 percent were Spanish speaking. The distribution by division is included in Table 113.

Table 113. Distribution of Beneficiaries by Division

Division	Number of Beneficiaries FY 22-23	Ethnicity		Language	
Children Services	1,871	90%	Hispanic	46%	Spanish
Youth and Young Adult Services	1,393	89%	Hispanic	29%	Spanish
Adult Services	2,087	82%	Hispanic	29%	Spanish
Mental Health Triage & Engagement	678	78%	Hispanic	21%	Spanish

Children Services: 98 percent of Children Services direct services staff were Hispanic with 88 percent fluent in Spanish. In addition, 95 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Youth and Young Adults Services: 93 percent of YAYA Services' direct services staff were Hispanic with 96 percent fluent in Spanish. In addition, 71 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adult Services: 96 percent of Adults Services' direct services staff were Hispanic with 82 percent fluent in Spanish. In addition, 80 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Mental Health Triage & Engagement: 100 percent of YAYA Services' direct services staff were Hispanic with 94 percent fluent in Spanish. In addition, 77 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

In FY 22-23, the DMC-ODS Plan provided services to 607 beneficiaries during the first two quarters of the fiscal year, unduplicated by team. Of these, 85 percent were Hispanic and 34 percent were Spanish speaking. The distribution by division is included in Table 114.

Table 114. DMC-ODS Distribution of Beneficiaries by Division

Division	Number of Beneficiaries FY 22-23	Ethnicity		Language	
Adults SUD	453	91%	Hispanic	19%	Spanish
Adolescents SUD	148	83%	Hispanic	77%	Spanish

Adult SUD Services: 64 percent of Adult Services direct services staff were Hispanic with 45 percent fluent in Spanish. In addition, 100 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adolescent SUD Services: 64 percent of YAYA Services' direct services staff were Hispanic with 45 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 DMC-ODS 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 115 and 116.

Table 115. FY 22-23 Comparison of MHP Clients and Staff Cultural Profiles

Division	Ethnicity		Language		Cultural Awareness
	Client	Staff	Client	Staff (Fluent)	
Children Services	90% Hispanic	80% Hispanic	46% Spanish	65% Spanish	98% Hispanic
YAYA Services	90% Hispanic	88% Hispanic	30% Spanish	72% Spanish	91% Hispanic
Adult Services	81% Hispanic	83% Hispanic	30% Spanish	68% Spanish	82% Hispanic
MHTE Services	79% Hispanic	93% Hispanic	23% Spanish	79% Spanish	94% Hispanic
MHP	**85% Hispanic**	**83% Hispanic**	**34% Spanish**	**70% Spanish**	**93% Hispanic**

Table 116. FY 22-23 Comparison of DMC-ODS Clients and Staff Cultural Profiles

Division	Ethnicity		Language		Cultural Awareness
	Client	Staff	Client	Staff (Fluent)	
Adults SUD	83% Hispanic	64% Hispanic	19% Spanish	45% Spanish	100% Hispanic
Adolescent SUD	91% Hispanic	64% Hispanic	77% Spanish	45% Spanish	100% Spanish
SUD Total	**85% Hispanic**	**82% Hispanic**	**34% Spanish**	**63% Spanish**	**88% Hispanic**

3) Staff Cultural Competence and Linguistic Capabilities

In FY 22-23 the QM Unit assessed the cultural competence and linguistic capabilities of staff by conducting a staff survey. 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 437 surveys were completed by staff, which represents a 90 percent response rate.

The total number of surveys includes:

- 59 in administrative services
- 71 in direct services-licensed (includes licensed/registered interns)
- 98 in direct services-unlicensed, and;
- 209 in support services.

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 survey results indicate that of the completed surveys, Hispanic/Latino population continues to be the largest portion of the department's population representing 84 percent of the population, while the second highest race, White, accounted for 11 percent. When addressing the language that the staff is competent enough to provide services to clients beside English, Spanish (69%) continues to be the most fluent language among the staff. Staff were also asked to identify if they had provided interpretation services in the last year – 27 percent of the staff reported that they provided interpretation services for clients in the last year.

The survey results also reported staff feeling quite a bit knowledgeable to very knowledgeable of the population staff work with; Hispanic/Latino, Mental Health Clients, and White. Staff were also asked to address the cultures that they believe training is necessary to meet cultural needs of the clients they served and 82 percent of the staff responded that they do not require any training needs related to cultural needs. However, for the remaining staff who expressed a need for training, American Indian/Alaskan Native, Asian/Pacific Islander, and Black/African American.

A total of 113 surveys were completed by contract providers, which represents a 38 percent response rate.

The total number of surveys includes:

- 40 in direct services-licensed (includes licensed/registered interns)
- 12 in direct services-unlicensed, and;
- 61 in support services.

The survey results indicate that of the completed surveys, Hispanic/Latino population continues to be the largest portion representing 51 percent of the population, while the second highest race, White, accounted for 21 percent. When addressing the language that the staff is competent enough to provide services to clients beside English, Spanish (42%) continues to be the most fluent language among the staff. Staff were also asked to identify if they had

provided interpretation services in the last year – 18 percent of the staff reported that they provided interpretation services for clients in the last year.

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 22-23, 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.

It has been determined that the following populations' categories are underserved based on the most recent data reviewed. Outreach activities should be conducted to reach out to these populations as a result.

Target Population	MHP Population	SUD Population
Ethnicity	Asian/Pacific Islander and Alaskan Native/American Indian	Hispanic
Language	Spanish	Spanish
Gender	Female	Female
Age Group	Age groups: 65+	Age groups: 12-20 & 65+
City of Residence	Winterhaven	Calexico, Holtville and Winterhaven

a) *Penetration Rates*

<u>Mental Health Services</u>
In FY 22-23, the QM Unit calculated and evaluated the mental health services penetration rate for FY 21-22 to ensure that persons of diverse ethnic backgrounds accessed the service delivery system. The FY 21-22 penetration rate was 7.48 percent, which is a increase from FY 20-21 when the penetration rate was 7.29 percent as seen in Table 117:

Table 117. Penetration Rate- Mental Health Services

Review Period	Medi-Cal Eligible	ICBHS Beneficiaries Served	Penetration Rate
FY 21-22	90,351	6,759	7.48%
FY 20-21	84,654	6,168	7.29%
FY 19-20	79,792	7,064	8.85%

The following section includes the penetration rates by category for FY 22-23:

i. Ethnicity
The group with the highest rate of utilization was African Americans at 21.71 percent. The groups with the lowest utilization were Asian/Pacific Islander at 0 percent, Alaskan Native/American Indian with 4.55 percent and Hispanics following at 7.19 percent. Although the penetration rate was low during FY 21-22, the Hispanic group increased from 6.94 percent.

ii. Gender
The group with the highest rate of utilization was males at 7.95 percent. The female group was the lowest utilization at 7.11 percent. Although the penetration rate was low during FY 21-22, the female group increased from 6.65 percent.

iii. Age
The group with the highest rate of utilization was the 14-20 age group at 14.08 percent. The groups with the lowest utilization were 65 + age group at 0.48 percent and the 0-5 age group following with a utilization rate of 1.91 percent. Although the penetration rate was low during FY 21-22, the 65+ age group increased from 0.45 percent.

iv. Language
The group with the highest rate of utilization was English speaking at 12.43%. The group with the lowest utilization were Spanish speaking at 4.25%. Although the penetration rate was low during FY 21-22, English speaking increased from 12.30 percent and Spanish speaking from 4.07 percent.

v. City
The city of residence with the highest rate of utilization was Westmorland at 58.70 percent. The groups with the lowest utilization were city of residences, Winterhaven at 4.13 percent and Calexico following at 5.25 percent. Although the penetration rate was low during FY 21-22, the city of Calexico increased from 4.71 percent

Substance Use Disorder Treatment Services

In FY 22-23 the QM Unit calculated and evaluated the SUD treatment services penetration rate for FY 21-22 to ensure that persons of diverse ethnic backgrounds accessed the service delivery system. The FY 21-22 penetration rate was 0.94 percent, which is an increase when compared to FY 20-21, as seen in Table 118:

Table 118. Penetration Rate – SUD Treatment Services

Review Period	Medi-Cal Eligible	ICBHS Beneficiaries	Penetration Rate
FY 21-22	90,351	847	0.94%
FY 20-21	84,654	627	0.74%
FY 19-20	79,792	681	0.85%

The following section includes the penetration rates by category for FY 21-22:

i. Ethnicity

The group with the highest rate of utilization was African Americans at 3.50 percent. The groups with the lowest utilization were native/American Indians and Asian/pacific islanders, both at 0 percent, with Hispanics following with a utilization rate of .84 percent. Although the penetration rate was low during FY 20-21, the Hispanic group increased from .62 percent.

ii. Gender

The group with the highest rate of utilization was males at 1.40 percent. The female group was the lowest utilization at .57 percent. Although the penetration rate was low during FY 21-22, the female group increased from .48 percent.

iii. Age

The group with the highest rate of utilization was 26-64 age group at 1.62 percent. The group with the lowest utilization were 12-20 and 65+ age group at .54 percent and .03 percent. Although the penetration rate was low during FY 20-21, the 12-20 age group increased from .30 percent and the 65+ age group slightly increased from .02 percent.

iv. Language

The group with the highest rate of utilization was English speaking at 1.96 percent. The group with the lowest utilization were Spanish speaking at .27 percent. Although the penetration rate was low during FY 20-21, Spanish speaking utilization from .18 percent.

v. City

The city of residence with the highest rate of utilization was Niland at 4.04 percent. The groups with the lowest utilization were city of residences, Calexico at .57 percent, Holtville at .67 percent, and Calexico following at .17 percent. Although the penetration rate was

low during FY 21-22, the city of Winterhaven decreased from .37 percent.

b) *Retention Rates*

The retention rate is calculated by dividing the number 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 22-23, the QM Unit calculated and evaluated service retention for FY 21-22 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 21-22 was 99 percent, which represents an increase when compared to FY 20-21 when the retention rate was 87 percent, as seen in Table 119:

Table 119. Retention Rate- Mental Health Services

Review Period	Intake Assessments	Met Medical Necessity Criteria	Beneficiaries Who Received 2+ Services	Retention Rate
FY 21-22	3,275	2,894	2,853	99%
FY 20-21	3,093	2,800	2,448	87%
FY 19-20	3,005	2,550	2,309	91%

The following section includes service retention for FY 21-22:

i. Ethnicity/Race

The highest utilization of services by ethnic/race group was the Hispanic population with a total of 6,226 beneficiaries served of whom 499 (8%) were new beneficiaries and the majority 3,123 (50%) received 12+ services. The lowest utilization of services by ethnic/race group was the Alaskan Native/American Indian population with a total of 36 beneficiaries served.

There were no major disparities in ethnic groups as the groups tended to stay within the same ten-percentage range for each service category.

ii. Gender

The highest utilization of services by gender group was the female population with a total of 3,922 beneficiaries served, of whom 305 (8%) were new beneficiaries and the majority 1,967 (50%) received 12+ services. The lowest utilization of services by gender group was the male population with 3,333 beneficiaries served, of whom 256 (7%) were new beneficiaries and the majority 1,689 (51%) received 12+ services.

The data indicates that 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 Group

The data indicates a disparity for the 18-20 age group who had the lowest retention rate of 42 percent when compared to the 65+ age group who had the highest retention rate of 60 percent in the 12+ services category. This is an 18 percent difference for these two age groups in the 12+ services category.

iv. Language

The highest utilization of services by language group was the English-speaking population with a total of 4,709 beneficiaries served, of whom 357 (8%) were new beneficiaries and the majority 2,319 (49%) received 12+ services. The lowest utilization of services by language group was the Other group population with a total of 11

beneficiaries served, of whom one (9%) was a new beneficiary and five (45%) received 12+ services.

The data indicates that 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 of Residence

The highest utilization of service was the Central region with a total of 3,716 beneficiaries served, of whom 279 (8%) were new beneficiaries and the majority 1,872 (50%) received 12+ services. The lowest utilization of service was the Eastern region with a total of 56 beneficiaries served, of whom 4 (7%) were new beneficiaries and the majority 31 (55%) received 12+ services.

The data indicates a disparity for utilization of services for Other Cities at 27% for 4-7 outpatient visits when compared to Northern Cities at 15% for 4-7 outpatient visits, which is a 12% difference between city of residences. This may indicate beneficiaries are utilizing more services in Other Cities, when compared to beneficiaries utilizing services in the Northern cities.

Substance Use Disorder Treatment Services

FY 21-22 was 94 percent, which represents a slight decrease compared to FY 20-21 at 95 percent, as seen in Table 120:

Table 120. Retention Rate- Substance Use Disorder Treatment Services

Review Period	Intake Assessments	Met Medical Necessity Criteria	Beneficiaries Who Received 2+ Services	Retention Rate
FY 21-22	647	565	531	94%
FY 20-21	479	422	402	95%
FY 19-20	593	541	503	93%

The following section includes service retention for FY 21-22:

i. Ethnicity/Race

The highest utilization of service by ethnic/race group was the Hispanic population with a total of 697 beneficiaries served of whom 112 (16%), received one service and 293 (42%) received 12+ services. The lowest utilization of service by ethnic/race group was the Alaskan Native/American Indian population with a total of two beneficiaries served.

The data indicates that 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 one exception, the African American had the lowest retention rate of 26 percent for beneficiaries utilizing 12+ services, when compared to the other

groups, while Other/Not reported had the highest retention rate of 57 percent utilizing 12+ services, when compared to other groups

ii. Gender
The highest utilization of services by gender group was the male population with a total of 567 beneficiaries served, of whom 86 (15%) received one service and 241 (43%) received 12+ services. The lowest utilization of services by gender group was the female population with 303 beneficiaries served, of whom 51 (17%) received one service and the majority 123 (41%) received 12+ services. The data indicates that 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 Group
The highest utilization of services by age group continues to be the 21-44 population with a total of 554 beneficiaries served, of whom 97 (18%) received one service and the majority 201 (36%) received 12+ services. The lowest utilization of services by age group was the 65+ population with eight beneficiaries served.

The data indicates that there were no major disparities in as the groups tended to stay within the same ten-percent range for each service category. The only exceptions were noted with the 65+ age group: the lowest retention rate of 38 percent for beneficiaries utilizing 12+ services, when compared to other groups, while the 6-17 age group had the highest retention rate of 63 percent when compared to other groups.

iv. Language
The highest utilization of services by language group was the English-speaking population with a total of 729 beneficiaries served, of whom 118 (16%) received one service and the majority 294 (40%) received 12+ services. The lowest utilization of services by language group was the Spanish-speaking population with a total of 141 beneficiaries served, of whom 19 (13%) received one service and 70 (50%) received 12+ services.

The data indicates that 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 of Residence
The highest utilization of service by city of residence was the Central population with a total of 431 beneficiaries served, of whom 69 (16%) received one service and 179 (42%) received 12+ services. The lowest utilization of service by city of residence was the Eastern population with two beneficiaries served, of whom one (50%) received 12+ services. Two disparities were identified: the Eastern population had the lowest retention rate of 0 percent for beneficiaries utilizing 2-11 services, when compared to the other

groups. Additionally, the Northern population had the lowest retention rate at 6 percent when compared to the other groups in the three services category.

b. Overview of the ICBHS objectives, scope, and planned activities for FY 23-24:

- 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.

- 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.

- The QM Unit will survey all ICBHS staff annually to identify the ethnicity, linguistic capabilities, diverse cultural group awareness, and staff function 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.