IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Quality Improvement Work Plan

FY 2024-2025

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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 It has been proven that outdated and inefficient processes are the main barriers and obstacles in the way of getting a high-quality job done.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, 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 its activities. This annual update reflects current goals, monitoring results and improvement processes. It also describes the FY 24-25 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 to assess and improve quality. This approach is designed to coordinate 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 (SMHS) 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 behavioral 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 – Quality Management
Administrative Analyst(s) – Quality Management
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. The QIC chairperson is responsible for the review of agenda items and materials with the QM Unit prior to distribution. In the QIC chairperson's absence, the chairperson will arrange 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 chairpersons 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.

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 – moved 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 recognized the need for a modern electronic health record (EHR) to remain compliant with evolving state and federal standards, including the adoption of CalAIM policies. 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 built 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 date 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.

The ICBHS FY 24-25 QI Work Plan incorporates all CalAIM behavioral health policy changes that have been initiated to date. The QI activities completed during FY 23-24 and the objectives identified for FY 24-25 reflect all monitoring activities completed by the Quality Management Unit and the Quality Improvement Committee, including those affected by CalAIM behavioral health initiatives.

III. Quality Improvement (QI) Work Plan

MENTAL HEALTH PLAN (MHP) SERVICES

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 23-24.

a. Update on the MHP objectives and planned activities for FY 23-24:

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 beneficiaries served, and the number of services claimed in FY 23-24.

As the MHP for Imperial County, ICBHS is responsible for providing or arranging medically 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*

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

<u>Central Services</u>
Children Services in the central region are provided at two outpatient clinics, a MHSA Prevention and Early Intervention program, 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.

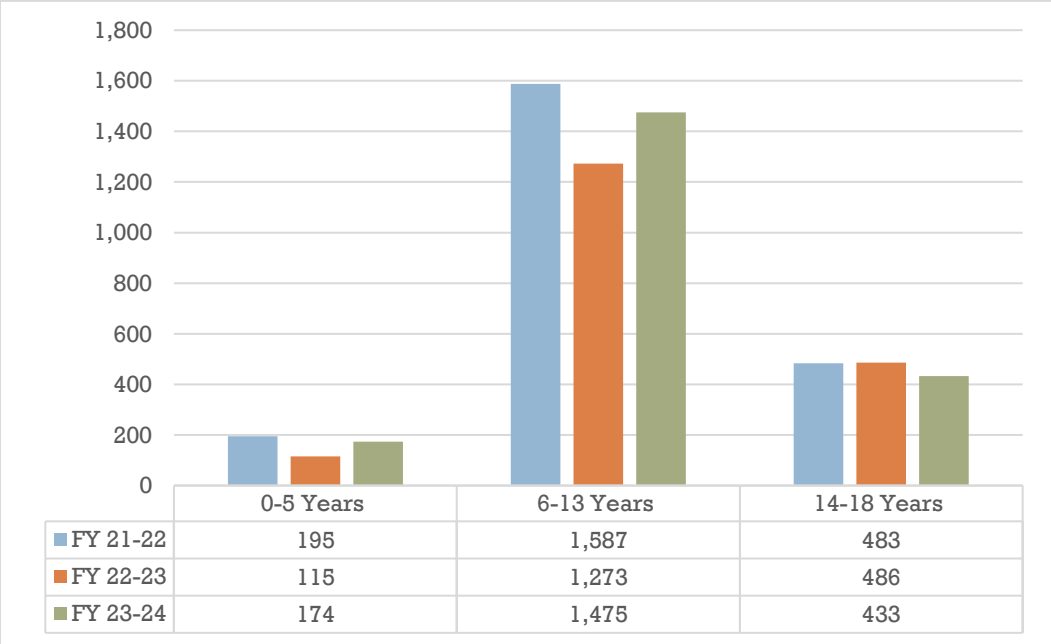
<u>Northern Services</u>
Children Services in the northern region are provided at an outpatient clinic and the Vista Sands Program located at an elementary school. All northern region services are provided in the city of Brawley. Residents of Brawley, Niland, Calipatria, Westmorland, and northern unincorporated 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.

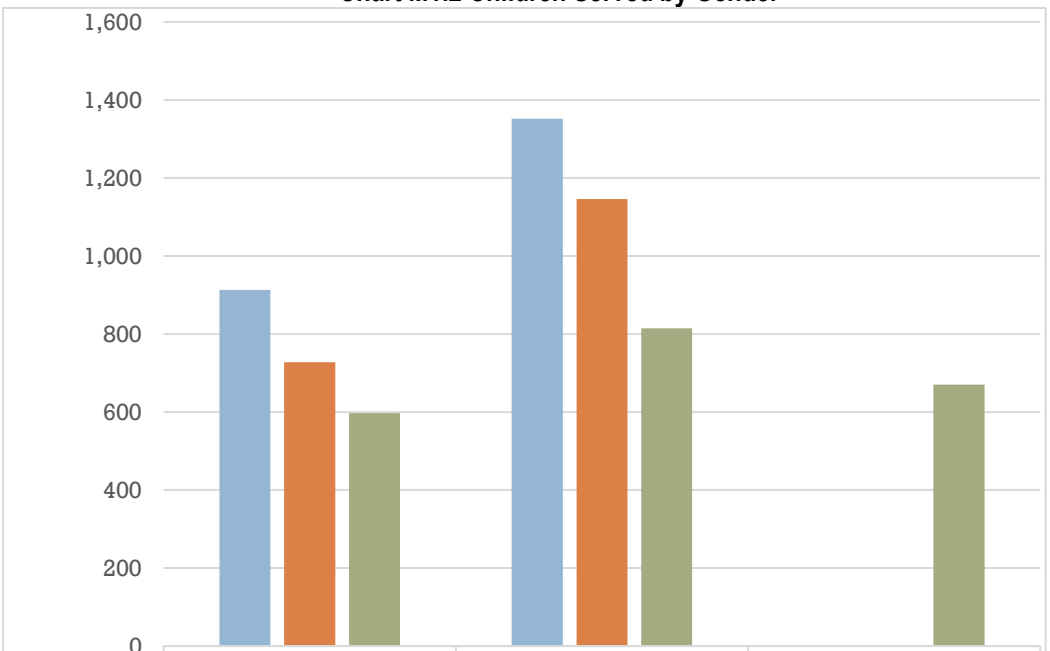
Charts M1.1-M1.6 indicate the demographic information for beneficiaries served by Children Services.

Chart M1.1 Children Served by Age Group



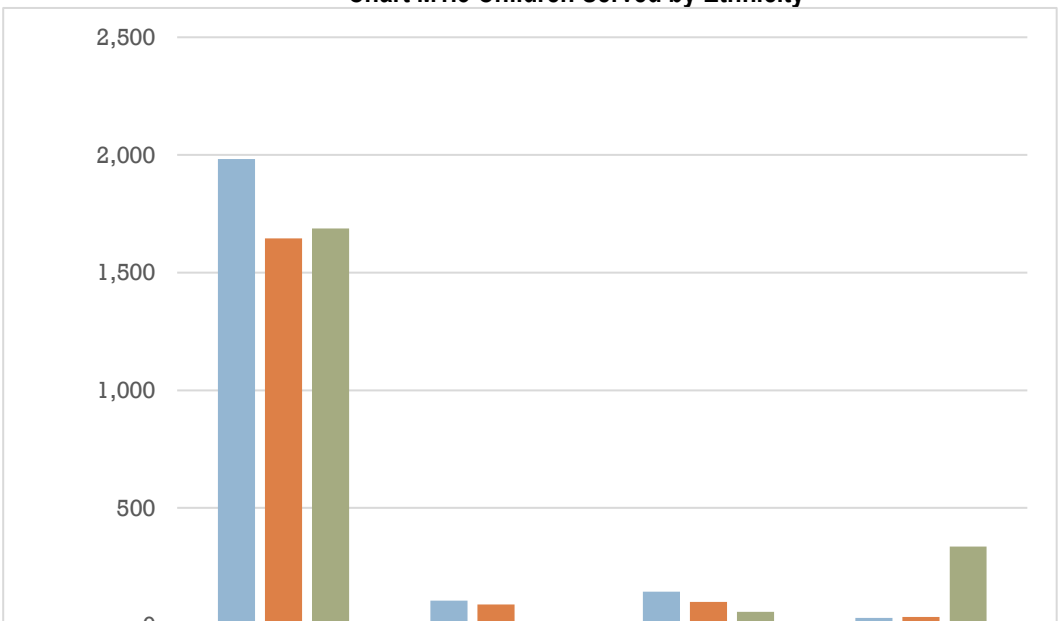
	0-5 Years	6-13 Years	14-18 Years
FY 21-22	195	1,587	483
FY 22-23	115	1,273	486
FY 23-24	174	1,475	433

Chart M1.2 Children Served by Gender



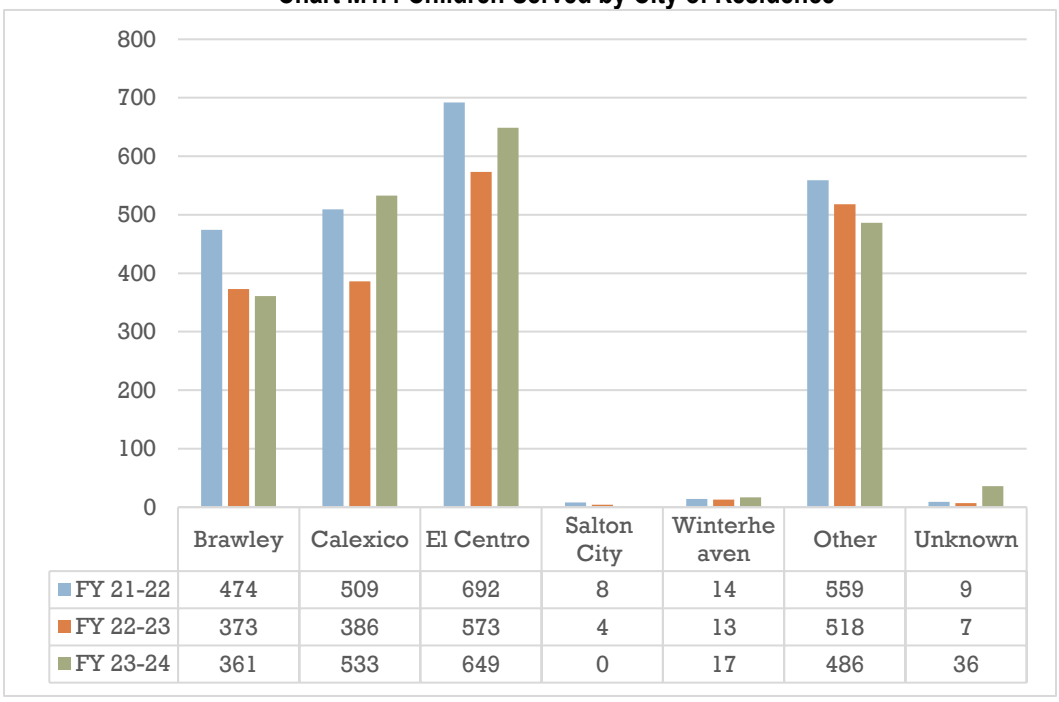
	Female	Male	Other/Unknown
FY 21-22	913	1,352	0
FY 22-23	728	1,146	0
FY 23-24	597	815	670

Chart M1.3 Children Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 21-22	1,982	106	144	33
FY 22-23	1,646	90	101	37
FY 23-24	1,688	0	58	336

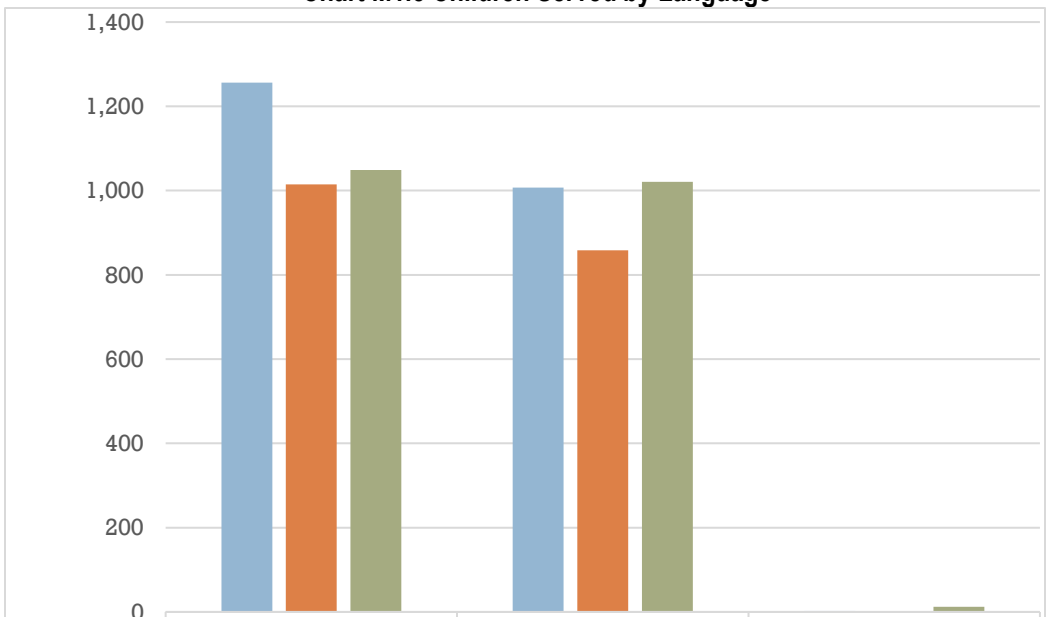
Chart M1.4 Children Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 21-22	474	509	692	8	14	559	9
FY 22-23	373	386	573	4	13	518	7
FY 23-24	361	533	649	0	17	486	36

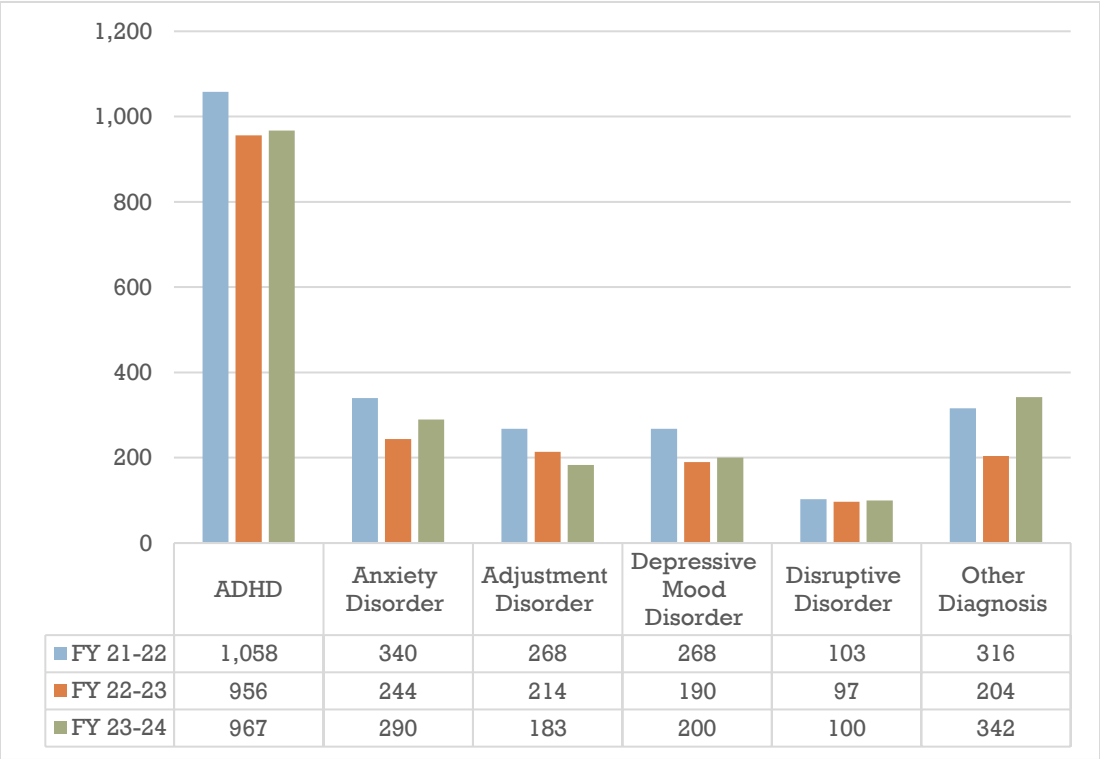
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart M1.5 Children Served by Language



	English	Spanish	Other
FY 21-22	1,256	1007	2
FY 22-23	1,015	858	1
FY 23-24	1,049	1,021	12

Chart M1.6 Children Served by Diagnosis



	ADHD	Anxiety Disorder	Adjustment Disorder	Depressive Mood Disorder	Disruptive Disorder	Other Diagnosis
FY 21-22	1,058	340	268	268	103	316
FY 22-23	956	244	214	190	97	204
FY 23-24	967	290	183	200	100	342

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

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.

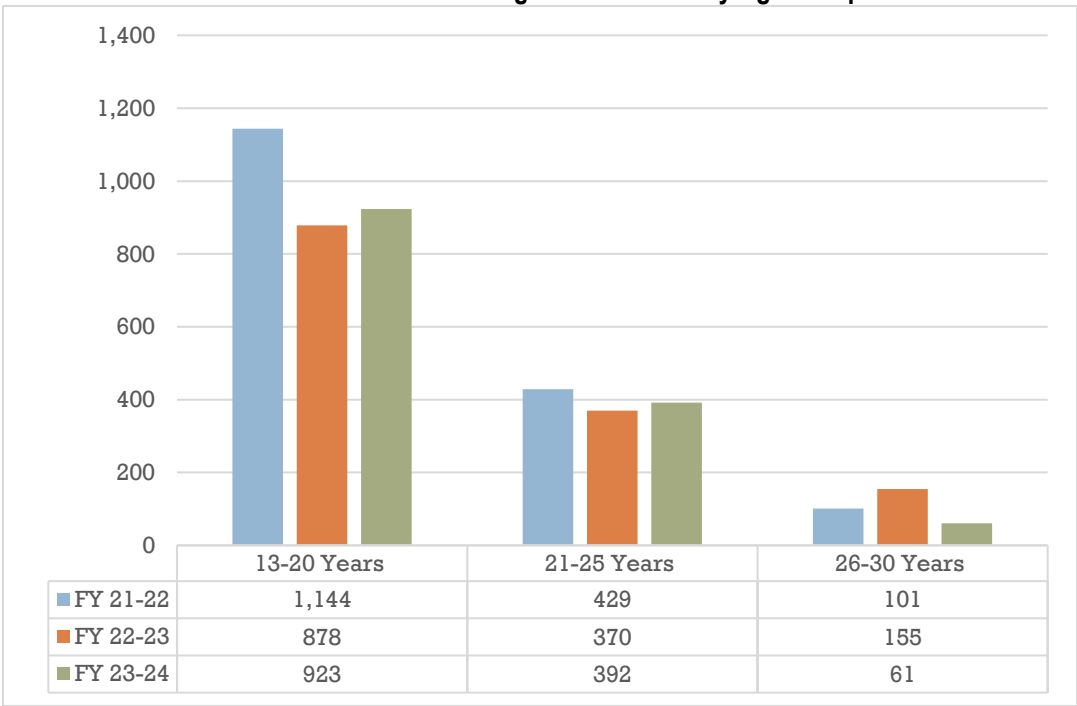
Northern Services

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.

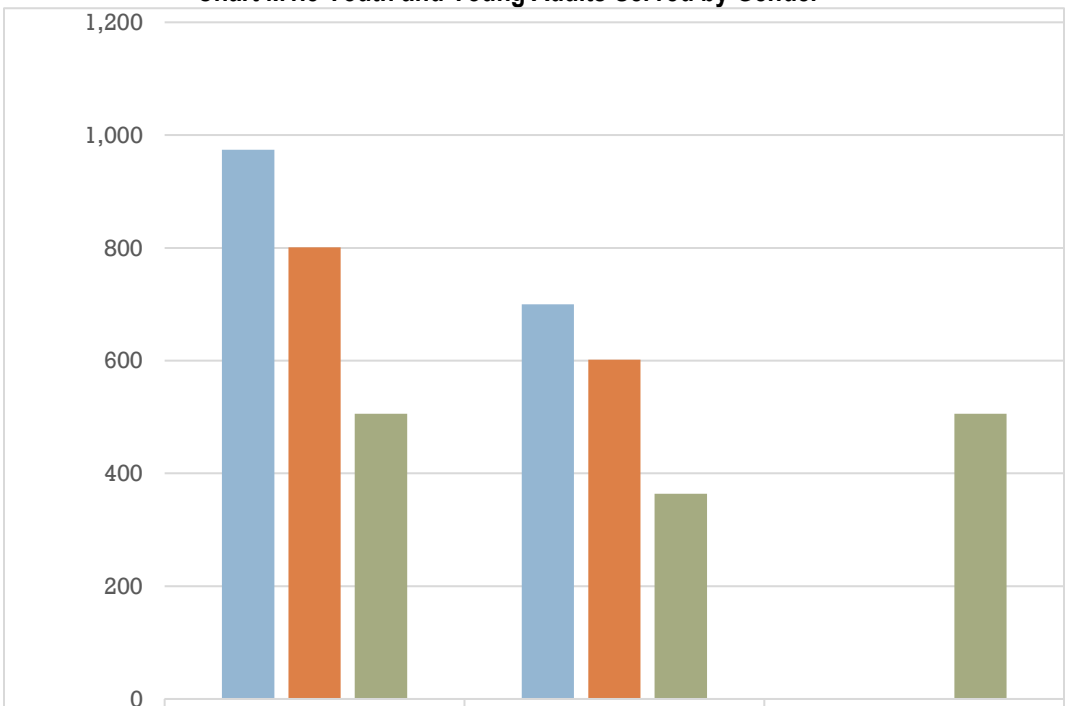
Charts M1.7-M1.12 indicate the demographic information for beneficiaries served by YAYA Services.

Chart M1.7 Youth and Young Adults Served by Age Group



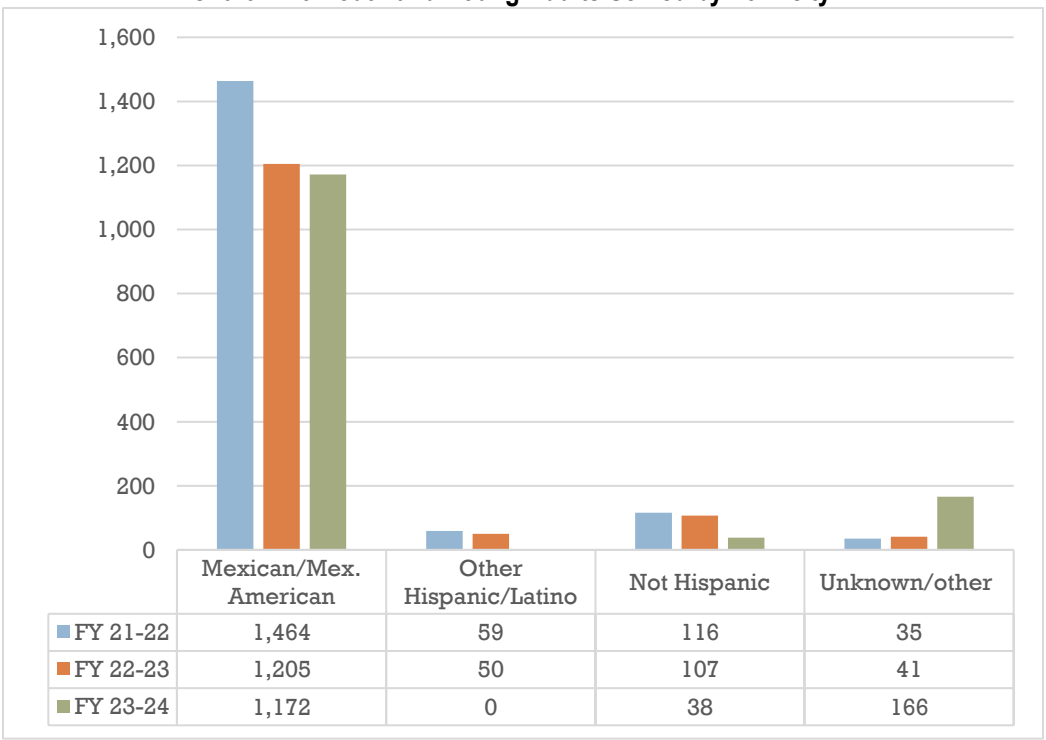
	13-20 Years	21-25 Years	26-30 Years
FY 21-22	1,144	429	101
FY 22-23	878	370	155
FY 23-24	923	392	61

Chart M1.8 Youth and Young Adults Served by Gender



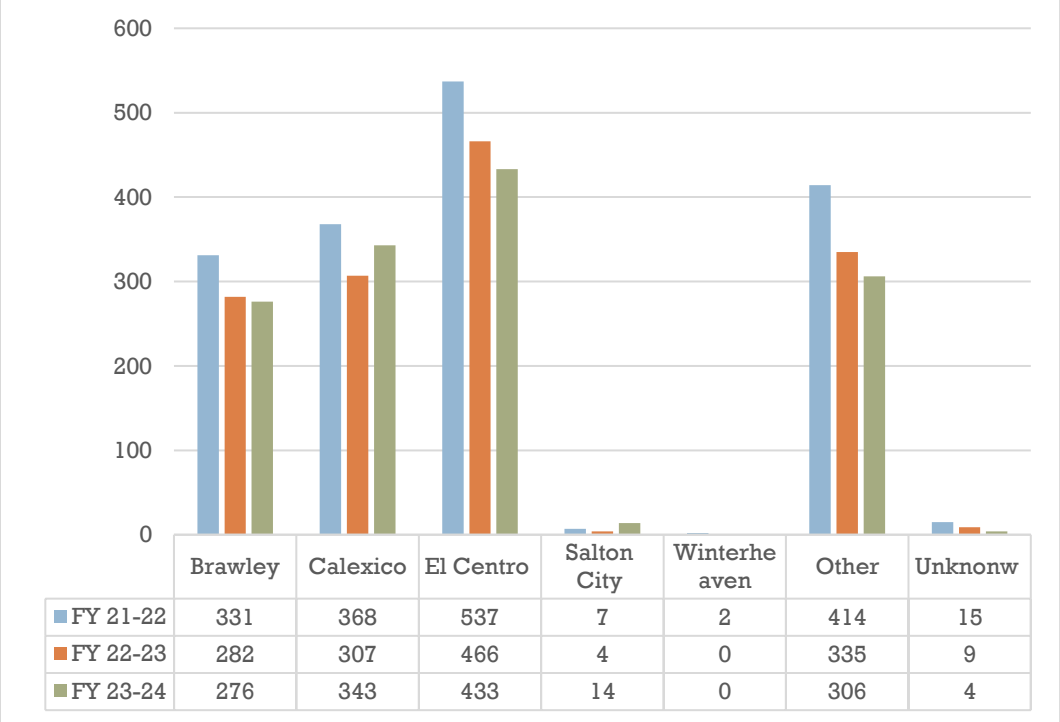
	Female	Male	Other/Unknown
FY 21-22	974	700	0
FY 22-23	801	602	0
FY 23-24	506	364	506

Chart M1.9 Youth and Young Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 21-22	1,464	59	116	35
FY 22-23	1,205	50	107	41
FY 23-24	1,172	0	38	166

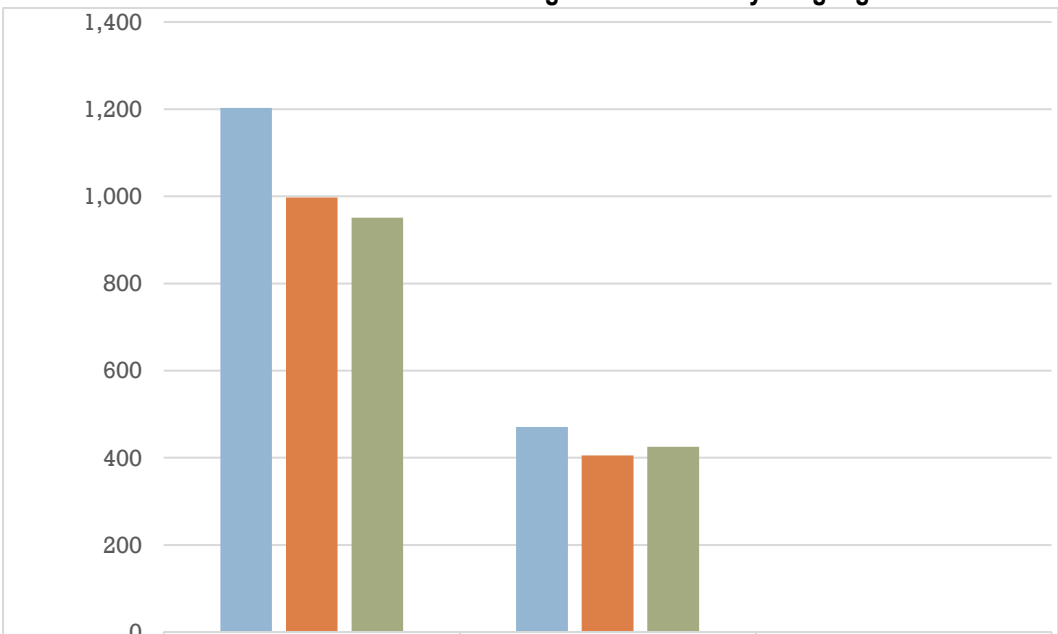
Chart M1.10 Youth and Young Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 21-22	331	368	537	7	2	414	15
FY 22-23	282	307	466	4	0	335	9
FY 23-24	276	343	433	14	0	306	4

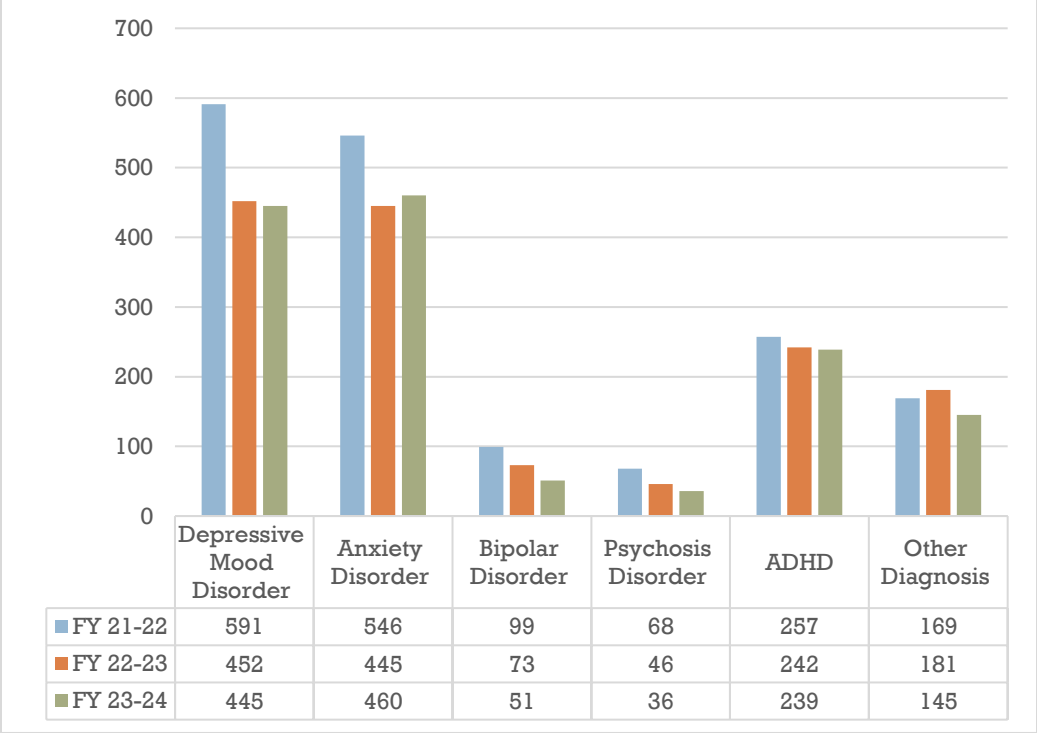
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart M1.11 Youth and Young Adults Served by Language



	English	Spanish	Other
FY 21-22	1,203	471	0
FY 22-23	997	405	1
FY 23-24	951	425	0

Chart M1.12 Youth and Young Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 21-22	591	546	99	68	257	169
FY 22-23	452	445	73	46	242	181
FY 23-24	445	460	51	36	239	145

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

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

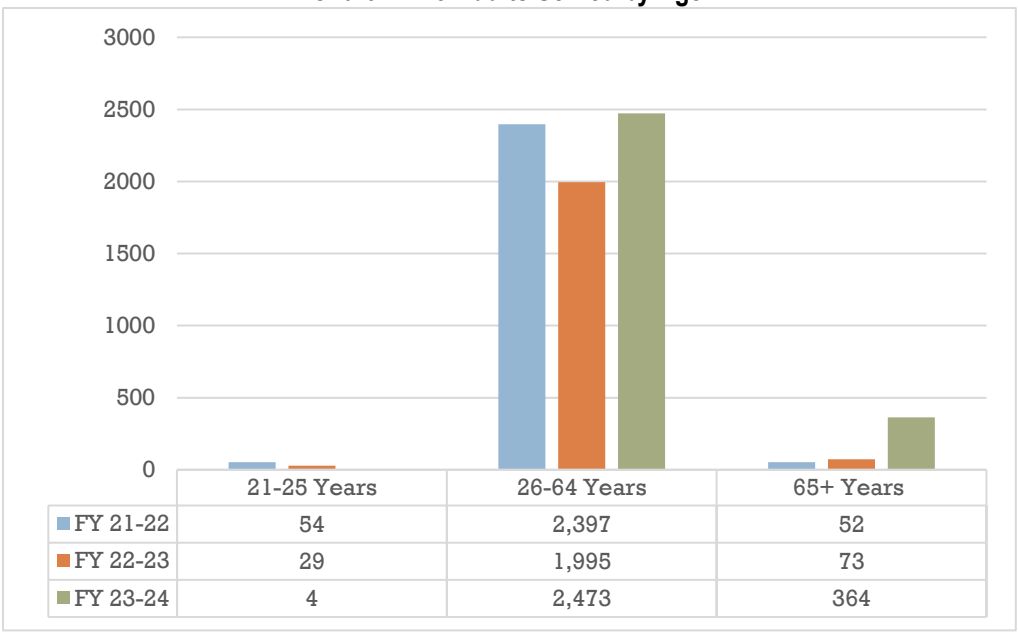
The Adult Brawley Anxiety and Depression and the Adult Brawley Full-Service Partnership programs provide services at outpatient clinics located in Brawley. These outpatient clinics serve residents of Brawley, Westmorland, Salton Sea area, Bombay Beach, Niland/Slabs, Calipatria, and Palo Verde that are 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.

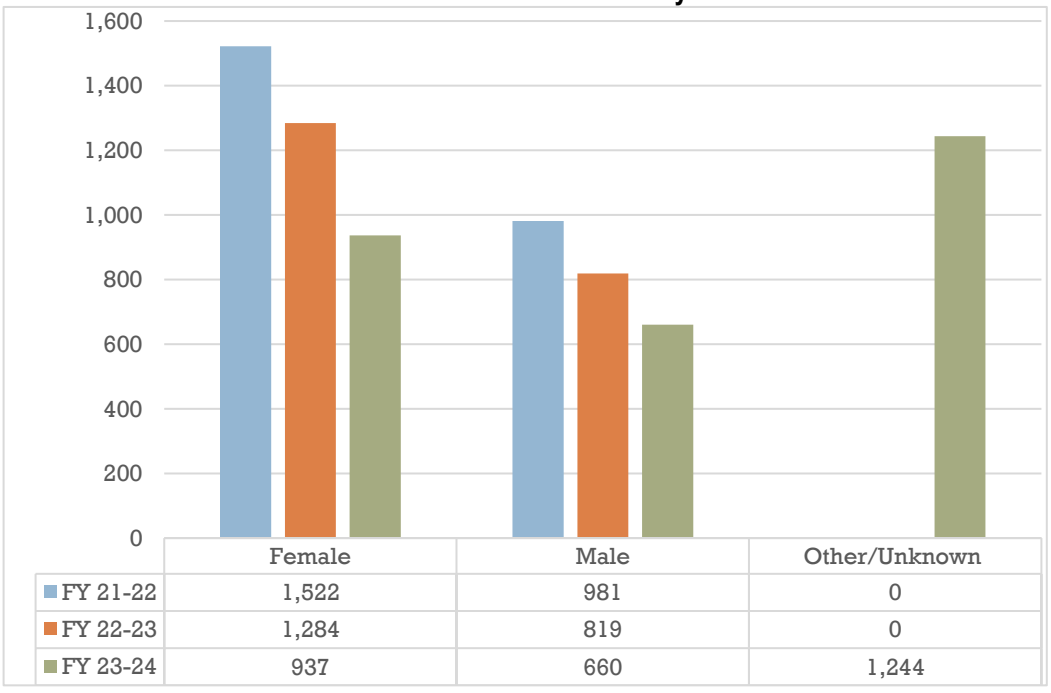
Charts M1.13-M1.18 indicate the demographic information for beneficiaries served by Adults Services.

Chart M1.13 Adults Served by Age



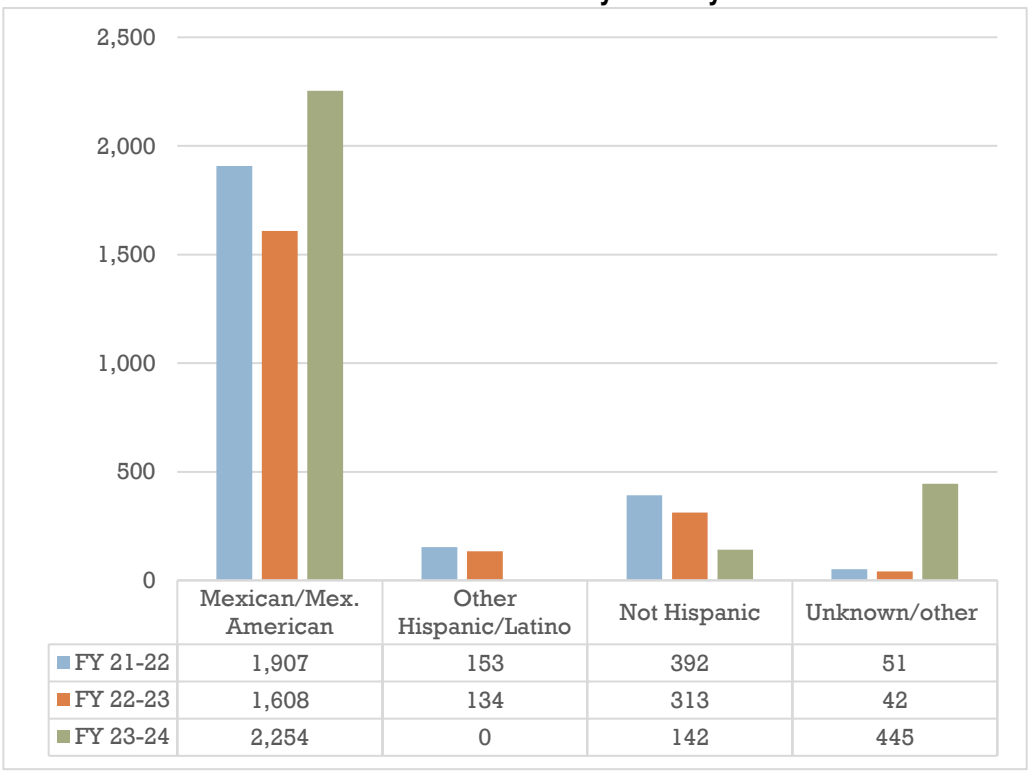
	21-25 Years	26-64 Years	65+ Years
FY 21-22	54	2,397	52
FY 22-23	29	1,995	73
FY 23-24	4	2,473	364

Chart M1.14 Adults Served by Gender



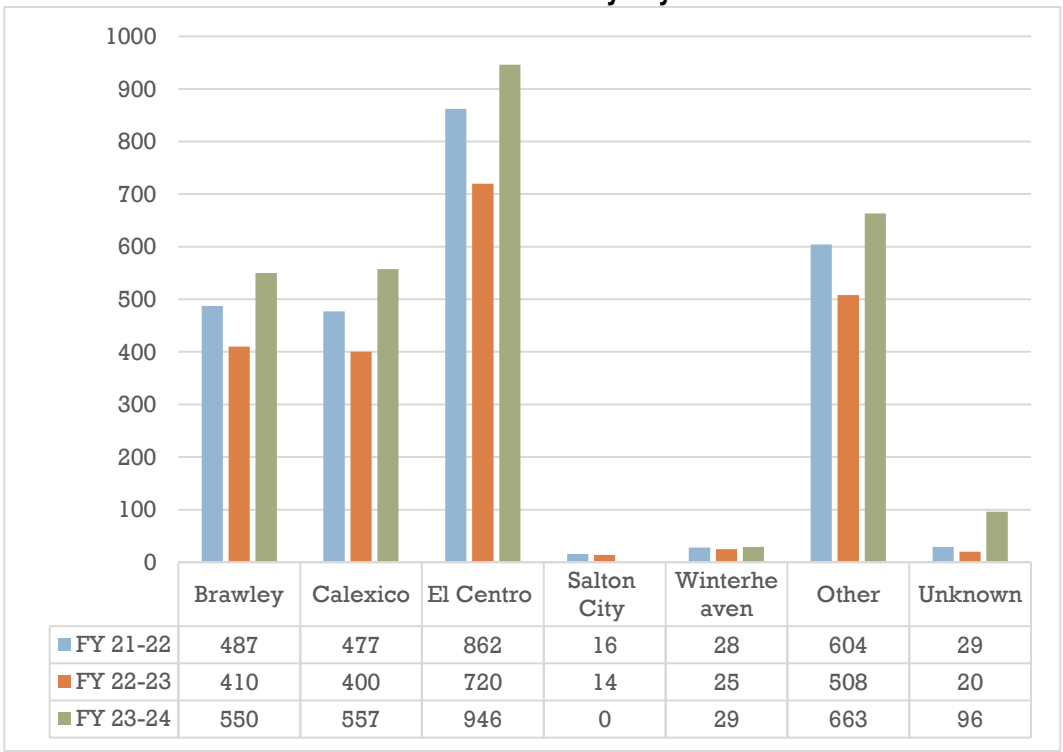
	Female	Male	Other/Unknown
FY 21-22	1,522	981	0
FY 22-23	1,284	819	0
FY 23-24	937	660	1,244

Chart M1.15 Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 21-22	1,907	153	392	51
FY 22-23	1,608	134	313	42
FY 23-24	2,254	0	142	445

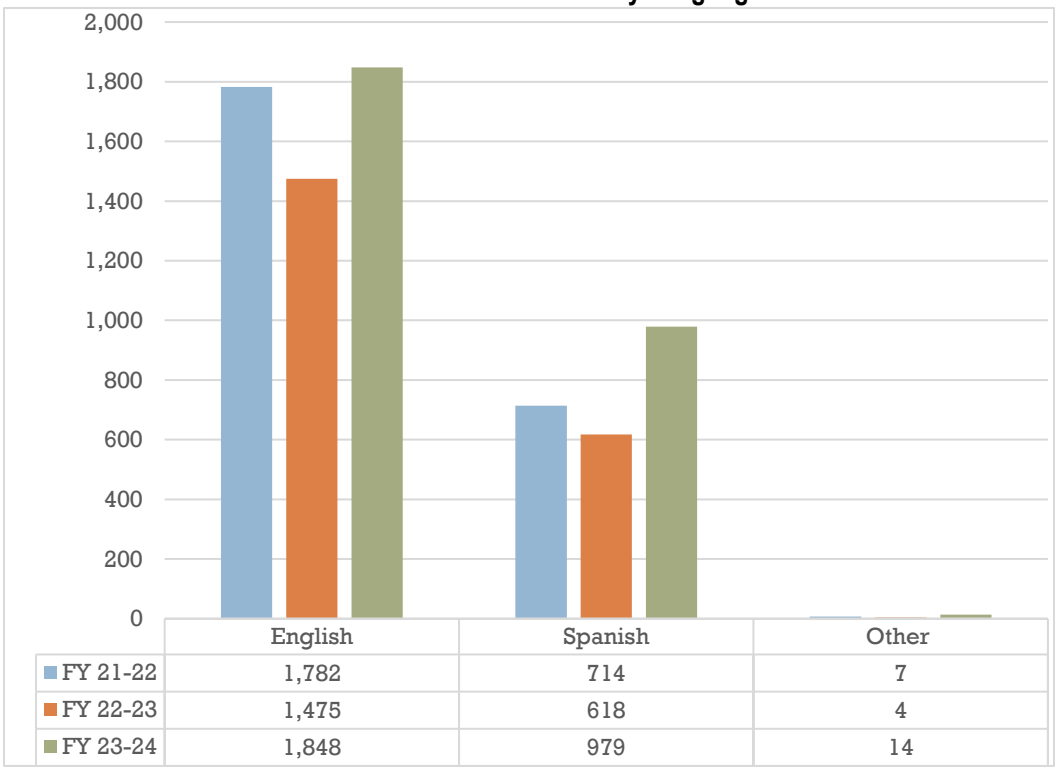
Chart M1.16 Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 21-22	487	477	862	16	28	604	29
FY 22-23	410	400	720	14	25	508	20
FY 23-24	550	557	946	0	29	663	96

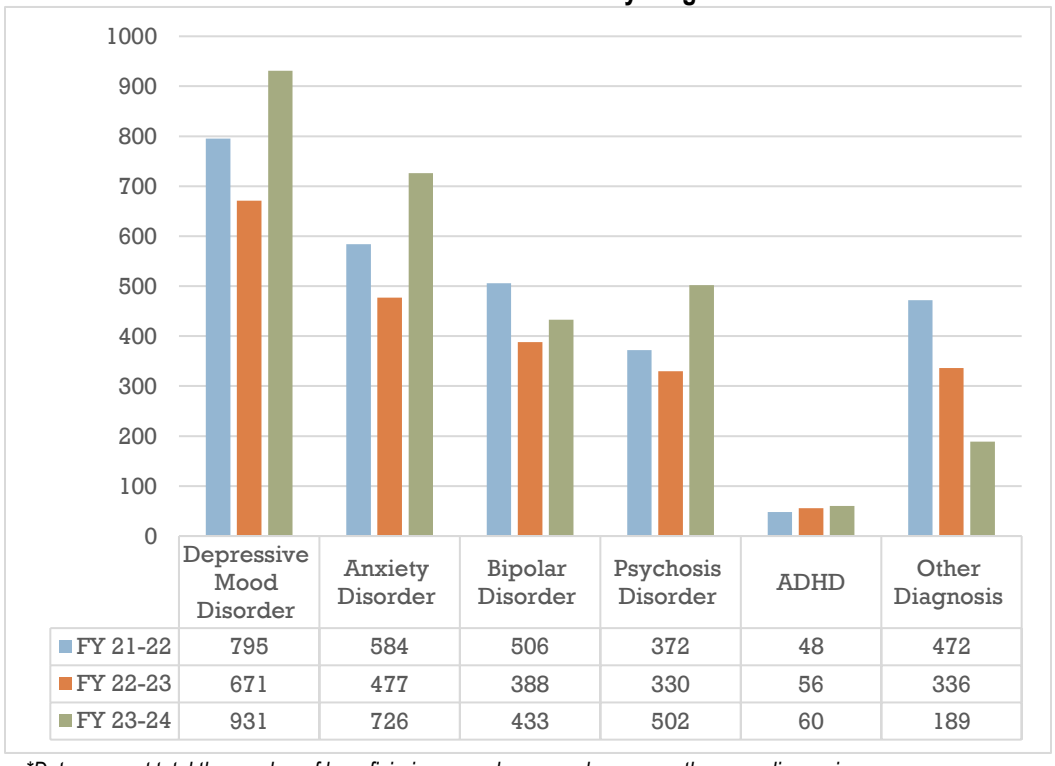
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart M1.17 Adults Served by Language



	English	Spanish	Other
FY 21-22	1,782	714	7
FY 22-23	1,475	618	4
FY 23-24	1,848	979	14

Chart M1.18 Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 21-22	795	584	506	372	48	472
FY 22-23	671	477	388	330	56	336
FY 23-24	931	726	433	502	60	189

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

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

Central Services

Children, adolescent, and adult emergency services are provided through the Mental Health Triage and Engagement Services Division. Services are available for children, adolescents/youth, and adults from all regions of Imperial County who need urgent mental health services. On-site services are provided in the city of El Centro.

The Mental Health Triage Unit provides immediate therapeutic response to individuals exhibiting psychiatric symptoms on a voluntary and involuntary basis pursuant to W&I Code 5150 during regular working hours (8a.m. to 5p.m.). Individuals requesting services, during regular work hours, will be screened for urgency of need and referred to the Mental Health Triage Unit if required. After working hours and weekends, individuals can only receive mental health services on an involuntary basis by law enforcement referral (5150 involuntary application). The goal of the Mental Health Triage Unit is to alleviate the threat of an individual being a danger to self or others, or being gravely disabled (unable to provide their own food, clothing, shelter). Services provided while at the Mental Health Triage Unit include an Initial Crisis Assessment, a Clinician Assessment, and Discharge Planning. If the person is determined to be unable to benefitted by voluntary services, the person may be involuntarily admitted to a psychiatric hospital in order to stabilize their psychiatric condition. If the person can be served voluntarily, he or she will be provided with a discharge plan and aftercare assistance to link the person to outpatient and other supportive services.

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 accessible to children and adolescent from ages 0-14; youth and young adults from ages 14-26; and adults from ages 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.

The Crisis Care Mobile Units (CCMU) Program consists of four mobile response teams:

- The Crisis Co-Response Team (CCRT) that works in collaboration with law enforcement officers and ICBHS staff out in the field to prevent unnecessary placement of individuals on involuntary holds and to avoid the use of acute involuntary psychiatric hospitalization by providing interventions and linkage to needed treatment and/or community services;

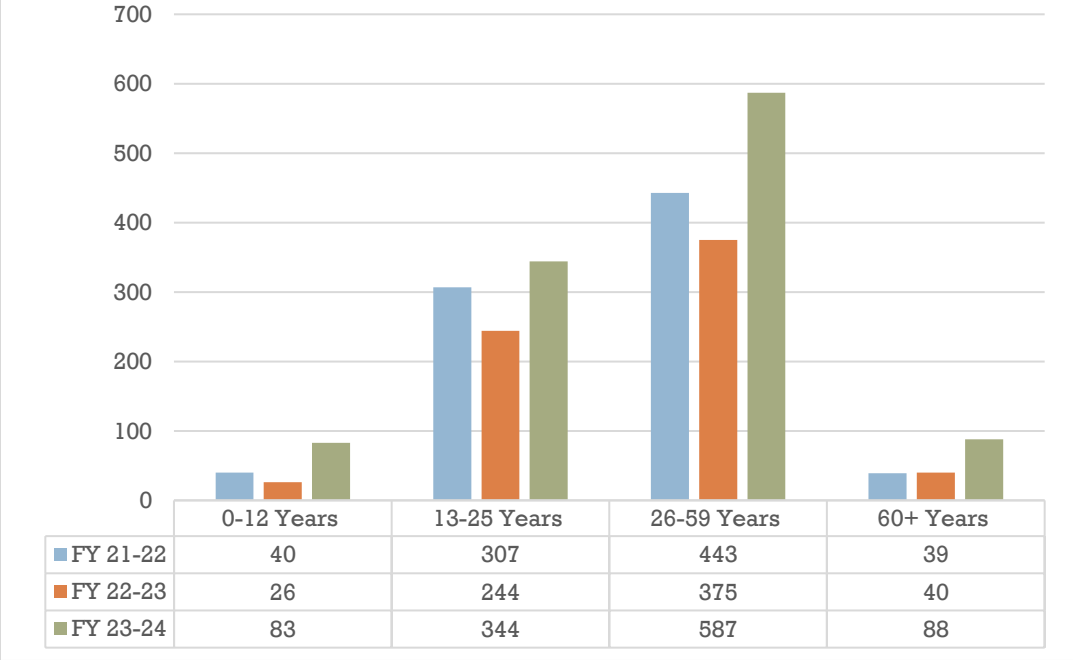
- The School Based Respond Team (SBRT), which provides mobile crisis intervention services to individuals experiencing a psychiatric or emotional crisis at the local schools;
- The Care Response Team (CRT), which provides assistance to the local hospital and ICBHS outpatient clinics; and,
- The Mobile Crisis Response Team (MCRT), which provides immediate field-based de-escalation services. The MCRT will respond to law enforcement agencies and other community agencies requesting interventions for individuals experiencing psychiatric or emotional distress.

The Transitional Engagement and Supportive Services (TESS) Program provides outreach and engagement activities to individuals 14 years and older who have recently experienced a personal crisis in their life requiring involuntary or voluntary mental health crisis intervention services. TESS creates a supportive services network that includes assisting the client in obtaining food, clothing, shelter, benefits assistance, assistance with public transportation, establishing contract with family, friends, significant others, and linkage to health care and other community resources. In addition, individuals who have recently been released from LPS Conservatorship receive supportive services to assist them in reintegrating back into the community, accessing mental health treatment, and securing a supportive environment.

The Community Engagement Supportive Services (CESS) Program provides community outreach and engagement services to individuals 14 years and older including those who are homeless or at risk of homelessness. The focus of the CESS Program is to engage and address the specific needs of each outreached individual in order to increase their support system and their willingness to seek needed mental health services. Based on medical necessity, assistance provided by the CESS Program can include an expedited intake assessment, linkage to an ICBHS clinic, and referrals to needed community resources. Additionally, the CESS Program provides screening and referral services at the Imperial County Jail to individuals who will soon be released from incarceration to ensure individuals are successfully reintegrated back into the community and linked to needed mental health treatment.

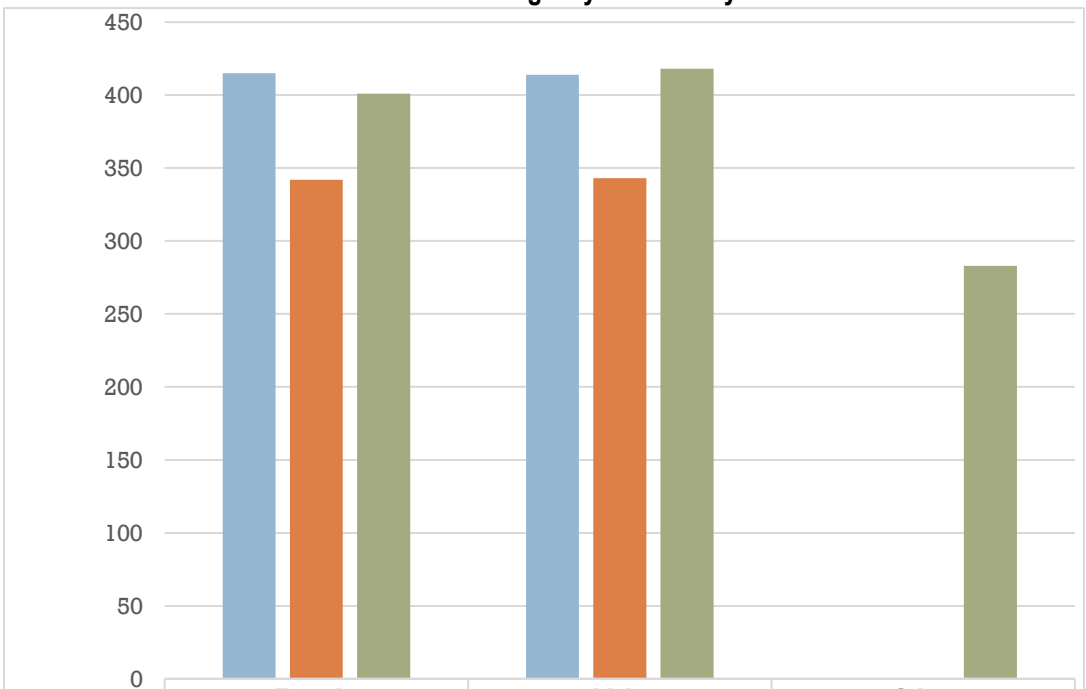
Charts M1.19-M1.24 indicate the demographic information for beneficiaries served by MHTES.

Chart M1.19 Emergency Services by Age Group



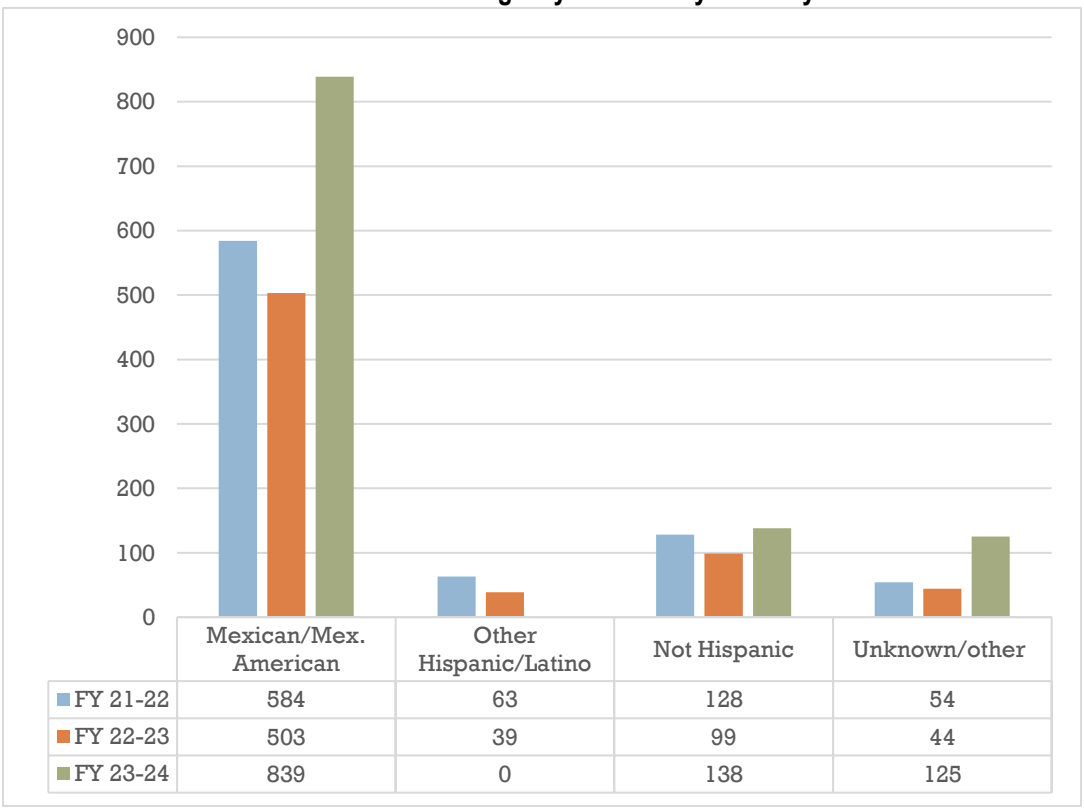
	0-12 Years	13-25 Years	26-59 Years	60+ Years
FY 21-22	40	307	443	39
FY 22-23	26	244	375	40
FY 23-24	83	344	587	88

Chart M1.20 Emergency Services by Gender



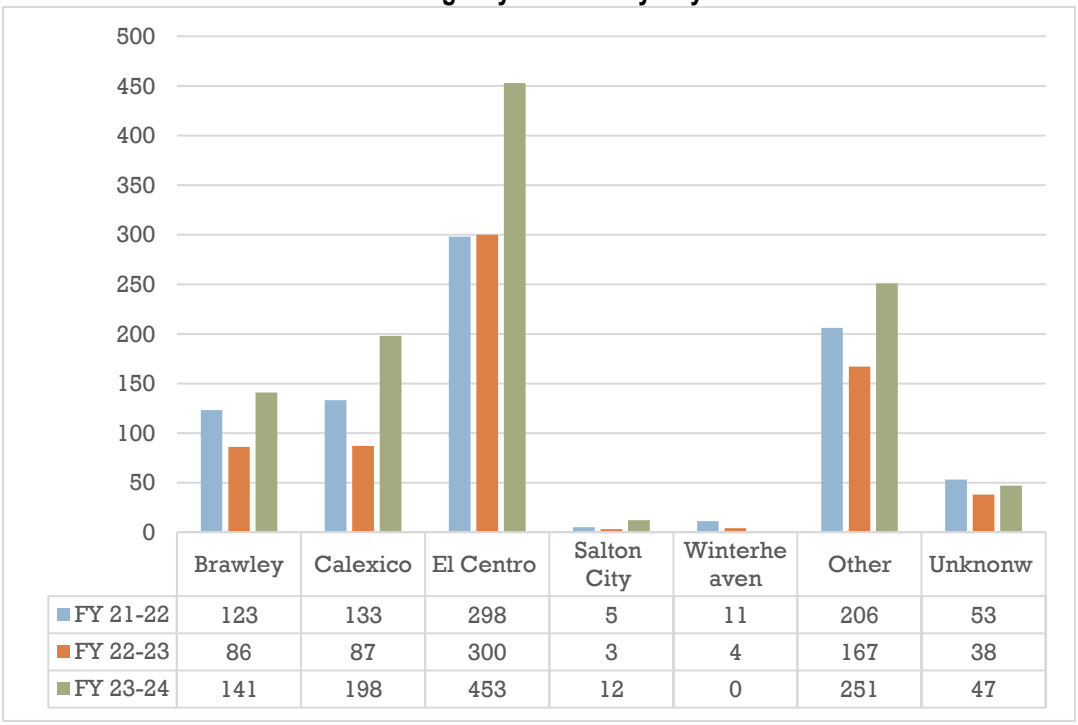
	Female	Male	Other
FY 21-22	415	414	0
FY 22-23	342	343	0
FY 23-24	401	418	283

Chart M1.21 Emergency Services by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 21-22	584	63	128	54
FY 22-23	503	39	99	44
FY 23-24	839	0	138	125

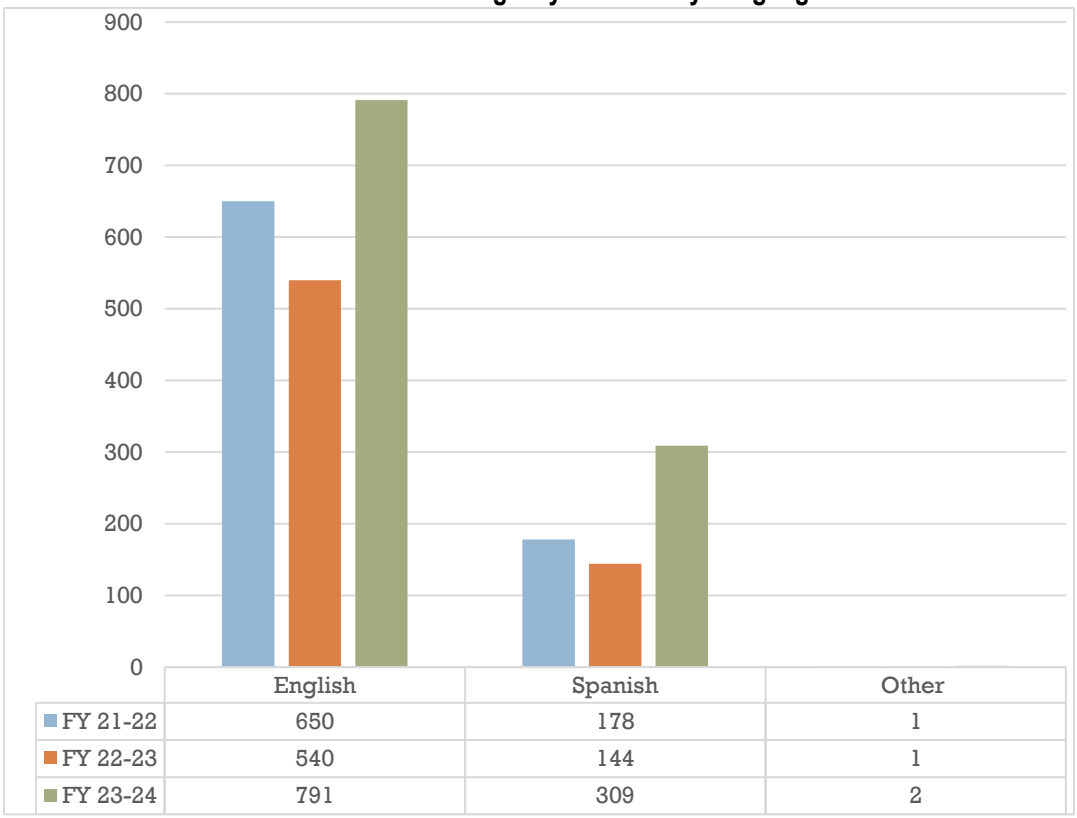
Chart M1.22 Emergency Services by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 21-22	123	133	298	5	11	206	53
FY 22-23	86	87	300	3	4	167	38
FY 23-24	141	198	453	12	0	251	47

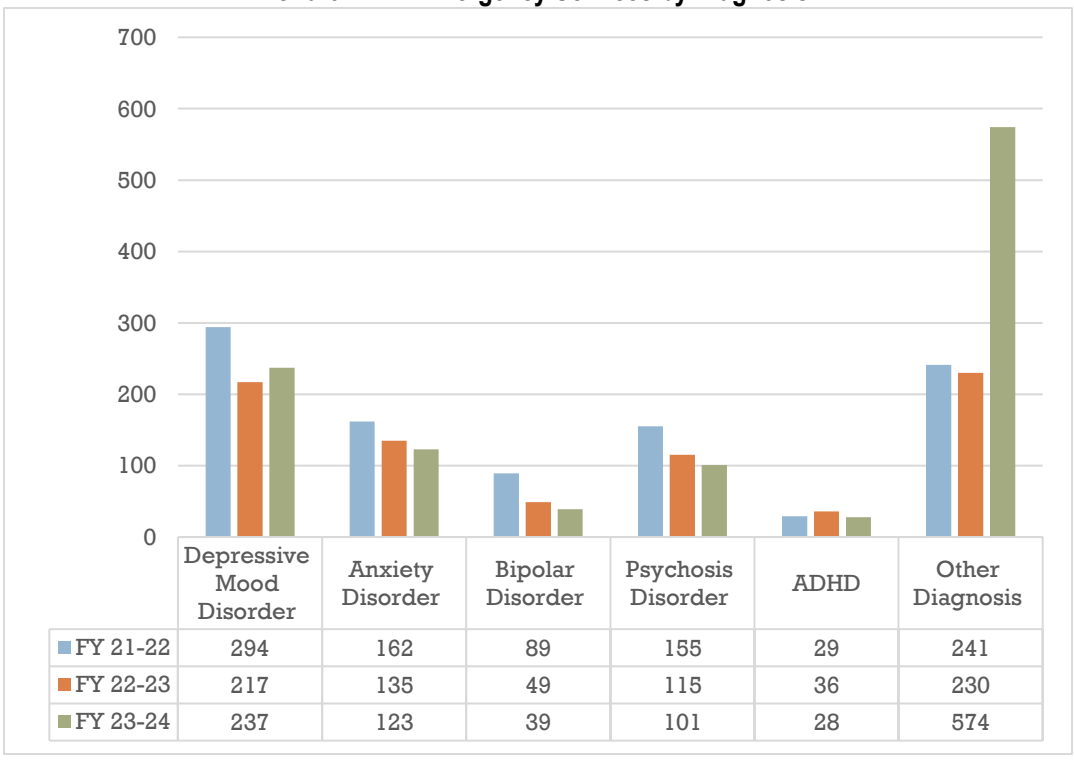
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart M1.23 Emergency Services by Language



	English	Spanish	Other
FY 21-22	650	178	1
FY 22-23	540	144	1
FY 23-24	791	309	2

Chart M1.24 Emergency Services by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 21-22	294	162	89	155	29	241
FY 22-23	217	135	49	115	36	230
FY 23-24	237	123	39	101	28	574

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

b) Services Provided

Medi-Cal SMHS 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 SMHS 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 unduplicated Medi-Cal beneficiaries served by division and the total MHP are included in the table below:

Table M1.1 Beneficiaries Served by Division and MHP

Division	FY 21-22	FY 22-23*	FY 23-24
Adults Services	2,503	2,097	2,841
YAYA Services	1,674	1,403	1,376
Children Services	2,265	1,874	2,082
MHTES	829	685	1,102
MHP	**7,739**	**6,059**	**7,401**

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

c) Utilization of Services for FY 23-24

Beginning July 1, 2023, the CalAIM Behavioral Health Payment Reform initiative changed the way county behavioral health plans claim federal reimbursement. This initiative moved counties away from cost-based reimbursement to better enable counties and providers to deliver value-based care that improves quality of life for Medi-Cal beneficiaries. Due to this change it was unfeasible to make a comparison of utilization of services with previous fiscal years. The utilization of services for FY 23-24 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

- Assessment: Assessments completed by a LPHA or MD; Assessment contribution by a non-LPHA; Review of hospital records; Psychological testing; Individual therapy, Family therapy with the client present; Report generation for care coordination; TBS; Psychosocial rehab-individual; Nursing evaluation; and add-on services such as interactive complexity, sign language or oral interpretative services, and prolonged office or other outpatient EM service(s) beyond the maximum time.

- Care Coordination: Targeted Case Management (TCM) and Intensive Care Coordination (ICC).

- Crisis Intervention: Crisis intervention/mobile crisis and psychotherapy for crisis.

- Medication Support Services: Medication training and support; Medication support to an existing client; Oral medication administration; Medication support telephone; Medical team conference with participation by Physician and patient and/or family not present; and Interpretation or explanation of results of psychiatric or other medical results.

- Medi-Cal Mobile Crisis Encounters: Mobile crisis encounters; Transportation mileage; and Transportation, staff time.

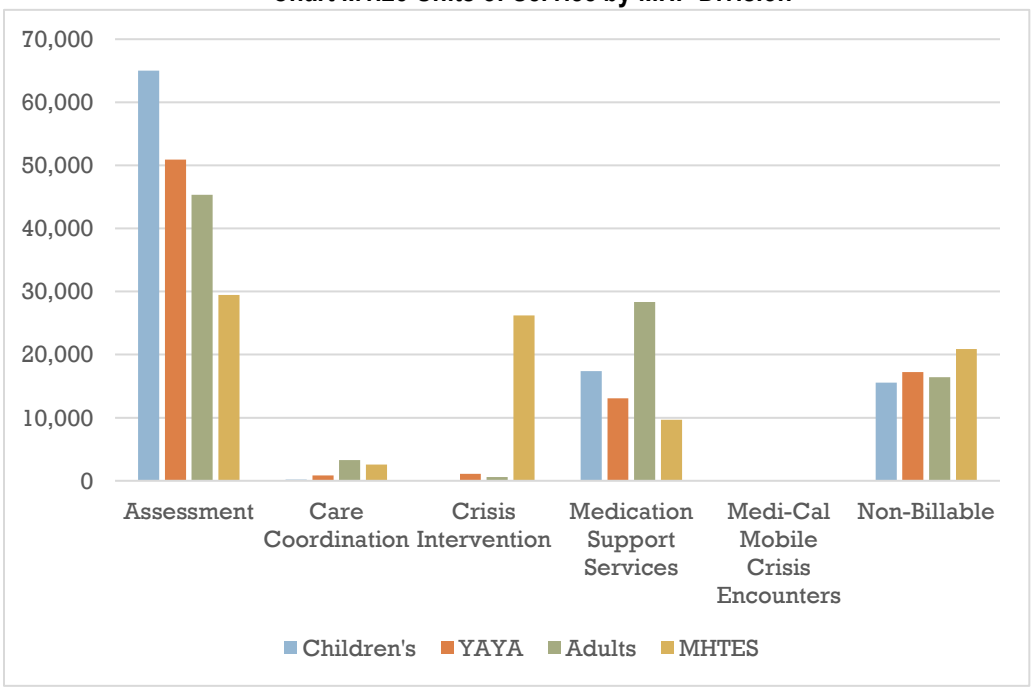
- Non-Billable: Any other non-billable service that must be documented and is not accounted for by other available non-billable procedure codes. Services may include those provided in the Wellness Center, homeless services, school-based socialization programs that are grant funded, and/or Conservatorship Services.

The MHP's units of service provided by the four service divisions during FY 23-24 is shown below:

Table M1.2 MHP Units of Service

Type of Service	Children Services	YAYA Services	Adults Services	MHTES	MHP
Assessment	65,012	50,896	45,335	29,436	190,679
Care Coordination	200	834	3,268	2,573	6,875
Crisis Intervention	64	1,123	614	26,233	28,034
Medication Support Services	17,389	13,089	28,355	9,664	68,497
Medi-Cal Mobile Crisis Encounters	0	0	0	108	111
Non-Billable	15,572	17,212	16,419	20,882	70,085

Chart M1.25 Units of Service by MHP Division



2) MHP Contracted Providers

a) Geographic Location and Target Population

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

i. *In-County*
During FY 23-24, 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 23-24, 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.

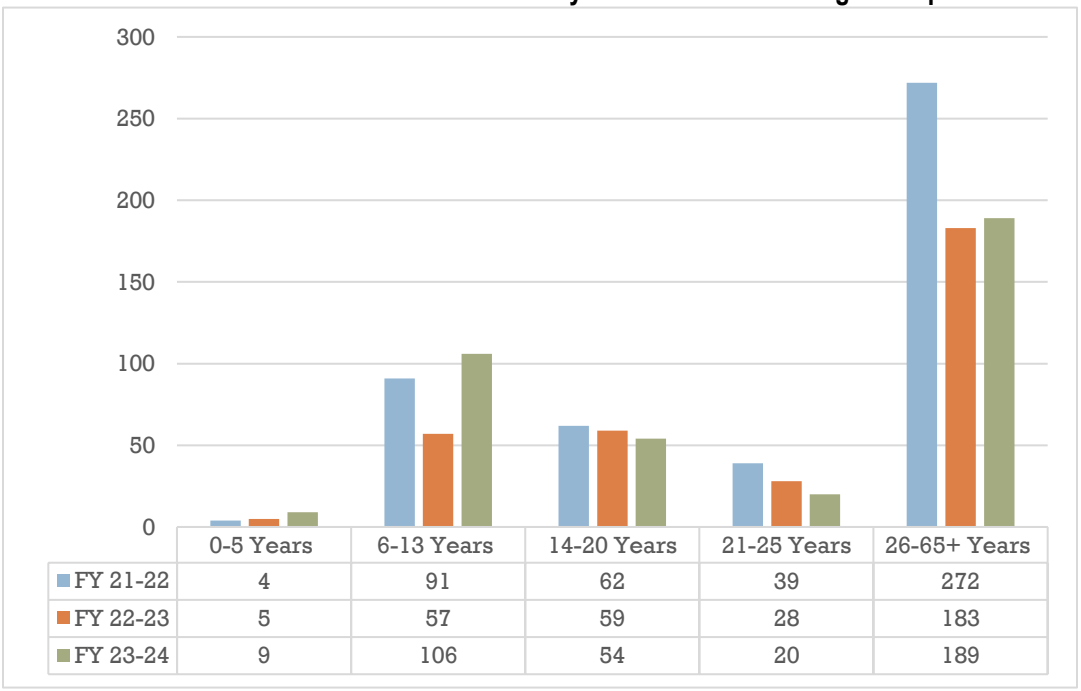
b) Services Provided
The table below indicates the number of beneficiaries served by contracted providers during FY 23-24, in addition to a comparison for the past three years.

Table M1.3 Beneficiaries Served by Contract Providers

Fiscal Year	Number of Beneficiaries
FY 23-24	378
FY 22-23	332
FY 21-22	468

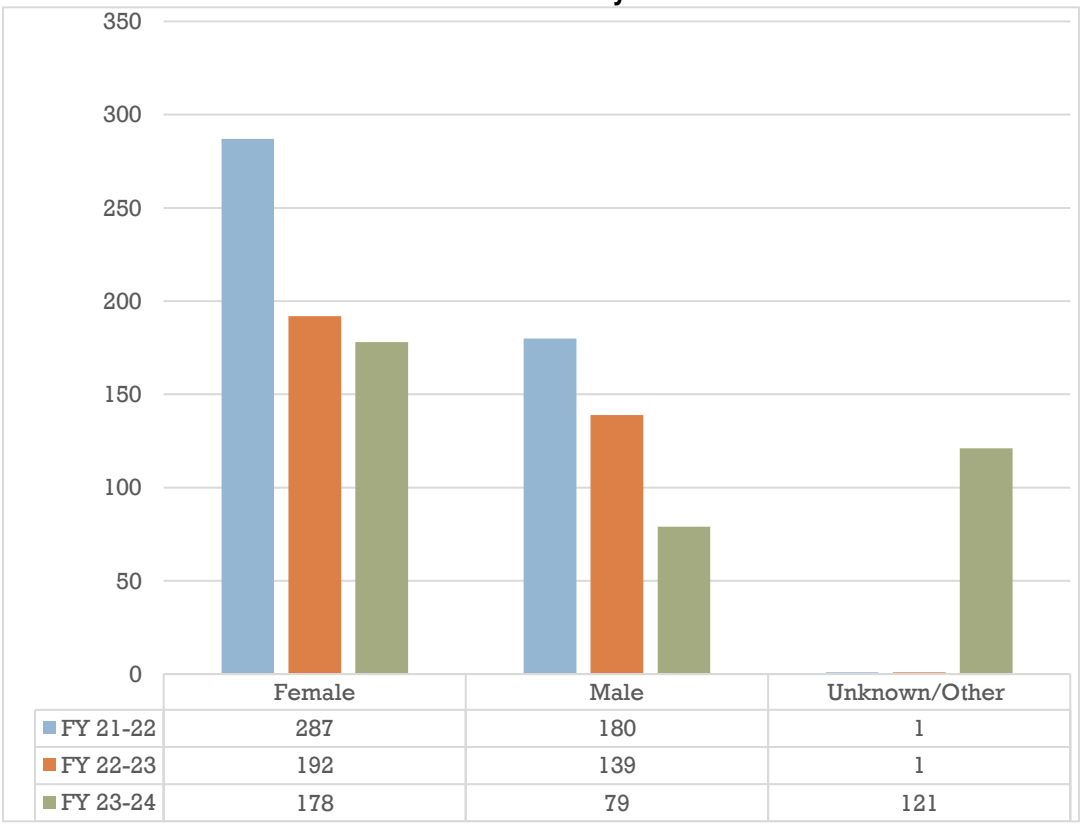
The graphs below indicate demographic information for beneficiaries served by the MHP's contracted providers.

Chart M1.26 Beneficiaries Served by Contact Providers - Age Group



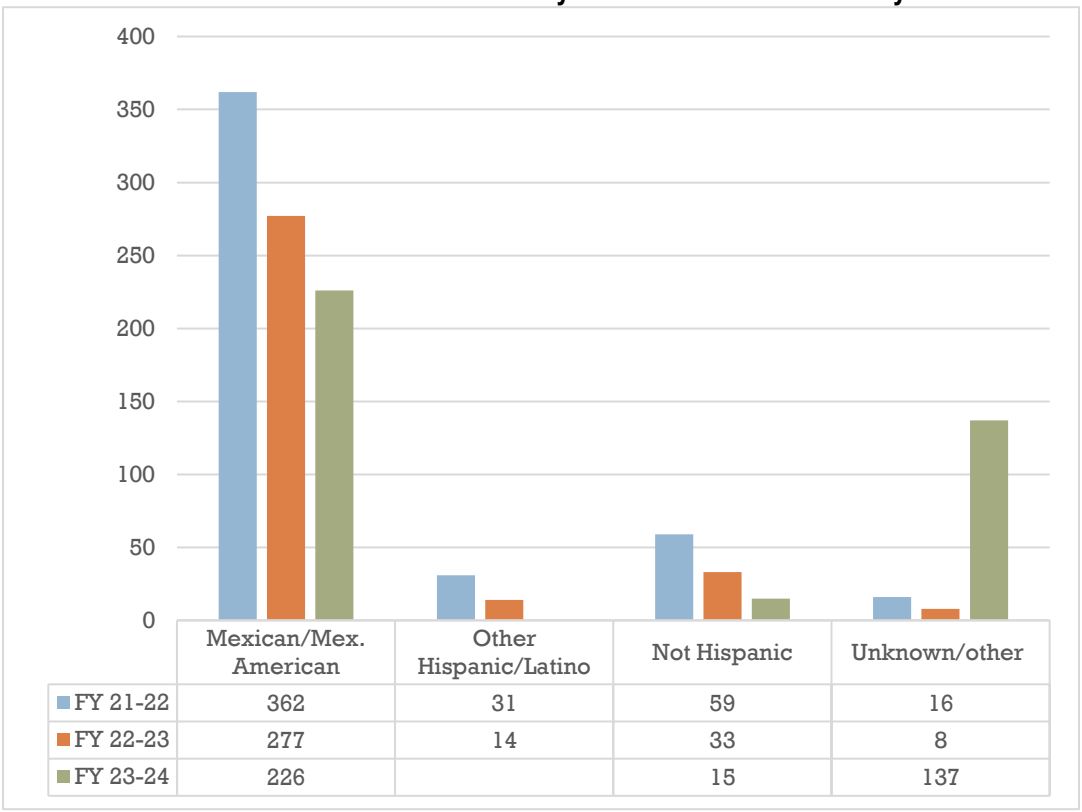
	0-5 Years	6-13 Years	14-20 Years	21-25 Years	26-65+ Years
FY 21-22	4	91	62	39	272
FY 22-23	5	57	59	28	183
FY 23-24	9	106	54	20	189

Chart M1.27 Beneficiaries Served by Contact Providers - Gender



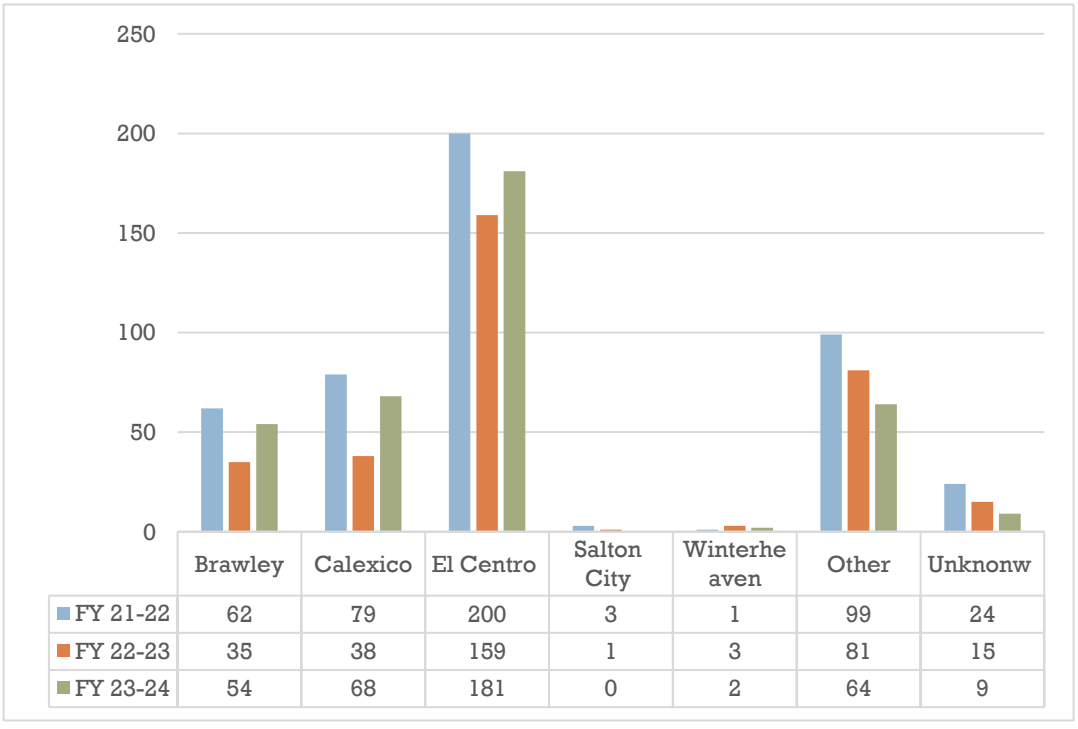
	Female	Male	Unknown/Other
FY 21-22	287	180	1
FY 22-23	192	139	1
FY 23-24	178	79	121

Chart M1.28 Beneficiaries Served by Contact Providers - Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 21-22	362	31	59	16
FY 22-23	277	14	33	8
FY 23-24	226		15	137

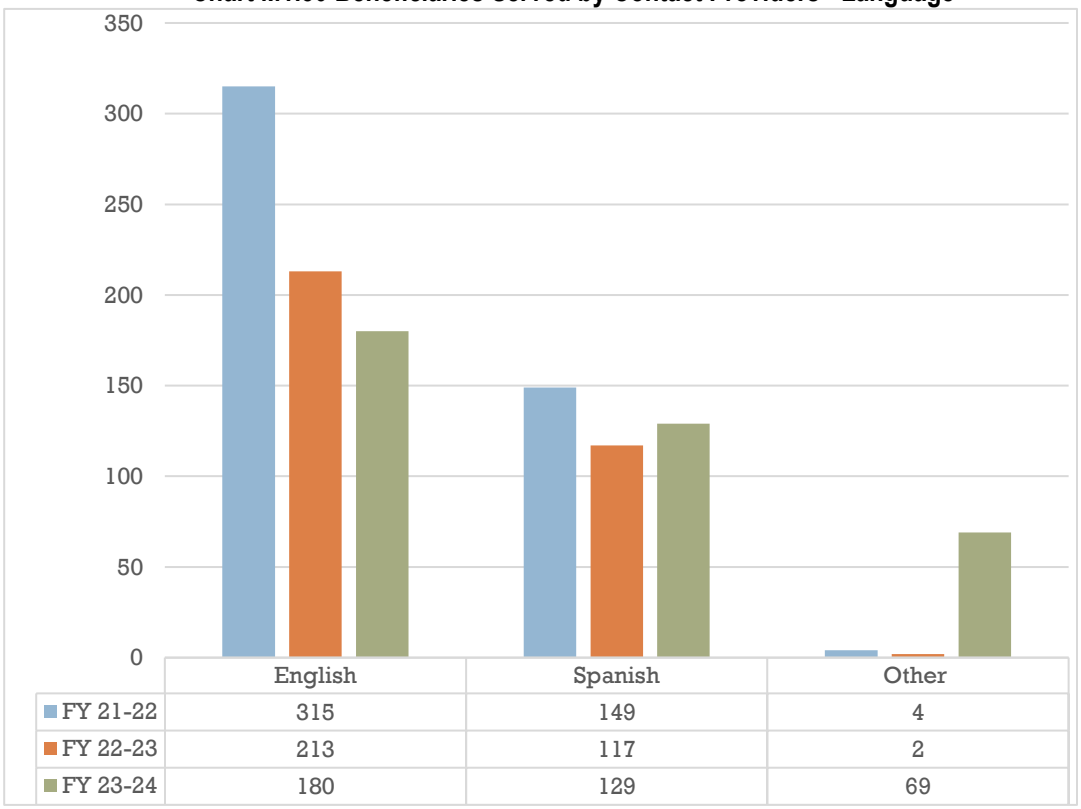
Chart M1.29 Beneficiaries Served by Contact Providers - City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknonw
FY 21-22	62	79	200	3	1	99	24
FY 22-23	35	38	159	1	3	81	15
FY 23-24	54	68	181	0	2	64	9

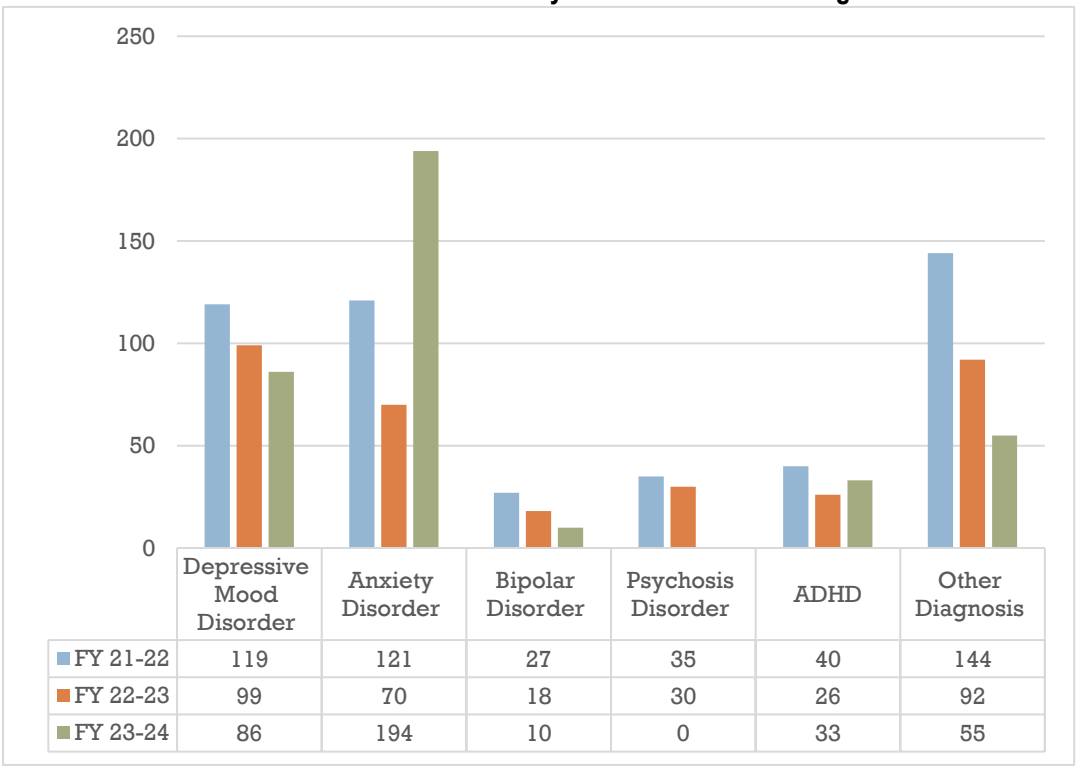
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart M1.30 Beneficiaries Served by Contact Providers - Language



	English	Spanish	Other
FY 21-22	315	149	4
FY 22-23	213	117	2
FY 23-24	180	129	69

Chart M1.31 Beneficiaries Served by Contact Providers - Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 21-22	119	121	27	35	40	144
FY 22-23	99	70	18	30	26	92
FY 23-24	86	194	10	0	33	55

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

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. Imperial County must meet the distances standard of up to 60 miles or 90 minutes from the beneficiary's place of residence. Timeliness standards for the MHP are as shown below.

Table M1.4 Timely Access Standards

Service Type	Timely Access
Urgent care appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Urgent care appointments for services that require prior authorization	Within 96 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Non-urgent appointments with specialist physicians (i.e., psychiatrists)	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments with a non-physician mental health care provider	Within 10 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent follow-up appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment as provided in HCS section 1357.03(a)(5)(F),(H)

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.

During FY 23-24, DHCS phased out the excel Network Adequacy Certification Tool (NACT) with the 274 Health Care Provider Directory, referred to as the "274 Standard". The 274 standard is an Electronic Data Interchange to ensure provider network data is consistent, uniform, and aligns with national standards. The MHP is required to submit the 274 standard files by the 10th of each month.

During FY 23-24, the MHP submitted the NACT to DHCS on October 27, 2023.

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will monitor the number, type, and geographic distribution of mental health services in order to verify that timely and appropriate SMHS are available to all Medi-Cal beneficiaries within Imperial County.
- The MHP will ensure service delivery capacity to meet the needs of beneficiaries.
- The MHP will monitor its network adequacy and submit data through the monthly submissions of the 274 standard files.

2. Timeliness of Services

The QM Unit monitors the MHP's ability to meet the following timeliness standards as established by DHCS:

Table M2.1 Timely Access Standards

Service Type	Timely Access
Non-urgent appointments with a non-physician mental health care provider	Within 10 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments with specialist physicians (i.e., psychiatrists)	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Urgent care appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Urgent care appointments for services that require prior authorization	Within 96 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)

The QM Unit collects data through the EHR monthly to verify that beneficiaries can access services timely without delay. Individual instances of access delays may result in the QM Unit conducting a more in-depth review to identify any potential quality of care issues. A corrective action plan is issued when the MHP's overall compliance rate with timeliness standards falls below 80 percent. Timeliness findings are reported to clinical management and/or the QIC, when appropriate.

a. Update on the MHP objectives and planned activities for FY 23-24:

1) Timeliness to First Non-Urgent Services

The DHCS standard for timelines to first non-urgent services 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 request the client requests a non-urgent service. The first offered non-urgent service is an intake assessment scheduled with a licensed/registered clinician. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. Due to the delayed implementation of timeliness data tracking in the EHR, the monitoring process involved gathering data from two separate sources within the EHR: data collected through Client Services Information (CSI) Timeliness Record and data collected through the

Timeliness Record. Data from both sources was merged to verify timeliness of services between July 1, 2023, through March 31, 2024. The Timeliness Record form was the only data source for verifying timeliness of services between April 1-June 30, 2024. The table below summarizes timeliness to first non-urgent services data for FY 23-24:

Table M2.2 Timeliness to First Non-Urgent Services

Review Period	Medi-Cal Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 23-24	2,728	2,592	136	95%
FY 22-23	2,902	2,761	141	95%
FY 21-22	5,905	5,751	154	97%

2) Timeliness to First Non-Urgent Psychiatric Services

The DHCS standard for timeliness to first non-urgent psychiatry service is 15 business days. The first offered non-urgent psychiatry service is an Initial Psychiatry Assessment (IPA) scheduled with a psychiatrist. Beneficiaries may request non-urgent psychiatry services by calling the MHP's 24/7 Line and requesting an appointment with a psychiatrist. Requests for non-urgent psychiatry services are recorded by the Access Unit.
The QM Unit evaluates timeliness to first non-urgent psychiatry services by reviewing the date of the request and determining the length of time to the first offered psychiatry appointment. Due to the delayed implementation of timeliness data tracking in the EHR, the monitoring process involved gathering data from two separate sources within the EHR: data collected through Inquiry Log and data collected through the Timeliness Record. Data from both sources was merged to verify timeliness of services between July 1, 2023, through January 31, 2024. The Timeliness Record form was the only data source for verifying timeliness of services between February 1-June 30, 2024. The table below summarizes timeliness to first non-urgent psychiatry services data for FY 23-24:

Table M2.3 Timeliness to First Non-Urgent Psychiatric Services

Review Period	Requests	Appointments Offered Within 15 Business Days	Appointments Offered Over 15 Business Days	Compliance Rate
FY 23-24	0	N/A	N/A	N/A
FY 22-23	8	7	1	88%
FY 21-22	1	1	0	100%

3) Timeliness to Urgent Services

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. Requests for urgent services not requiring prior authorization are recorded by the Access Unit, while requests for urgent services requiring prior authorization are recorded by the Payment Authorization Unit.

The MHP provides urgent services upon request or when it is determined that a beneficiary's "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 evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. Due to the delayed implementation of timeliness data tracking in the EHR, the monitoring process involved gathering data from two separate sources within the EHR: data collected through Inquiry Log and data collected through the Timeliness Record. Data from both sources was merged to verify timeliness of services between July 1, 2023, through January 31, 2024. The Timeliness Record form was the only data source for verifying timeliness of services between February 1-June 30, 2024. The table below summarizes the FY 23-24 data related to timeliness to urgent services not requiring prior authorization:

Table M2.4 Timeliness to Urgent Services Not Requiring Authorization

Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 23-24	152	134	18	88%
FY 22-23	17	15	2	88%

The QM Unit evaluates timeliness to urgent services requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service following authorization. The monitoring process involves gathering data from the Payment Authorization Unit's treatment authorization log. The table below summarizes the FY 23-24 data related to timeliness to urgent services requiring prior authorization:

Table M2.5 Timeliness to Urgent Services Requiring Authorization

Review Period	# of TARs Submitted	Requests for Urgent Services	Services Offered Within 96 Hours	Compliance Rate
FY 23-24	218	0	N/A	N/A
FY 22-23	196	0	N/A	N/A
FY 21-22	297	0	N/A	N/A

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will monitor the timeliness to non-urgent services, non-urgent psychiatry services, and urgent services monthly to verify beneficiaries can access services without delay.

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

- The QM Unit will issue corrective action plans to MHP providers if less than 80 percent of beneficiary requests were not offered a service within the required timeframe.

- The QM Unit will begin monitoring timeliness to follow-up appointments to ensure beneficiaries receive appropriate and timely follow-up after receiving a first service.

3. Accessibility of Services

The QM Unit monitors accessibility of MHP services and information by evaluating the responsiveness of the 24/7 Beneficiary Access Line and the Mental Health Triage Unit.

a. Update on the MHP objectives and planned activities for FY 23-24:

1) Responsiveness of the MHP's 24/7 Beneficiary Access Line

The QM Unit monitors the responsiveness of the MHP's 24/7 Beneficiary Access Line monthly by 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 24/7 Beneficiary Access Line is available to beneficiaries 24 hours a day, seven days a week.

Test calls determine the ability of the 24/7 Beneficiary Access Line to provide information related to 1) available SMHS, 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 whether or not the 24/7 Beneficiary Access Line appropriately determines the urgency of callers' requests; answers calls within five rings; provides information related to TTY/TDY services; and providers written MHP materials upon request.

During FY 23-24, the QM Unit conducted 48 test calls, 26 during business hours and 22 after hours. Below are the findings related to the test calls conducted by the QM Unit:

Table M3.1 24/7 Beneficiary Access 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%
Urgency Assessment	100%	75%	86%
Beneficiary Resolution and Fair Hearing Process	100%	75%	86%
Access Log Criteria	**Percentage of Test Calls Where Requirement Was Met**		
	Business Hours	**After Hours**	**All Calls**
Name of the caller	81%	89%	85%
Date of the request	81%	93%	87%
Initial disposition of the request	81%	100%	75%

2) 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 24/7 Beneficiary Access 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 after-hours care was provided within one hour.
In review of the data for FY 23-24, the QM Unit determined that access to after-hours care was provided within one hour for only 47 percent of requests. This is a significant decrease when compared to last fiscal year, likely attributed to staff failing to log their after-hours encounters with beneficiaries.

Table M3.2 Access to After-Hours Care

Review Period	Requests	Within Standard	Compliance Rate
FY 23-24	440	206	47%
FY 22-23*	164	161	98%
FY 21-22	309	307	99%

**Inclusive of July-December 2022 data only due to EHR transition.*

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will continue to monitor the 24/7 Beneficiary Access Line to verify that MHP services and information are available to beneficiaries at all hours through the 24/7 Beneficiary Access Line and the Mental Health Triage Unit.

- The Mental Health Triage Unit will implement interventions to improve availability of after-hours care from 47 percent to 52 percent, with the end goal being to reach the 90th percentile.

4. 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. Update on the MHP objectives and planned activities for FY 23-24:

1) MHP Consumer/Family Satisfaction Survey

During CY 2023, the MHP administered the Statewide Consumer Perception Survey (CPS) to beneficiaries 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.

397 surveys were completed during the CY 2023 CPS period. Survey participation increased by 39 surveys from CY 2022.

67 youth surveys were completed during the CY 2023 CPS. Data shown in Table 46 indicates a significant decrease in the areas of "Treatment Planning", with a decrease of 17 percentage points; and "Outcome of Services", with a decrease of 21 percentage points.

There was a notable increase in “Improvement in Functioning”, with an increase of 12 percentage points. Survey findings for youths are summarized below:

Table M4.1 Youth CPS Results

Survey Area	CY 2021 (n=3)	CY 2022 (n=82)	CY 2023 (n=67)	Difference in % (2022 to 2023)
General Satisfaction	96%	86%	81%	-5
Perception of Access	95%	95%	87%	-8
Participation in Treatment Planning	80%	94%	77%	-17
Outcome of Services	90%	94%	73%	-21
Social Connectedness	100%	69%	80%	+11
Cultural Sensitivity	90%	82%	85%	+3
Perception of Functioning	90%	66%	78%	+12

156 youth family surveys were completed during the CY 2023 CPS. Although most areas either stayed the same or had slight improvements, there was a slight decrease in “General Satisfaction”, with 1 percentage point decrease. Survey findings for youth families are summarized in Table 47, including a side-by-side comparison with CY 2022 findings:

Table M4.2 Youth Families CPS Results

Survey Area	CY 2021 (n=27)	CY 2022 (n=138)	CY 2023 (n=156)	Difference in % (2022 to 2023)
General Satisfaction	88%	90%	89%	-1
Perception of Access	89%	93%	93%	0
Participation in Treatment Planning	88%	90%	90%	0
Outcome of Services	80%	70%	75%	+5
Social Connectedness	82%	87%	96%	+9
Cultural Sensitivity	90%	96%	98%	+2
Perception of Functioning	80%	68%	72%	+4

128 adult surveys were completed the during CY 2023 CPS. Adult beneficiaries reported high satisfaction perception (71 percent to 92 percent). Findings remained consistent from the previous year, excluding “General Satisfaction” which increased by 9 percentage points. Survey findings for adults are summarized below:

Table M4.3 Adult CPS Results

Survey Area	CY 2021 (n=66)	CY 2022 (n=93)	CY 2023 (n=128)	Difference in % (2022 to 2023)
General Satisfaction	86%	81%	90%	+9
Perception of Access	88%	94%	90%	-4
Quality and Appropriateness	87%	90%	88%	-2
Participation in Treatment Planning	84%	95%	92%	-3
Outcome of Services	83%	72%	74%	+2
Social Connectedness	77%	83%	80%	-3
Perception of Functioning	85%	71%	71%	0

46 older adult surveys were completed during the CY 2023 CPS. Older adult beneficiaries reported high satisfaction perception (74 percent to 96 percent). Findings remained consistent from the previous year, excluding “Outcome of Services”, which increased by 13 percentage points, “Social Connectedness”, which increased by 10 percentage points, and “Perception of Access”, which decreased by 4 percentage points. Survey findings for older adults are summarized below:

Table M4.4 Older Adult CPS Results

Survey Area	CY 2021 (n=16)	CY 2022 (n=45)	CY 2023 (n=46)	Difference in % (2022 to 2023)
General Satisfaction	85%	92%	96%	+4
Perception of Access	86%	92%	88%	-4
Quality and Appropriateness	87%	83%	88%	+5
Participation in Treatment Planning	85%	91%	96%	+5
Outcome of Services	90%	70%	83%	+13
Social Connectedness	80%	67%	77%	+10
Perception of Functioning	98%	80%	74%	-2

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.

During FY 23-24, the QM Unit conducted monthly phone surveys to gauge client satisfaction with ICBHS, their treatment provider and/or team, and their overall services. 259 clients/parents/guardians receiving services from ICBHS participated in this year’s survey process. Over 90 percent of participants reported being satisfied with ICBHS and its providers. Of the clients receiving SMHS who participated in the survey, none reported any dissatisfaction or made any comments of concern that would be indicators of why there have been decreases in certain categories of the CPS.

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 23-24, the MHP received 122 grievances (representing both Medi-Cal beneficiaries and non-Medi-Cal clients), 2 standard appeals, and 9 expedited appeals. This is an increase in grievances, but a decrease in appeals when compared to FY 22-23. The table below summarizes grievances and appeals by category:

Table M4.5 Grievances & Appeals by Category

Grievance Category	FY 21-22	FY 22-23	FY 23-24
Related to Customer Service	0	0	0
Related to Case Management	0	0	0
Access to Care	2	20	9
Quality of Care	91	97	106
County (Plan) Communication	0	0	0
Confidentiality	0	0	2
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
Filed for other reasons	7	4	5
Appeal Category	**FY 21-22**	**FY 22-23**	**FY 23-24**
Denial or Limited Authorized or Service (s)	0	1	0
Reduction, Suspension, or Termination of a Previously Authorized Service	23	28	11
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 23-24, acknowledgments for three grievances were issued to the beneficiaries late and two grievances were resolved 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 23-24, the MHP received 253 requests to change persons providing services from Medi-Cal beneficiaries, which is an increase when compared to 187 requests received in FY 22-23. This is likely due to an increased volume of clients requesting to change from telehealth to in-person services.

ICBHS also 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 249 (95 percent) and denied 13 (5 percent) of the requests, representing both Medi-Cal beneficiaries and non-Medi-Cal clients. Thirteen requests were withdrawn. The table below summarizes the requests to change persons providing services by category:

Table M4.6 Reason for Requests for Change of Provider

Reason	FY 21-22	FY 22-23	FY 23-24
Quality of Care Treatment Concerns	18	57	70
Quality of Care-Staff Behavioral Concerns	7	20	24
Service Not Available	9	18	21
Request Transfer to Another Clinic	4	2	8
Language Barrier	13	10	15
Not Feeling Comfortable with Provider	5	10	85
In-Person Provider	N/A	N/A	36
No Therapeutic Alliance with Provider	10	5	8
Dissatisfaction with Provider	27	22	4
Disagreement with Course of Treatment	44	1	3
Confidentiality	2	0	1

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will continue to conduct monitoring activities to determine beneficiary/family satisfaction with MHP services.

- The QM Unit will conduct follow-up surveys and/or focus groups with youth beneficiaries to identify quality improvement issues related to: general satisfaction, perception of access, participation in treatment planning, and outcome of services.

- The QM Unit will conduct follow-up surveys and/or focus groups with older adult beneficiaries to identify quality improvement issues related to perception of access. This is an important issue for the MHP to explore as penetration rates for the older adult population have historically been low.

- 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.

5. 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.

a. Update on the MHP objectives and planned activities for FY 23-24:

1) Medication Monitoring

The Medication Monitoring reviews are conducted monthly by seven 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 23-24, the medication monitoring committee reviewed 312 charts: 96 from Adults Services, 104 from Children Services, and 112 from Youth and Young Adults Services. Areas at 85 percent or below are identified as opportunities for improvement. The MHP was 92 to 100 percent compliant in all the sixteen areas evaluated, with the exception of "If patient is on controlled substance, physician reviewed CURES in timely manner?" at 75 percent compliance. This is a decrease from 99 percent in FY 22-23. No significant findings were otherwise identified, which indicates that MHP prescribers are following best practices in the implementation of medication support services.

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 23-24, the QM Unit received quality of care referrals for 12 clients served by the MHP. Quality of care referrals were submitted by the ICBHS Patients' Rights Advocate, the MHP QI Coordinator, QM staff, and the Compliance Unit. 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 was 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 23-24:

- Ensure meaningful care coordination occurs between mental health providers, significant supports, and/or community agencies to support the client towards improving their overall mental health condition.
- Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating timely services accessed by the beneficiary
- Conduct home visits timely to assess environmental stressors and/or family dynamics affecting client's mental health condition. When appropriate, document barriers that prevented service providers from conducting home visits. This is a repeat recommendation from the previous fiscal year.

b) Quality Management Chart Reviews

The QM Unit conducts routine chart reviews to verify the overall quality of services provided by the MHP. Chart reviews were conducted for each service division of the MHP using 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 management, with each division receiving 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. Compliance referrals were submitted to the Compliance Unit when instances of potential fraud, waste, or abuse were identified.

During FY 23-24, the QM Unit reviewed 106 MHP cases, of which 35 were from Children Services, 34 were from Youth and Young Adults Services, 19 were from Adults Services, and 18 were from Mental Health Triage and Engagement Services. The below summary of findings were areas identified as needing correction:

<u>Access</u>

- The services provided prior to diagnosis were not medically necessary and clinically appropriate.
- No timely mental health services (interventions/assessment) rendered – provider did not contact client within 7-days after case being assigned, as required by the MHRT Practice Guidelines.

<u>Assessment /Re-Assessment</u>

- *No assessment of ICC/IHBS in accordance with the client's presenting problem, as appropriate.* ***(Repeat finding from FY 22-23)***
- *No ongoing assessment, including but not limited to client's presenting problem, risks factors, and strengths, impacting the treatment process.* ***(Repeat finding from FY 22-23)***
- No assessment for other treatment interventions, as recommended at the time of the initial assessment or the presenting problem.
- No evidence of documented efforts to involve client's significant support systems (outside support) to assist with the assessment and treatment recommendations.
- A safety plan was not developed, when appropriate.

Problem List

- *No evidence of client participation and/or contribution in the development of the Problem List.* ***(Repeat finding from FY 22-23)***
- *Problem List is not being updated by the provider to reflect client's presenting problems and/or reported symptoms and behaviors.* ***(Repeat finding from FY 22-23)***
- No Problem List was developed/completed.

Treatment Interventions

- No meaningful interventions provided in accordance with the client's presenting problem.
- No evidence of clients and/or significant support engagement or response with treatment and/or discharge planning.
- No timely access to services in accordance with the clients' mental health needs/presenting problem (no attempts to facilitate home and/or school visits, as appropriate).
- *Outcome measurement tools were not administered throughout the course of treatment, as required, to measure progress or lack of progress.* ***(Repeat finding from FY 22-23)***
- *Provider did not educate the client on the clinical findings of administered tools to assess current mental health status.* ***(Repeat finding from FY 22-23)***
- No evidence of exploring in great depth concerns, suicidal thoughts, red flags and/or other indications of possible risks and tracked in the problem list.
- No documentation of plan for follow up for future encounters for the provider and/or client and to evaluate effectiveness of the intervention and/or progress with mental health conditions.
- No timely documentation of the services provided to maintain the integrity of the service.

Care Coordination

- *No meaningful coordination of care with mental health treatment team members that will assist client in making progress towards goals, when appropriate.* ***(Repeat finding from FY 22-23)***
- *No engagement and/or involvement of family members with the treatment process in a meaningful manner to care coordinate, as appropriate and authorized, with the intent of helping client reach goals and conduct a thorough assessment of the client.* ***(Repeat finding from FY 22-23)***
- No referrals to community resources to support client with recovery.
- No valid Release of Information (missing required elements).
- Cases are not taken to team as needed to discuss lack of progress, significant events/changes, appropriateness of diagnosis, need for additional interventions or higher level of services.

In addition to the regularly scheduled reviews conducted for each MHP division, the QM Unit also conducted ad hoc focus reviews. Focus reviews are assigned as a follow-up from any type of prior case review, as referred by management or supervisors, or as requested by individual providers.

During FY 23-24, the QM Unit conducted seven focus reviews: two requested by management, two requested by individual providers, and three conducted as follow-up reviews. The following findings were identified during these focus reviews:

- No interventions provided directly to the client.
- No baseline symptoms or behaviors obtained from the client.
- Lack of care coordination amongst treatment team.
- Lack of coordination with/observation of the client to better understand symptoms and behaviors.
- No timely contact.

Findings were reported to the individual(s) requesting each focus review, as well as the affected supervisor(s) and management.

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.

- The MHP will implement interventions to ensure home visits are conducted timely, when appropriate, to assess environmental stressors and/or family dynamics affecting clients' mental health condition.

- The MHP will provide training to providers to ensure improvements are made in the areas identified as repeat findings from the previous year, specifically under the categories of Assessment/Reassessment, Problem List, Treatment Interventions, and Care Coordination.

6. Continuity and Coordination of Care with Medi-Cal Managed Care Plans

As the MHP for Imperial County, ICBHS is responsible for providing SMHS to Medi-Cal beneficiaries who meet both access and medical necessity criteria. The MHP is expected to coordinate with the local Medi-Cal Managed Care Plans (MCP) to coordinate services for Medi-Cal beneficiaries who do not meet criteria for SMHS. During FY 22-23, Imperial County transitioned from its previous Medi-Cal MCPs, Molina Health Care and California Health & Wellness, to Kaiser Permanente and Community Health Plan of Imperial Valley (CHPIV). As of the beginning of FY 24-25, MOUs with both MCPs are pending to be executed, although agreements have been made as to the language and scope of each MOU.

a. Update on the MHP objectives and planned activities for FY 23-24:

1) Adult and Youth Screening Tools for Medi-Cal Mental Health Services

DHCS requires the use of the adult and youth screening tools to ensure Medi-Cal beneficiaries are guided to the appropriate Medi-Cal mental health system (i.e. MCP or MHP). The screening tools identify initial indicators of beneficiary's needs in order to make a determination for referral to either the beneficiary's MCP for a clinical assessment and medically necessary non-SMHS or to the MHP for a clinical assessment and medically necessary SMHS.

The table below summarizes the screening tools implemented by the MHP during FY 23-24:

Table M6.1 Adult and Youth Screening Tools

Period	Category	MCP Score (0-5)	MHP Score (6+)	Total	Urgent	Referred to SUD
FY 23-24	Adult	1,828	337	2,165	209	317
	Youth	2,234	321	2,555	104	73
	Total	**4,062 86.06%**	**658 13.94%**	**4,720**	**313**	**390**

**ICBHS implements the screening tool to all clients regardless of payor source.*

The adult and youth screening tools have assisted the MHP in the process of assessing the beneficiary's immediate needs to provide the needed care, especially when it is an urgent situation; however, they have not been effective in identifying the beneficiary's appropriate level of care. The implementation of the screening tools is facing significant challenges, which include lack of cultural competence and the stigma associated with behavioral health services within the Imperial County population. This results in individuals not feeling comfortable disclosing all of their symptoms and life-functioning impairments with the screening staff, the process which takes place over the phone in the majority of cases. Consequently, lower screening tool scores are typically reported, which do not accurately convey a measurement that will assist screening staff in identifying the proper level of care for the individual requesting services. As a result, all clients are referred for a full intake assessment, regardless of the outcome of the screening tool. During FY 23-24, the MHP determined that 2,708 Medi-Cal beneficiaries met access criteria and medical necessity for SMHS, illustrating that the adult and youth screening tools do not fully support their intended purpose.

During FY 23-24, no Medi-Cal beneficiaries were referred to the MHP by any of the local MCPs.

2) Transition of Care Tool for Medi-Cal Mental Health Services

DHCS requires the use of the transition of care tool to ensure that beneficiaries who are receiving mental health services from one delivery system (i.e. MCP or MHP) receive timely and coordinated care when either 1) their existing services need to be transitioned to the other delivery system; or 2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies.

Until the change in local MCPs effective January 1, 2024, the MHP was a contracted MCP non-SMHS provider. As a result, any beneficiaries who needed to transition down to the level of the MCP were retained by ICBHS and provided "mild-to-moderate" mental health services. Since January 1, 2024, the MHP has been establishing processes to implement the transition of care tools for Medi-Cal beneficiaries who are determined not to meet access criteria or medical necessity criteria upon completion of the initial intake assessment, as well as for those MHP beneficiaries who are stable enough to transition down to the MCP level.

During FY 23-24, the MHP did not implement any transition of care tools. No transition of care tools were received by any of the local MCPs.

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will monitor the implementation of the Medi-Cal screening and transition of care tools to ensure that Medi-Cal beneficiaries receive timely, coordinated services across Medi-Cal mental health delivery systems.

- The MHP will ensure the Medi-Cal transition of care tool is implemented as required.

7. Provider Complaints and Appeals

The QM Unit monitors provider disputes with ICBHS concerning the request for authorization or payment for SMHS. The QM Unit also monitors provider appeals through the written appeals submitted to ICBHS by providers for denial of authorization or payment, or modification of requests for authorization.

a. Update on the MHP objectives and planned activities for FY 23-24:

During FY 23-24, 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 23-24, no complaints were reported to the QM Unit. Similarly, no appeals were submitted. The lack of submission of both complaints and appeals is consistent with previous years.

All requests for services requiring prior or concurrent authorization were processed as requested, except for 7 inpatient authorization requests; however, the inpatient providers did not appeal the decision by the MHP to deny payment.

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The Provider Relations staff will provide technical assistance to providers and/or MHP staff as needed to resolve complaints at the lowest possible level.

8. Inpatient Psychiatric Hospitalization Monitoring

The QM Unit tracks and monitors the admission and readmission of the MHP's inpatient psychiatric hospitalizations in order to identify any potential quality of care issues. 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. Update on the MHP objectives and planned activities for FY 23-24:

1) Inpatient Psychiatric Admissions

During FY 23-24, there were 177 Medi-Cal beneficiaries and 63 non-Medi-Cal clients hospitalized, for a total of 304 admissions, which is a significant increase (nearly 50 percent) from the previous fiscal year. A comparison to prior fiscal years is included below:

Table M8.1 Inpatient Psychiatric Admissions

Review Period	# of Clients Hospitalized			# of Admissions		
	Medi-Cal	Non Medi-Cal	Total	Medi-Cal	Non Medi-Cal	Total
FY 23-24	177	63	240	232	72	304
FY 22-23	80	77	157	112	93	205
FY 21-22	73	37	110	91	41	132

Of the 304 admissions during FY 23-24, 61 percent were for active clients receiving services from the MHP at the time of the hospitalization. The status by division is as follows:

- Children Services – 11 (3%) active clients at time of hospitalization, 5 (2%) inactive that were assigned for follow-up
- Youth & Young Adults Services – 38 (13%) active clients at time of hospitalization
- Adults Services – 93 (31%) active clients at time of hospitalization
- Mental Health Triage & Engagement Services – 43 (14%) active clients at time of hospitalization, 114 (38%) that were assigned for follow-up

2) Inpatient Psychiatric Readmissions

Of the 304 admissions during FY 23-24, 47 were readmissions. The MHP's overall readmission rate is 15 percent. This is a decrease from FY 22-23 when the readmission rate was 23 percent.

There were 26 readmissions that occurred within 30 days of discharge, resulting in a 15 percent 30-day readmission rate. This is a decrease from FY 22-23 when the 30-day readmission rate was 16 percent. The table below summarizes the MHP's inpatient psychiatric readmissions:

Table M8.2 Inpatient Psychiatric Readmissions

Review Period	FY 21-22	FY 22-23	FY 23-24
Total Readmissions	22	48	47
Total Admissions	132	205	304
Readmission Rate	**17%**	**23%**	**15%**
Readmissions Within 30 Days	12	33	26
Total Admissions	132	205	304
30-Day Readmission Rate	**9%**	**16%**	**15%**

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 23-24, the QM Unit reviewed 303 hospitalizations: 92 for Adults Services, 38 for YAYA Services, 16 for Children Services, and 157 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. The QM Unit identified the following as areas for improvement:

Hospitalization Discharge Planning

- Confirm medication supply (3-day and 30-day prescription) for clients at the time of the discharge planning.

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, coordination of care and/or needed referrals).* ***(Repeat finding from FY 22-23)***

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

4) 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 23-24 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.

The monitoring process entailed collecting data for all clients who are discharged from a psychiatric hospital. The data sources utilized are the Payment Authorization Unit 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 23-24, there were 304 hospitalizations. Of those, 104 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 (4%); residing out of county (22%); being unable to make contact with (4%); or refusing services (3%).

Of the 200 clients that received follow-up psychiatric appointments, 134 (67%) were actively receiving services from the MHP and 66 (33%) were not. The average wait time to receive an appointment was 3 days for active clients and inactive clients.
During FY 23-24, the MHP was 62 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 when the follow-up rate within 7 business days was 84 percent. The significant decrease in the follow-up rate is due to the QM Unit changing the methodology for measuring timeliness. Previously, the QM Unit factored out clients that

refused services or received follow-up care from outside the MHP; however, regardless of the outcome, the MHP still maintains the responsibility of providing appropriate follow-up care to these individuals, therefore, effective FY 23-24, the QM Unit began calculating the rate of follow-up for all individuals hospitalized, regardless of outcome.

Of the 200 clients that received a follow-up psychiatric appointment during FY 23-24, 7 percent received an appointment within 8 to 30 days after hospitalization.

A comparison to prior years is included below:

Table M8.3 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.**	**Compliance Rate**
FY 23-24	185	126	8	3 days	68%
FY 22-23	86	70	85	5 days	84%
FY 22-23	56	51	56	3 days	91%
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.**	**Compliance Rate**
FY 23-24	119	60	5	3 days	50%
FY 22-23	32	22	30	10 days	69%
FY 21-22	23	20	23	5 days	87%

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QM Unit will investigate why the number of inpatient psychiatric hospital admissions increased by nearly 50 percent from FY 22-23 to FY 23-24.
- The MHP will provide training to providers to ensure a home visit or Zoom appointment is provided to clients within 3 business days of discharge from an inpatient psychiatric hospital.
- The QM Unit will calculate timeliness of first follow-up after hospitalization for mental illness by measuring against the first service provided to the client, regardless of the service type.

9. 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. Data related to appointments 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 can plan and implement interventions to increase client engagement and decrease wait times for services.

a. Update on the MHP objectives and planned activities for FY 23-24:

1) Psychiatric No Show Rates

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

The MHP no show rate to IPA was 25 percent during FY 23-24, which is an increase from 19 percent in FY 22-23. The Children, Youth & Young Adults, and Mental Health Triage & Engagement Services divisions exceed their no-show benchmarks. Trends for the divisions 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 below:

Table M9.1 No Show Rates - Initial Psychiatric Assessment

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 23-24	105	19%	129	24%	355	33%	121	19%	710	25%
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%

b) No Show Rates to Medication Support Appointments

The no show rate to psychiatrist medication support appointments was 22 percent during FY 23-24, which is an increase from 15 percent in FY 22-23. The Youth & Young Adults Division exceeded its no-show benchmark. Trends for the divisions 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 – 22 percent
- Adults Services – 23 percent

The results by division are summarized below:

Table M9.2 No Show Rates - Psychiatrist 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 23-24	861	18%	895	24%	2,575	23%	4,331	22%
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%

2) Clinician No Show Rates

a) No Show Rates to Intake Assessments

The MHP no show rate to initial intake assessment was 27 percent during FY 23-24, which is a slight increase from 26 percent in FY 22-23. The Adults and Mental Health Triage & Engagement Services divisions exceeded their no-show benchmark. Trends for the Adults and Mental Health Triage & Engagement Services divisions 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 below:

Table M9.3 No Show Rates – Intake Assessment

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 23-24	345	20%	322	25%	544	33%	327	34%	1,538	27%
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%

b) *No Show Rates to Psychotherapy Appointments*

The MHP no show rate for psychotherapy appointments was 19 percent during FY 23-24, which is an increase from 15 percent in FY 22-23. The Adults Division exceeded their no-show benchmark. Trends for the Adults Division were identified at 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 below:

Table M9.4 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 23-24	1,426	17%	1,186	22%	579	19%	3,191	19%
FY 22-23	365	13%	282	24%	108	9%	755	15%
FY 21-22	873	17%	1,036	24%	936	21%	2,845	20%

3) Nurse No Show Rates

a) No Show Rates to Nursing Evaluations

The MHP no show rate to nursing evaluations was 18 percent during FY 23-24. The Youth & Young Adults and Mental Health Triage Engagement Services divisions exceeded their no-show benchmark. Trends for both divisions were identified at program level and were shared with management. 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

Effective FY 23-24, the no-show rate for nursing evaluations was inclusive of both initial nursing assessments and annual nursing assessments, as both appointment types now utilize the same procedure code and are not possible to distinguish from each other. Prior to FY 23-24, nursing evaluations only reflected initial nursing assessment appointments.

The results by division are below:

Table M9.5 No Show Rates – Initial Nursing Evaluations

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 23-24	424	14%	590	26%	669	17%	188	20%	1,871	18%

b) *No Show Rates to Medication Support Appointments*

The MHP no show rate to nurse medication support appointments was 17 percent during FY 23-24, which is an increase from 12 percent in FY 22-23. No trends were identified. 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 below:

Table M9.6 No Show Rates – Nurse 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 23-24	918	18%	1,091	25%	991	12%	3,000	17%
FY 22-23	58	12%	76	27%	208	10%	342	12%
FY 21-22	154	15%	321	34%	893	21%	1,368	22%

b. Overview of the MHP objectives and planned activities for FY 24-25:

- The QIC will consider adopting a lower no-show benchmark for all appointment types and will aim for incremental improvements of 5 percent until reaching the new no-show benchmark.

- The QM Unit will conduct an analysis to determine the causes for high no-show rates in youth services, as recommended by the EQRO.

10. Performance Improvement Projects

The QIC oversees the development of clinical and non-clinical Performance Improvement Projects (PIPs). The QIC reviews data indicating the need for quality improvement activities, taking into consideration recommendations made by the QM Unit, and selects the PIPs and the individuals assigned to participate in a PIP taskforce. Members of the PIP taskforce are responsible for developing the PIPs, collecting and analyzing data, developing goals and key performance indicators, implementing interventions, and measuring outcomes. Progress on each PIP is presented during the monthly QIC meetings and to the EQRO during the annual external quality review.

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 was 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. ICBHS submitted its BHQIP PIPs on March 20, 2024, and received a response from DHCS on April 24, 2024, stating that all supporting documents submitted were sufficient for meeting this milestone. Of the three BHQIP PIPs, one was related to SMHS: Follow-Up After Emergency Department Visit for Mental Illness (FUM).

a. Update to the MHP objectives and planned activities for FY 23-24:

1) Increasing Access to Mental Health Services to 65+ Older Adult Population

As part of its ongoing monitoring activities, the QM Unit reviewed and analyzed client demographics and penetration rates for older adults. Data showed that the older adult population (65+) was and had been low for accessing SMHS.

The tables below indicate prior fiscal years data for elderly population 65+ from the Mental Health Client Demographics and Penetration Rates reports:

Table M10.1 Percentage of Older Adults Served by MHP

Review Period	# of Medi-Cal Beneficiaries	# of Medi-Cal Beneficiaries 65+	
	#	#	%
FY 22-23	2,097	73	3%
FY 21-22	2,50	52	2%
FY 20-21	2,307	47	2%

Table M10.2 Older Adult Penetration Rate

Review Period	# of Medi-Cal Eligible	Medi-Cal Served	Penetration Rate
FY 21-22	12,491	60	0.48%
FY 20-21	12,194	55	0.45%
FY 19-20	11,400	77	0.68%

This PIP focused on increasing older adult access to services and retaining and engaging the older adult population by providing the Program to Encourage Active, Rewarding Lives (PEARLS) evidence-based model along with community outreach. PEARLS utilizes prevention methods in identifying/educating on mental illness, skill building techniques, increase social and physical activation and coordination of care. The improvement strategy and interventions consisted of community service workers, peer supporters, and mental health professional staff from the Adults Division providing supportive services to older adults who were accessing SMHS.

The PIP initiated in July 2023, with the aim being to increase access to services and retain the 65+ population by using prevention methods in identifying/educating for mental health illness, skill building techniques, and coordination of care for mental health services from 73 to 93 beneficiaries during FY 23-24, to overall improve the psychological well-being for older adults.

The interventions implemented are included in the table below:

Table M10.3 PIP Interventions

Intervention	Corresponding Indicator	Date Applied
-Community Outreach Engagement Services -Monitor and track new beneficiaries and implement the PEARLS Treatment Model.	# of individuals provided with outreach engagement services # of individuals offered the PEARLs Program & # of individuals who completed the PEARLs program	July 2023

Out the 69 beneficiaries who were potential candidates for the PEARLS program, 17 (24%) completed a PEALRS assessment. Out of the 17 who completed an assessment, 5 (29%) met criteria, 9 (53%) did not meet criteria, 2 (12%) no showed to appointment and 1 (6%) declined services. The remaining 52 beneficiaries declined the PEARLS program.

Due to the challenges encountered with this PIP, the QM Unit conducted a focus group at the ICBHS El Centro Adult Wellness Center on April 23, 2024, with 20 consumers. The purpose of the focus group was to explore the older adults' experiences with mental health services, barriers to treatment and how to improve the quality of services. The group expressed the following as barriers to accessing treatment: stigma, fear of asking for help, cultural belief systems, and the lack of being listened to attributed. The group suggested increasing informational brochures within the community and media exposure (television, social media, radio) regarding mental illness.

65 older adults were served by the MHP during FY 23-24. The MHP plans to continue this PIP and adjust interventions to make improvements in access to SMHS for the older adult population.

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 was to improve coordination and exchange of data between the Managed Care Plans and the MHP.

The data provided by DHCS in FY 22-23 indicated that only 66 percent of ED visits for a mental illness by Imperial County Medi-Cal beneficiaries were followed up by MHP within 7 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 MHP previously established a process with the ED located in El Centro (ECRMC) where a case manager is stationed on site Monday through Friday from 8:00 a.m. to 5:00 p.m. During FY 23-24, the MHP expanded this arrangement to the county's second ED, located in Brawley, Pioneers Memorial Health (PMH). Although this staff person is only available during traditional working hours, having someone co-located at the EDs helped facilitate the data exchange process, allowing the MHP to become aware of and intervene timely for those beneficiaries who were presenting in the ED for a mental health related concern.

Although the intervention of having a case manager in the EDs has helped facilitate care coordination between the EDs and the MHP, the main goal of this PIP was to establish a data exchange process with the MCP. This component of the PIP has proven to be the most challenging for two reasons: 1) the local MCPs changed mid-year, with one completely leaving the county while the other re-organized and 2) the MCP that remained in the county is reluctant to share any data. Currently, the MHP is in the process of establishing MOUs with both MCPs and the opportunity for data exchange appears promising.

During FY 23-24 the aim statement for this PIP was to improve the MHP follow-up rate for Medi-Cal beneficiaries visiting the ED for a mental illness 66 percent to 71 percent by June 30, 2024. The MHP has demonstrated progress towards the aim statement by increasing follow-up appointments after ED visits for mental illness by 94 percent. The MHP monitors interventions by evaluating two Key Performance Indicators (KPI) during FY 23-24:

- KPI #1: The number of beneficiaries successfully scheduled for a follow-up appointment after emergency department visit.
- KPI #2: The number of beneficiaries who kept a follow-up appointment after emergency department visit.

The table below summarizes the data collected and analyzed by the MHP:

Table M10.4 Timeliness of MHP Services After ED Visit

Period	# of individuals who met criteria and attended ED for MH Illness	# of individuals who received a same-day crisis intervention		# of individuals who were referred to the MHP		# of individuals who were scheduled a follow-up apt.		# of individuals who kept follow-up apt.	
		#	%	#	%	#	%	#	%
FY 23-24	158	158	100%	65	41%	141	89%	133	94%

The interventions implemented to date are included below:

Table M10.5 PIP Interventions

Intervention	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	• 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.	07/01/2023

are not accessing services through the MHP.	• Number of clients who kept follow-up appointment after emergency department visit.	

a. Overview of the MHP objectives and planned activities for FY 24-25:

- The MHP will continue to implement interventions to improve access to SMHS for older adults.

- The MHP will continue to work with the local MCPs to establish data exchange processes in order to better coordinate care for Imperial County Medi-Cal beneficiaries who are accessing the local EDs for a mental illness.

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

1. Service Delivery Capacity

As the DMC-ODS Plan 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 DMC-ODS services within the ICBHS delivery system and Federal Network Adequacy Standards for FY 23-24.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

The QM Unit compiled information on the current number, type, and geographical distribution of DMC-ODS 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 beneficiaries served, and the number of services claimed in FY 23-24.

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 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 provide accommodation 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 DMC-ODS services to all areas of the county and to make those services easily available and accessible for Imperial County residents, ensuring that staff are allocated according to the cultural needs of the population it serves. During FY 23-24, four DMC certified sites provided services to Imperial County residents. The treatment sites include two outpatient clinics for adults – one in El Centro and one in Calexico – and two outpatient clinics for adolescents – one in El Centro and one in 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

Southern Services

Adult SUD services in the southern region are provided at a DMC-certified outpatient clinic in Calexico. Services are targeted towards adults 18 years of age and older who reside in the southern region of Imperial County.

Central Services

Adult SUD services in the central region are provided at a DMC-certified outpatient clinic in El Centro. Services are targeted towards adults 18 years of age and older who reside in El Centro, Imperial, Holtville, Seeley, Ocotillo, and Heber.

Northern Services

ICBHS has made numerous attempts to open a DMC-certified outpatient clinic in the city of Brawley, which is the largest municipality in the northern region, that would serve the adult population. Adults 18 years of age and older who reside in Brawley, Calipatria, Niland, Westmorland, and northern unincorporated areas are served through the outpatient clinic in El Centro. Transportation is available when needed. Telehealth services are also available to meet the needs of adults who are not able to attend services in-person.

Charts S1.1-S1.6 indicate the demographic information for beneficiaries served by the Adult SUD Programs.

Chart S1.1 Adults Served by Age Group

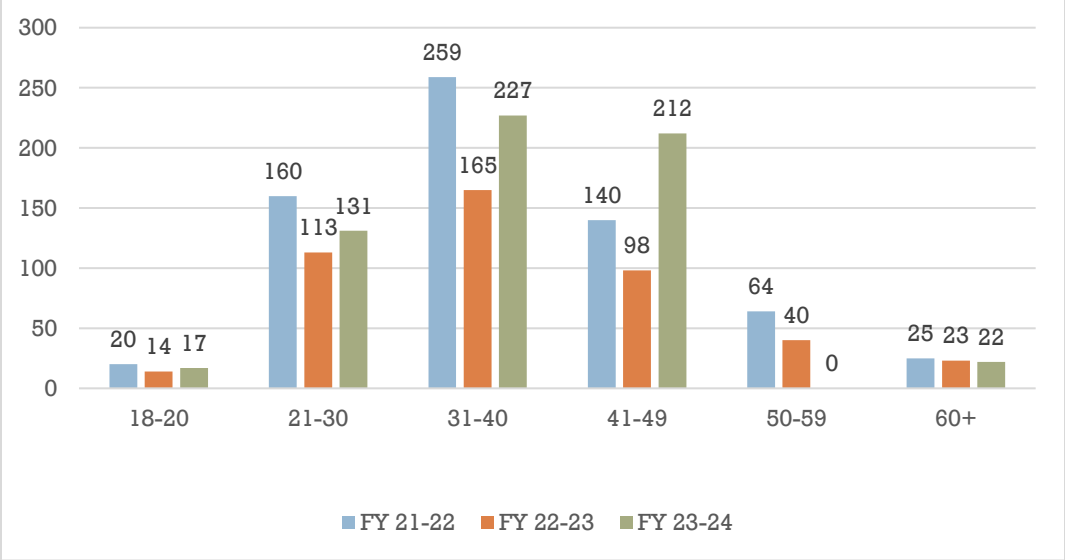


Chart S1.2 Adults Served by Gender

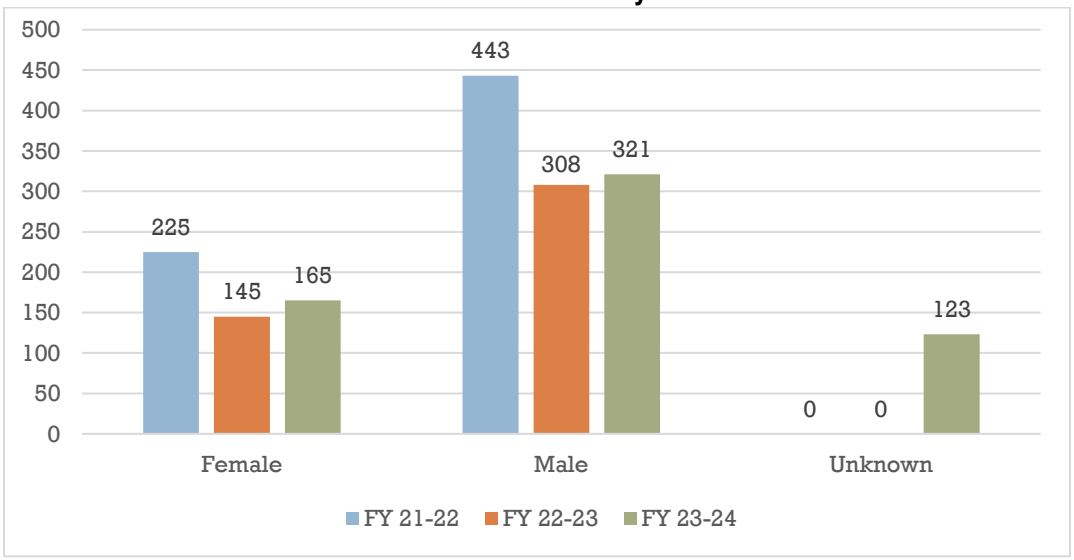


Chart S1.3 Adults Served by Ethnicity

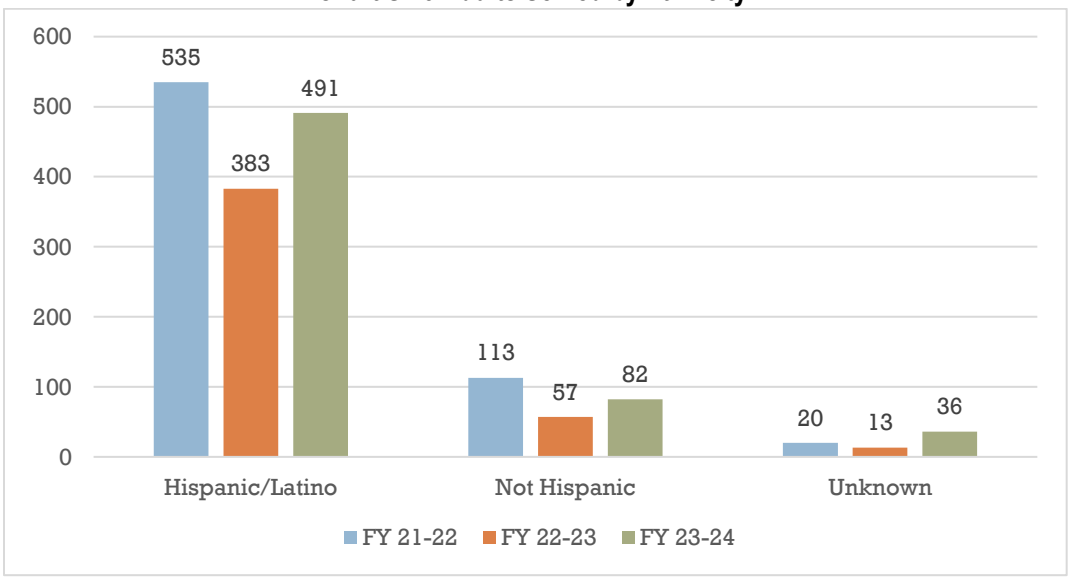
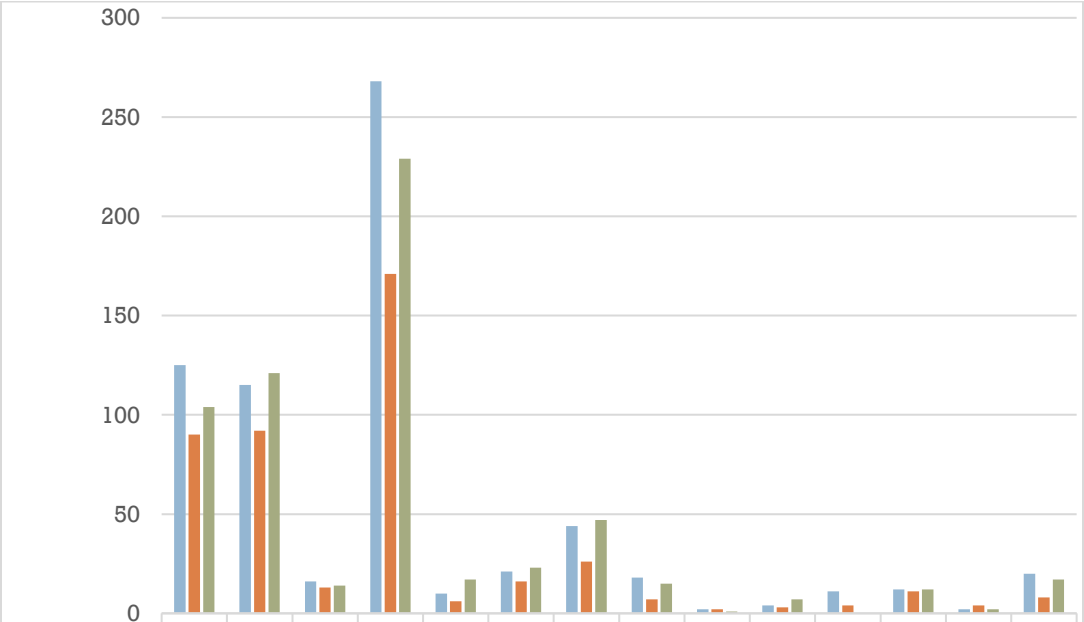


Chart S1.4 Adults Served by City of Residence



	Brawley	Calexico	Calipatria	El Centro	Heber	Holtville	Imperial	Niland	Salton City	Seeley	Thermal	Westmorland	Winterhaven	No Entry
Fy 21-22	125	115	16	268	10	21	44	18	2	4	11	12	2	20
FY 22-23	90	92	13	171	6	16	26	7	2	3	4	11	4	8
FY 23-24	104	121	14	229	17	23	47	15	1	7	0	12	2	17

Chart S1.5 Adults Served by Language

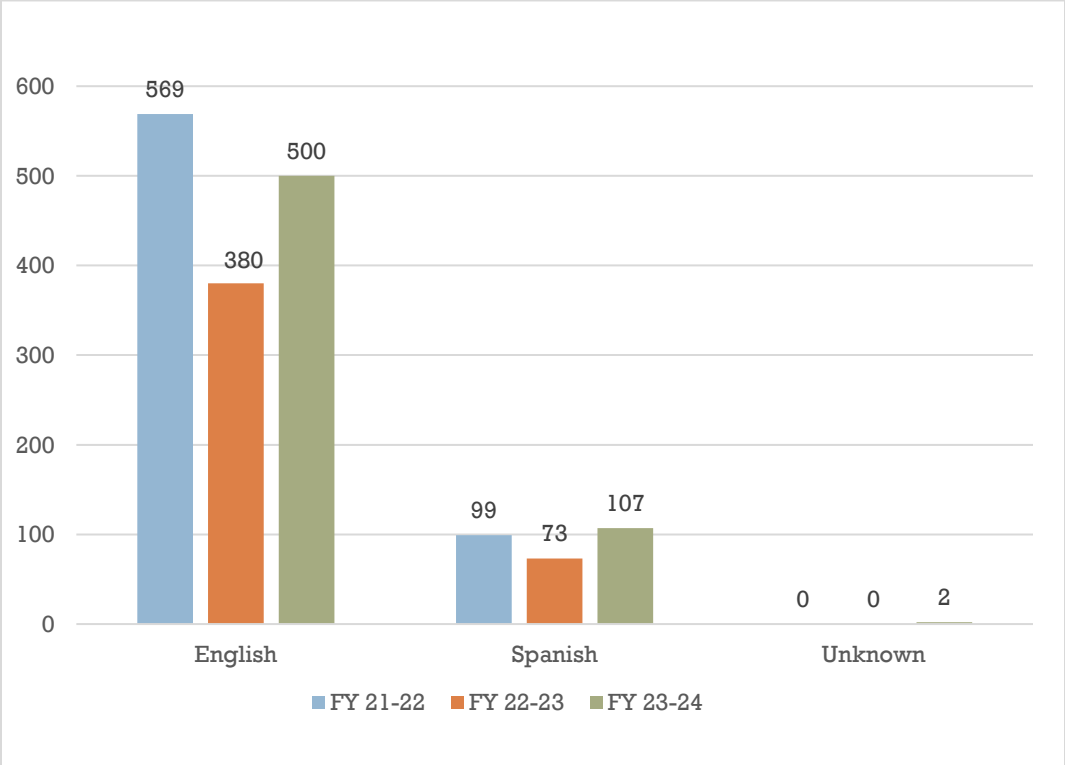
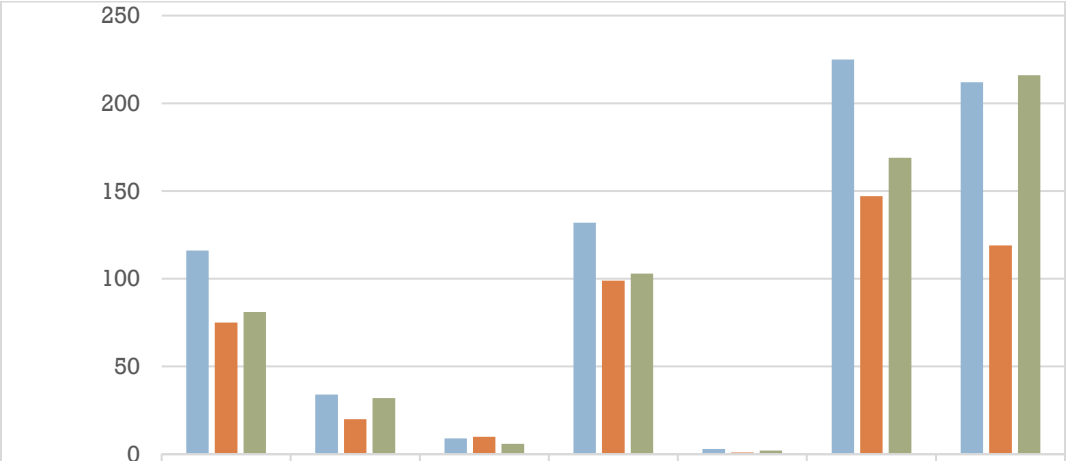


Chart S1.6 Adults Served by Diagnosis



	Alcohol	Cannabis	Cocaine	Opioid	Sedative, Hypnotic or Anxiolytic Use	Other Stimulant Use	Other
FY 21-22	116	34	9	132	3	225	212
FY 22-23	75	20	10	99	1	147	119
FY 23-24	81	32	6	103	2	169	216

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*
**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

ii. Adolescent SUD Programs

Southern Services

Adolescent SUD services in the southern region are provided at a DMC-certified outpatient clinic in Calexico. Services are targeted towards youth ages 13 through 18 who reside in the southern region of Imperial County. Individuals aged 18 or older who enrolled in school may continue receiving Adolescent SUD services.

Central Services

Adolescent SUD services in the central region are provided at a DMC-certified outpatient clinic in El Centro. Services are targeted towards youth ages 13 through 18 who reside in El Centro, Imperial, Holtville, Seeley, Ocotillo, and Heber. Individuals aged 18 or older who enrolled in school may continue receiving Adolescent SUD services.

Northern Services

ICBHS has made numerous attempts to open a DMC-certified outpatient clinic in the city of Brawley, which is the largest municipality in the northern region, that would serve the adolescent population. Adults 18 years of age and older who reside in Brawley, Calipatria, Niland, Westmorland, and northern unincorporated areas are served through the outpatient clinic in El Centro. Transportation is available when needed. Telehealth services are also available to meet the needs of adults who are not able to attend services in-person.

Community-Based Services

In addition to the two established outpatient clinics, SUD services for adolescents are also provided in the community. SUD adolescent providers provide individual counseling, group counseling, care coordination, and recovery services at many schools and other community locations, when appropriate.

Charts S1.7-S1.12 indicate the demographic information for beneficiaries served by the Adolescent SUD Programs.

Chart S1.7 Adolescents Served by Age Group

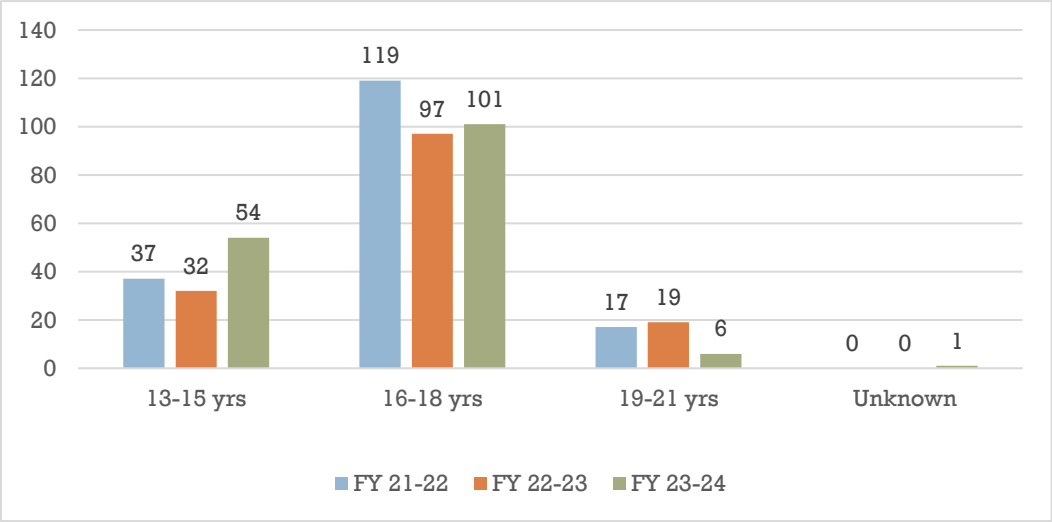


Chart S1.8 Adolescents Served by Gender

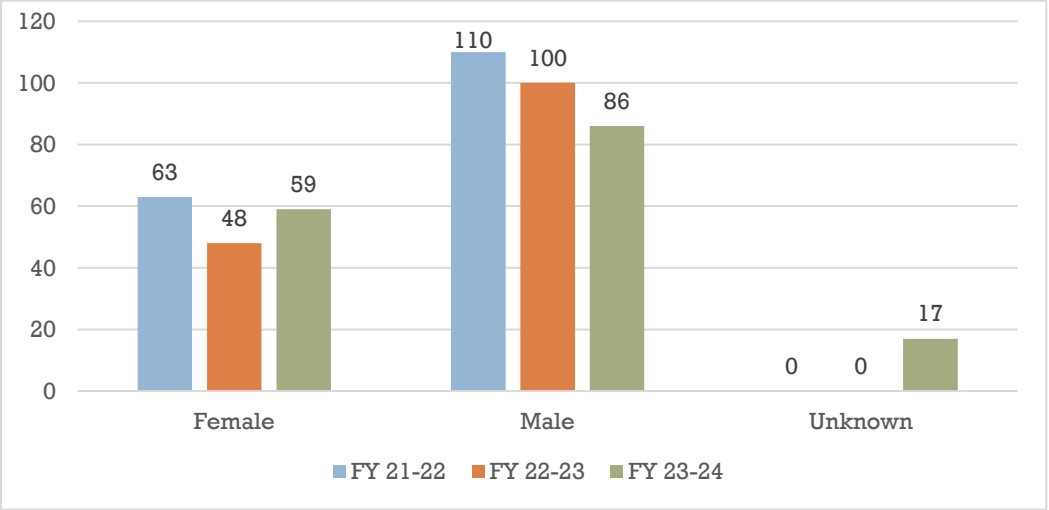


Chart S1.9 Adolescents Served by Ethnicity

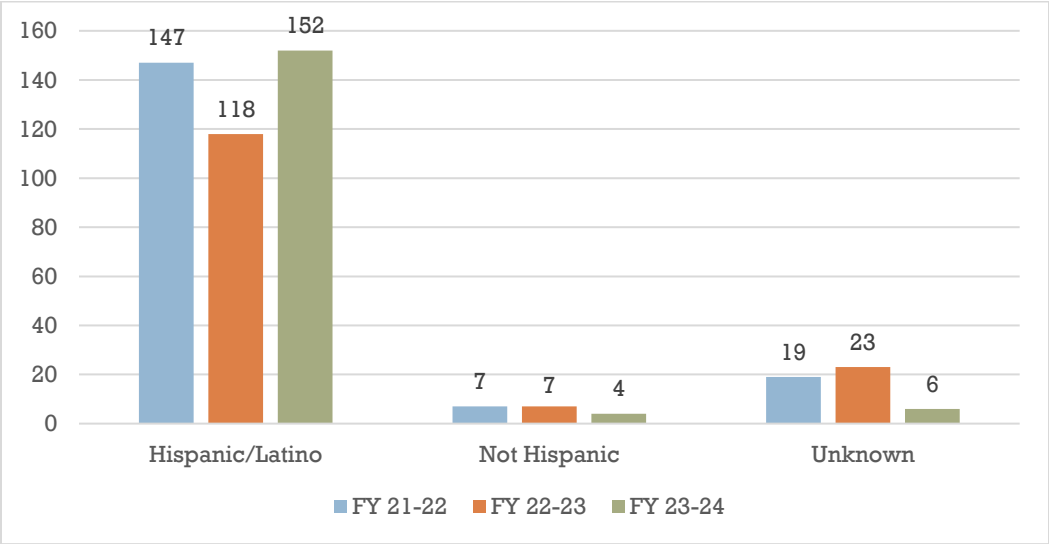
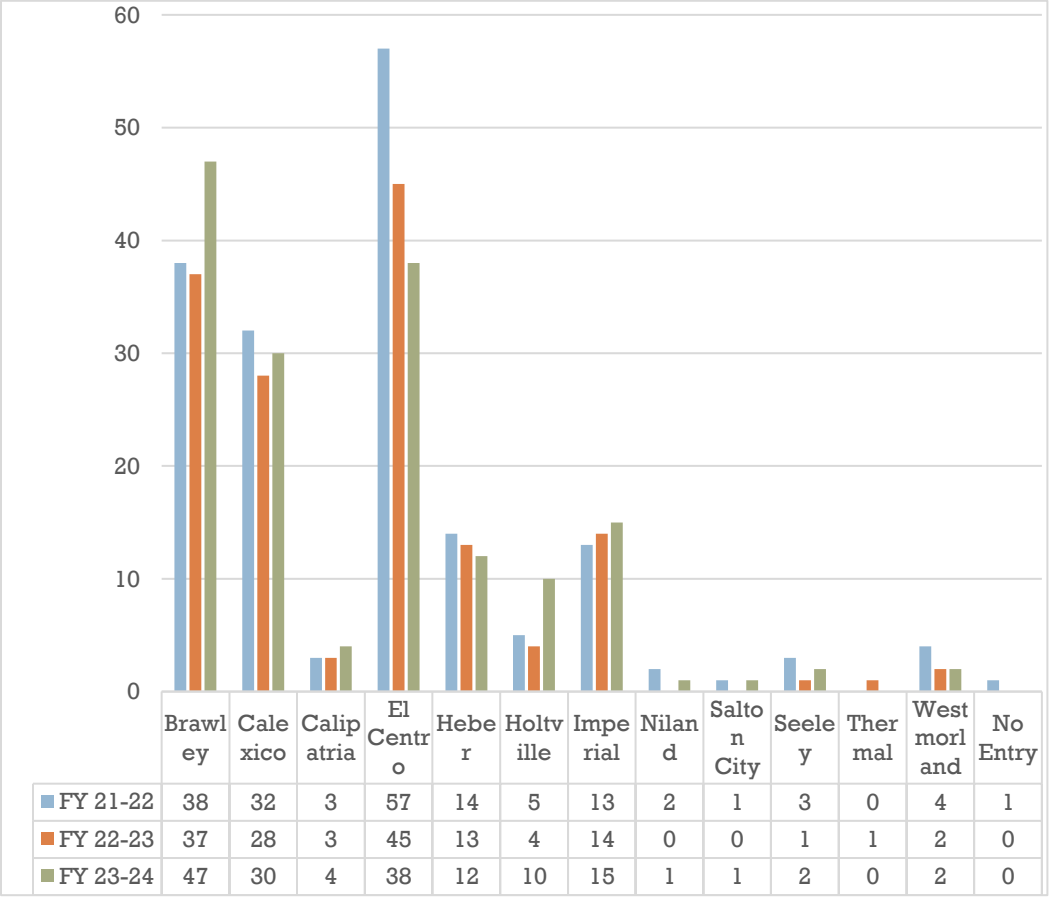


Chart S1.10 Adolescents Served by City of Residence



	Brawley	Calexico	Calipatria	El Centro	Heber	Holtville	Imperial	Niland	Salton City	Seeley	Thermal	Westmorland	No Entry
FY 21-22	38	32	3	57	14	5	13	2	1	3	0	4	1
FY 22-23	37	28	3	45	13	4	14	0	0	1	1	2	0
FY 23-24	47	30	4	38	12	10	15	1	1	2	0	2	0

Chart S1.11 Adolescents Served by Language

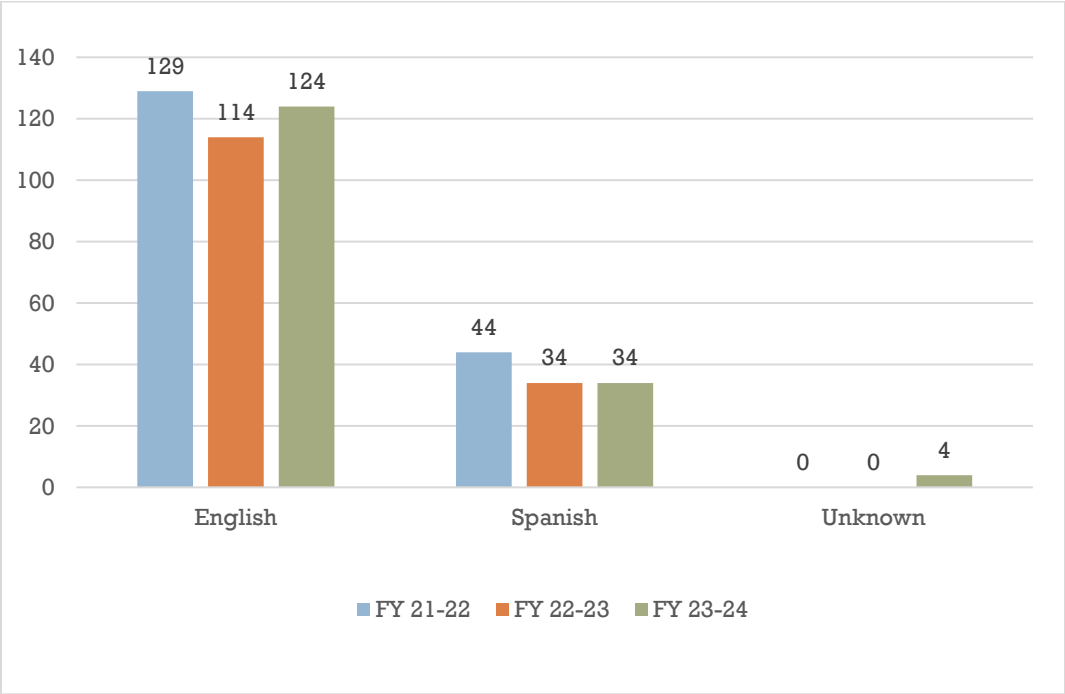
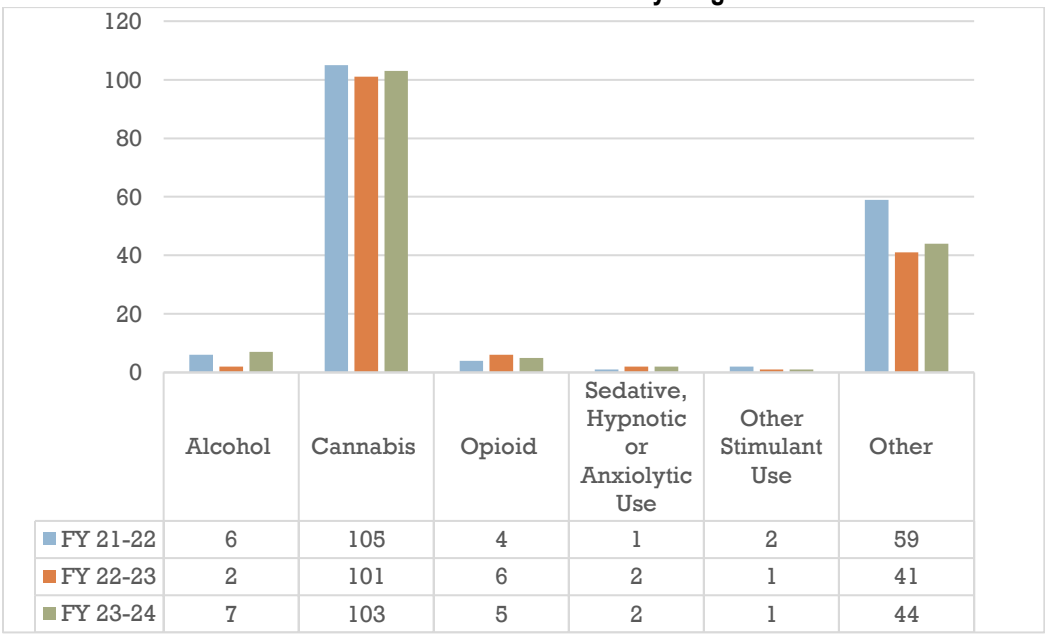


Chart S1.12 Adolescents Served by Diagnosis



	Alcohol	Cannabis	Opioid	Sedative, Hypnotic or Anxiolytic Use	Other Stimulant Use	Other
FY 21-22	6	105	4	1	2	59
FY 22-23	2	101	6	2	1	41
FY 23-24	7	103	5	2	1	44

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*
**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

b) Drug Medi-Cal Services Provided

DMC-ODS services are provided based on a completed ASAM assessment. DMC-ODS services provided by ICBHS 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 also offers 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, Brixadi

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

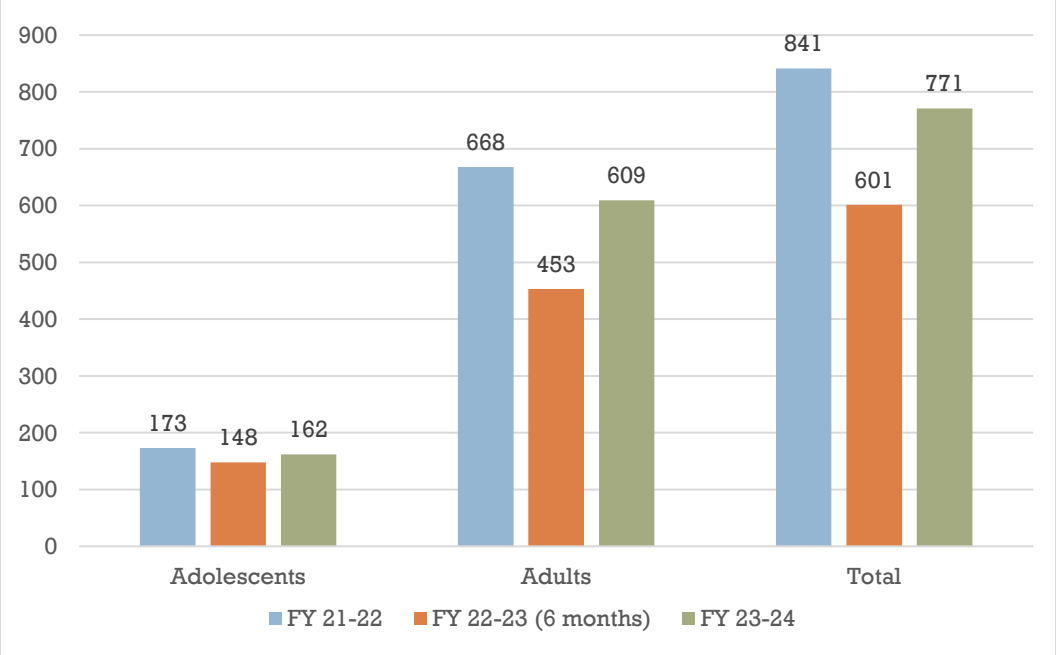
The number of unduplicated beneficiaries are included in the table and chart below:

Table S1.1 Unduplicated Medi-Cal Beneficiaries Served

SUD Programs	FY 21-22	FY 22-23*	FY 23-24
Adolescent SUD Services	173	148	162
Adult SUD Services	668	453	609
Total	**841**	**601**	**771**

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

Chart S1.13 Beneficiaries Served by SUD Programs



c) *Utilization of Services for FY 23-24*

Beginning July 1, 2023, the CalAIM Behavioral Health Payment Reform initiative changed the way county behavioral health plans claim federal reimbursement. This initiative moved counties away from cost-based reimbursement to better enable counties

and providers to deliver value-based care that improves quality of life for Medi-Cal beneficiaries. Due to this change it was unfeasible to make a comparison of utilization of services with previous fiscal years. The utilization of services for FY 23-24 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

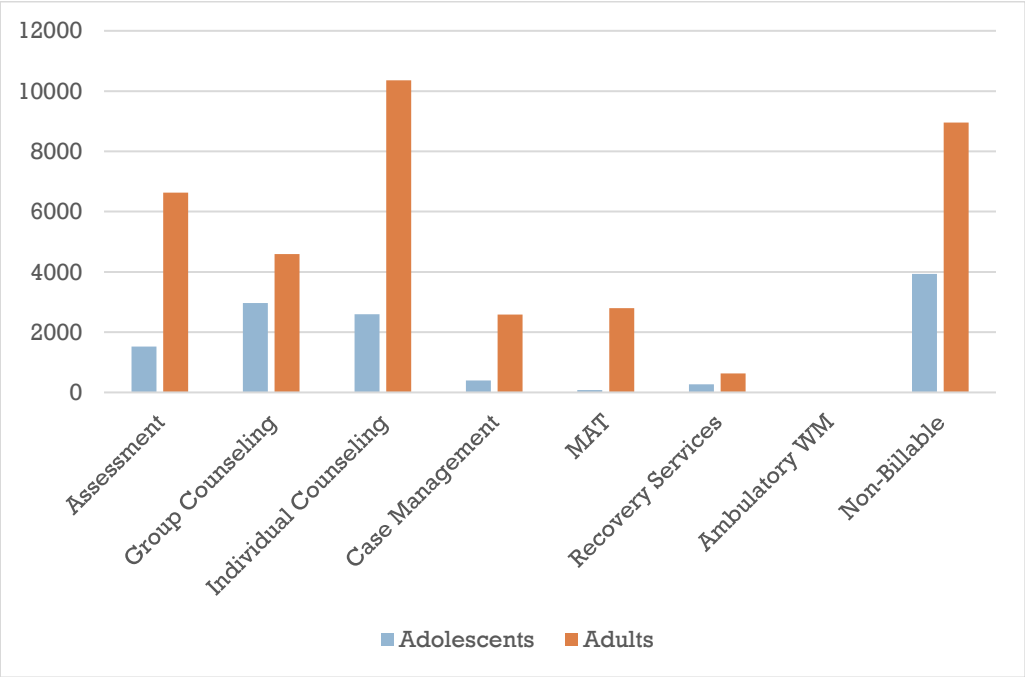
- Assessment: Assessments completed by a LPHA or MD; ASAM assessment or other structured SUD assessment; and SUD screening.
- Group Counseling: Group counseling services.
- Individual Counseling: Individual counseling services; Contingency Management; and any SUD crisis interventions.
- Case Management: Targeted Case Management/Intensive Care Coordination; Medical team conference with participation by the physician, patient and/or family not present.
- Medication Assisted Treatment: Medication training and support and/or oral medication administration.
- Recovery Services: Psychosocial rehabilitation individual; Psychosocial rehabilitation group; and comprehensive community support services.
- Ambulatory Withdrawal Management: Ambulatory withdrawal management services delivered in an office setting with the frequency to be determined by the severity of withdrawal symptoms.
- Non-Billable: Any other non-billable service that must be documented and is not better accounted for by other available non-billable procedure codes.

DMC-ODS units of service provided by the Adolescent SUD Program and the Adult SUD Program during FY 23-24 is shown below:

Table S1.2 DMC-ODS Units of Service

Type of Service	Adolescents	Adults
Assessment	1526	6630
Group Counseling	2968	4587
Individual Counseling	2599	10353
Case Management	401	2586
Medication Assisted Treatment	81	2800
Recovery Services	266	627
Ambulatory Withdrawal Management	0	0
Non-Billable	3936	8957

Chart S1.14 Units of Service by SUD Programs



2) DMC-ODS Contracted Providers

a) Geographic Location and Target Population

To ensure the appropriate levels of care are available to Imperial County residents, ICBHS contracts with local and out-of-county providers to DMC-ODS services:

i. *In-County*
During FY 23-24, ICBHS had one contracted provider for NTP services. NTP services were provided 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 23-24, ICBHS had three DMC certified contracted providers for residential treatment services. The residential programs provided adolescent and adult residential treatment services, which are limited to 14-day detox services. ABC Recovery provided levels 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) 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 designation.

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 is also required to provide other 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 providers offer 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 services provided by contracted providers to Imperial County residents in FY 23-24 are displayed below:

Table S1.3 NTP Utilization of Services

Type of Service	FY 21-22	FY 22-23	FY 23-24
Buprenorphine/Naloxone	13	7	8
NTP – Dose Methadone	306	218	224
Individual Counseling	301	217	229
Group Counseling	283	203	211

Table S1.4 Residential Admissions by Level of Care

Type of Service	FY 21-22 Admissions	FY 22-23 Admissions	FY 23-24 Admissions
ASAM Level 3.1	28	27	30
ASAM Level 3.2	27	12	6
ASAM Level 3.3	2	0	0
ASAM Level 3.5	22	62	55
ASAM Level 3.7	0	0	0
ASAM Level 4.0	0	0	0
OTP – Level 1	0	0	0

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 DMC-ODS Plan 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. Imperial County must meet the distances standard of up

to 60 miles or 90 minutes from the beneficiary's place of residence. Timeliness standards for DMC-ODS are as shown below.

Table S1.5 Timely Access Standards

Service Type	Timely Access
Urgent care appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Urgent care appointments for services that require prior authorization	Within 96 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program	Within three business days of request.
Non-urgent follow-up appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment as provided in HCS section 1357.03(a)(5)(F),(H)

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.

During FY 23-24, DHCS began testing DMC-ODS submissions of the 274 Health Care Provider Directory, referred to as the "274 Standard". The 274 standard is an Electronic Data Interchange to ensure provider network data is consistent, uniform, and aligns with national standards. ICBHS is required to submit the 274 standard files by the 10th of each month.

Upon successful completion of the testing requirements and approval from DHCS, DHCS will use the 274 standard files as the sole source for analysis and the Network Adequacy Certification Tool (NACT) will be phased out. Until the full 274 standard file submission replaces the NACT, both the Network Adequacy Certification Tool (NACT) and 274 standards files submissions are required.

During FY 23-24, the MHP submitted the NACT to DHCS on October 27, 2023.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QM Unit will monitor the number, type, and geographic distribution of DMC-ODS services in order to verify that timely and appropriate services are available to all Medi-Cal beneficiaries within Imperial County.

- ICBHS will ensure service delivery capacity for DMC-ODS services to meet the needs of beneficiaries.

- ICBHS will monitor its network adequacy and submit data through the monthly submissions of the 274 standard files.

- The Adult SUD Program will assess its ambulatory withdrawal management services to ensure that services provided are correctly coded and claimed.

- The ICBHS SUD Programs will work to conduct an analysis of the high non-billable services to determine how non-billable activities affect delivery of services to beneficiaries and implement corrective action accordingly.

2. Timeliness of Services

The QM Unit monitors ICBHS' ability to meet the following timeliness standards as established by DHCS:

Table M2.1 Timely Access Standards

Service Type	Timely Access
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program	Within three business days of request.
Urgent care appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)

The QM Unit collects data through the EHR monthly to verify that beneficiaries can access services timely without delay. Individual instances of access delays may result in the QM Unit conducting a more in-depth review to identify any potential quality of care issues. A corrective action plan is issued when the ICBHS overall compliance rate with timeliness standards falls below 80 percent for DMC-ODS services. Timeliness findings are reported to clinical management and/or the QIC, when appropriate.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Timeliness to First Non-Urgent Services

The DHCS standard for timelines to first non-urgent services is 10 business days. The current intake process for DMC-ODS services allows for clients to be scheduled an appointment with a SUD professional if at the time of the request the client requests a non-urgent service. The first offered non-urgent service is a clinically appropriate outpatient service scheduled with a SUD counselor or a licensed/registered clinician, which can include prevention, screening, assessment, individual counseling, group counseling, or recovery service. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. Due to the delayed implementation of timeliness data tracking in the EHR, the QM Unit couldn't obtain timeliness data until February 2024. Effective February 2024, the QM Unit is utilizing the Timeliness Record form within the EHR as its data source for verifying timeliness of services. Comprehensive data regarding access to timely services will resume in FY 24-25.

2) *Timeliness to First Non-Urgent Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP) Services*

The DHCS standard for timeliness to first opioid treatment services is 3 business days. Beneficiaries request services directly from ICBHS' contracted NTP provider, although they may also request opioid treatment services by contacting the 24-hour beneficiary access line or through referral from another provider. The first non-urgent opioid treatment service is an initial assessment.

The QM Unit evaluates timeliness to first opioid treatment services by reviewing the date of the request and determining the length of time to the first offered appointment. This data is gathered and reported by the NTP provider monthly using an Excel spreadsheet. The table below summarizes the timeliness to opioid treatment services data for FY 23-24:

Table S2.1 Timeliness to First NTP/OTP Services

Review Period	Medi-Cal Requests	Appointments Offered Within 3 Business Days	Appointments Offered Over 3 Business Days	Compliance Rate
FY 23-24	182	182	0	100%
FY 22-23	200	200	0	100%

The QM Unit utilizes the same data to also verify how soon after requesting opioid treatment services do beneficiaries receive their first NTP/OTP dose. The table below summarizes the timeliness to first dose of opioid treatment services data for FY 23-24:

Table S2.2 Timeliness to First NTP/OTP Dose

Time Period	Intake Appointments	Provided Within 3 Business Days	Provided Over 3 Business Days	Compliance Rate	Average Wait Time for NTP Dose
FY 23-24	116	116	0	100%	0 days
FY 22-23	98	98	0	100%	0 days
FY 21-22	97	96	1	99%	0 days

3) *Timeliness to Urgent Services*

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. All requests for urgent services not requiring prior authorization are recorded by the Access Unit.

ICBHS provides urgent DMC-ODS services upon request or when it is determined that a beneficiary's "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 evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. The monitoring process involved gathering data collected through the EHR Inquiry Log. The table below summarizes the FY 23-24 data related to timeliness to urgent services not requiring prior authorization:

Table S2.3 Timeliness to Urgent Services Not Requiring Authorization

Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 23-24	11	10	1	91%
FY 22-23	4	2	2	50%
FY 21-22	14	8	6	57%

The QM Unit also evaluates timeliness to urgent services requiring prior authorization by reviewing the information collected in the EHR Inquiry Log. To date no beneficiary requests have been made for urgent services requiring prior authorization.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QM Unit will monitor the timeliness to non-urgent services, non-urgent NTP/OTP services, and urgent services monthly to verify beneficiaries can access services without delay.
- The QM Unit will closely monitor requests for urgent services to ensure beneficiaries are screened appropriately and receive timely services, reducing the risks associated with delayed SUD treatment.
- The QM Unit will issue corrective action plans to DMC-ODS providers if less than 80 percent of beneficiary requests were not offered a service within the required timeframe.
- The QM Unit will begin monitoring timeliness to follow-up appointments to ensure beneficiaries receive appropriate and timely follow-up after receiving a first service.

3. Accessibility of Services

The QM Unit monitors accessibility of DMC-ODS services and information by evaluating the responsiveness of the 24/7 Beneficiary Access Line and the Mental Health Triage Unit.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Responsiveness of the 24-Hour Toll-Free Telephone Line

The QM Unit monitors the responsiveness of the DMC-ODS 24/7 Beneficiary Access Line monthly by 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 24/7 Beneficiary Access Line is available to beneficiaries 24 hours a day, seven days a week.

Test calls determine the ability of the 24/7 Beneficiary Access Line to provide information related to 1) available DMC-ODS services and referrals to 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 whether or not the 24/7 Beneficiary Access Line appropriately determines the urgency of callers' requests; answers calls within five rings; provides information related to TTY/TDY services; and providers written DMC-ODS materials upon request.

During FY 23-24, the QM Unit conducted 48 test calls, 26 during business hours and 22 after hours. Below are the findings related to the test calls conducted by the QM Unit:

Table S3.1 24/7 Beneficiary Access 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	92%	100%	95%
Urgent Condition Information	88%	100%	91%
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	90%	93%	90%
Date of the request	90%	100%	94%
Initial disposition of the request	90%	100%	94%

2) 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 Beneficiary Access 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 after-hours care was provided within one hour. During FY 23-24, no requests were made for after-hours care for DMC-ODS services.

Table S3.2 Access to After-Hours Care

Review Period	Requests	Verified	Compliance Rate
FY 23-24	0	0	N/A
FY 22-23	5	2	40%
FY 21-22	7	6	86%

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QM Unit will continue to monitor the 24/7 Beneficiary Access Line to verify that DMC-ODS services and information are available to beneficiaries at all hours through the 24/7 Beneficiary Access Line and the Mental Health Triage Unit.

4. Beneficiary/Family Satisfaction

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

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Beneficiary/Family Satisfaction Survey

During CY 2023, ICBHS administered the Statewide Treatment Perception Survey (TPS) during fall 2023 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.

14 youth surveys were completed during the CY 2023 TPS period. Surveys were collected from beneficiaries receiving services from the two outpatient adolescent SUD clinics. Participation in the CY 2023 survey was lower than the previous year, which was already noted as having low participation with only 21 surveys completed. Given the low participation of youth beneficiaries in the survey, it is difficult to gauge the response categories as indicators of needed change. Survey findings for youths are summarized below:

Table S4.1 Youth TPS Results

Survey Area	CY 2021 % (n=24)	CY 2022 % (n=21)	CY 2023 % (n=14)	Difference in % (2022 to 2023)
Convenient location	82.6	81.0	92.9	+11.9
Services available at a convenient time	83.3	90.5	92.9	+2.4
Good enrollment experience	87.0	81.0	92.9	+11.9
Received services right for me	87.5	90.5	85.7	-4.8
Staff treated me with respect	95.8	100	92.9	-7.1
Staff sensitive to cultural background	54.5	68.4	85.7	+17.3
Counselor provided necessary services	90.0	80.0	71.4	-8.6
Worked with counselor on treatment goals	91.3	95.2	92.9	-2.3
Counselor took the time to listen	95.7	95.2	92.9	-2.3
Developed positive trusting relationship with counselor	91.7	80.0	85.7	+5.7
Counselor was sincerely interested	87.5	90.5	78.6	-11.9
Liked my counselor here	95.8	90.5	85.7	-4.8
Counselor is capable of helping me	100	100	85.7	-14.3
Staff helped with health and emotional needs	95.8	100	92.9	-7.1

Staff helped with other issues	91.3	90.0	92.3	+2.3
Better able to do things	82.6	85.7	71.4	-14.3
Feel less craving for drugs and alcohol	N/A	N/A	64.3	N/A
Satisfied with services I received	91.7	100	85.7	-14.3
Would recommend the services to a friend	95.5	81.0	71.4	-9.6

245 adult beneficiary surveys were completed during the CY 2023 TPS period, which includes 204 surveys from two in-county NTP clinics, 40 surveys from the two outpatient adult SUD clinics, and one survey from a contracted out-of-county residential treatment provider. Adult survey participation increased by 53 surveys compared to CY 2022, although participation by beneficiaries receiving outpatient and residential services continues to be low. Survey findings for adults are summarized below:

Table S4.2 Adult TPS Results

Survey Area	CY 2021 % (n=253)	CY 2022 % (n=192)	CY 2023 % (n=245)	Difference in % (2022 to 2023)
Convenient location	88.8%	85.3%	90.4%	+5.1
Convenient time	91.6%	90.5%	95.0%	+4.5
I chose my treatment goals	92.8%	88.7%	91.9%	+3.2
Staff gave me enough time	93.6%	93.7%	95.8%	+2.1
Treated with respect	93.2%	91.0%	95.0%	+4.0
Understood communication	96.0%	90.5%	97.1%	+6.6
Cultural sensitivity	93.7%	90.5%	95.3%	+4.8
Work with physical health care providers	90.8%	88.2%	92.9%	+4.7
Work with mental health providers	89.1%	87.2%	91.1%	+3.9
Staff helped connect with services	N/A	N/A	87.3%	N/A
Better able to do things	94.4%	89.9%	93.8%	+3.9
Feel less cravings for drugs and alcohol	N/A	N/A	94.6%	N/A
Felt welcomed	94.0%	92.6%	95.8%	+3.2
Overall satisfied with services	91.4%	94.2%	94.6%	+0.4
Got the help I needed	91.2%	91.1%	93.2%	+2.1
Recommend agency	92.4%	92.3%	93.7%	+1.4

The results of the surveys were provided to management, as appropriate, and an overview of the survey results was presented to DMC-ODS staff, while report findings were sent to the DMC-ODS contracted providers.

During FY 23-24, the QM Unit conducted monthly phone surveys to gauge client satisfaction with ICBHS, their treatment provider and/or team, and their overall services. 259 clients/parents/guardians receiving services from ICBHS participated in this year's survey process. Over 90 percent of participants reported being satisfied with ICBHS and its providers. Of the clients receiving DMC-ODS services who participated in the survey, none reported any dissatisfaction or made any comments of concern that would be indicators of why there have been decreases in certain categories of the TPS.

2) *Beneficiary Grievances and Appeals*

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 23-24, ICBHS received 10 grievances from both Medi-Cal and Non-Medi-Cal clients. There was also 1 standard appeal submitted. The table below summarizes grievances and appeals by category:

Table S4.3 Grievances & Appeals by Category

Grievance Category	FY 21-22	FY 22-23	FY 23-24
Related to Customer Service	0	0	0
Related to Case Management	0	0	0
Access to Care	0	0	1
Quality of Care	1	7	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	1	0	2
Appeal Category	**FY 21-22**	**FY 22-23**	**FY 23-24**
Denial or Limited Authorized or Service (s)	0	0	0
Reduction, Suspension, or Termination of a Previously Authorized Service	0	0	1
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

All grievances and appeals received during FY 23-24 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 23-24, ICBHS received 28 requests to change persons providing services from beneficiaries, which is a 100 percent increase from the previous year. The number of

requests to change the persons providing services received has gradually increased since FY 21-22. This is likely related to the overall increase in individuals being served by ICBHS.

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. All requests were approved and notified of the decision by telephone, by mail, or in person within the requisite 14 business days.

The table below summarizes the requests to change persons providing services by category:

Table S4.4 Reason for Requests for Change of Provider

Reason	FY 21-22	FY 22-23	FY 23-24
Quality of Care Treatment Concerns	N/A	N/A	2
Prefer a Spanish Speaking Provider	N/A	1	0
Not feeling comfortable with Male/Female Provider	1	3	4
No therapeutic Alliance with Provider	1	5	2
Dissatisfaction with Provider	4	N/A	0
Disagreement with Course of Treatment	1	1	0
Uncomfortable with Provider	3	4	20

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QM Unit will continue to conduct monitoring activities to determine beneficiary/family satisfaction with MHP services.

- The ICBHS SUD programs will implement strategies to increase both youth and adult participation during the upcoming TPS period.

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

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

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Medication Monitoring

The ICBHS Medical Director and two medical doctors conducted quarterly medication monitoring reviews for the SUD county-operated programs providing Medication Assisted

Treatment (MAT) while the ICBHS Medical Director conducted monthly medication monitoring reviews for the NTP provider. Utilizing a review tool, the Medical Director and physicians 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 MAT; 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, 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.

During FY 23-24, the Medical Director and two medical doctors reviewed 40 charts from the SUD county-operated programs providing MAT with an average of 95 percent compliance in all eight areas evaluated. The committee identified three findings in the areas of: medication consent forms being completed, appropriate, and up to date; the CURES report being reviewed for controlled substance prescriptions prior to starting the patient on controlled substance medications; documentation indicating laboratory panels were ordered and reviewed when indicated. Compared to the previous year, there was an increase in identified findings, with no issues reported in the prior fiscal year.

On the other hand, during FY 23-24, the Medical Director reviewed 44 charts from the NTP provider, which demonstrated 100 percent compliance in all 18 areas, maintaining consistency with the previous fiscal year.

2) Quality Management Chart Reviews

The QM Unit conducts routine chart reviews to verify the overall quality of DMC-ODS services provided by ICBHS. Chart reviews were conducted using a chart review tool that evaluated the following areas: Criteria, Assessment, Physical Examination, Problem List, Treatment Interventions, Care Coordination, Perinatal Services, Family Counseling, Adolescent SUD Best Practices Guide, and Other Areas of Review. Effective FY 23-24, the QM chart review tool focused solely on areas of quality and removed questions that were more compliance related.

The QM Unit compiled reports that identified opportunities for improvement and areas of concern, as appropriate. Reports were provided to management along with corrective action plans when necessary. The QM Unit approved corrective action plans, prior to implementation, and followed up with to ensure all corrective actions were completed, as appropriate. Compliance referrals were submitted to the Compliance Unit when instances of potential fraud, waste, or abuse were identified.

During FY 23-24, the QM Unit reviewed a total of 20 clinical charts for ICBHS, of which 10 charts were for the Adolescent SUD Program and 10 charts were for the Adult SUD Program. The below summary of findings were areas identified as needing correction:

<u>Assessment</u>

- Documentation did not clearly describe why a client was placed in a different LOC from the LOC designated by the ASAM.

Physical Examination

- Beneficiary did not receive a physical examination within the 12-month period prior to the beneficiary admission date.
- Provider did not document the efforts made to obtain and include in the beneficiary's record documentation of the most recent physical examination.

Treatment Interventions

- No evidence of timely documentation of the services/interventions provided.

Care Coordination

- Care coordination services did not include one or more of the required service components.
- Providers did not engage family members with the treatment process in a meaningful manner with the intent of helping the client reach treatment goals.

Other Areas of Review

- No evidence that written materials that are critical to obtaining services were available to beneficiaries in non-English languages.

The QM Unit also conducted a review of clients receiving residential treatment services to identify quality of care issues in both the pre-admission and post-discharge process. During FY 23-24, the QM Unit reviewed a total of 10 clinical charts for clients referred to the three contracted residential treatment providers. The below summary of findings were areas identified as needing correction:

Pre-Residential Treatment

- Client admission to residential treatment was past 14 days from authorization date.
- No evidence that the referring service coordinator contacted the residential facility to monitor the referral and/or treatment changes, as appropriate in the best interests of the client.

Post-Residential Treatment

- Service coordinator did not contact residential staff to coordinate care.
- Service coordinator did not schedule the client's next appointment within an appropriate amount of time (within 7 days of discharge).
- No evidence the assigned service coordinator followed-up with the client to ensure a smooth transition from residential treatment to the outpatient clinic.
- There was no meaningful coordination of care between SUD team members and residential treatment staff that will assist client in maintaining sobriety, when appropriate (not just merely providing updates, is there documentation of how information provided will assist in making changes to treatment course).
- No evidence the assigned service coordinator reviewed the residential treatment discharge summary and followed discharge instructions/recommendations, when appropriate.

3) Length of Time from Residential Treatment Authorization Approval to Residential Treatment Admission

The QM Unit monitors the length of time from the authorization approval for residential treatment to admission to a residential facility to determine how long clients wait to receive residential treatment services. The monitoring process entails reviewing the Residential Treatment Services Log, which identifies the ASAM assessment when the client met the

residential treatment level of care, the residential authorization approval date, and the client's admission date into residential treatment services. The benchmark from the time the authorization is approved to the residential treatment admission date is 14-business days.

During FY 23-24, there were 79 unduplicated clients who received authorization approvals for the residential treatment level of care. Three adolescents placed at the residential treatment level of care were admitted into a residential treatment program in an average of 6 days while the 776 adults were admitted in an average of 15 days. In some instances, the wait time was significantly high; however, these delays were due to clients experiencing mental/physical health concerns, pending signatures of probation officers, clients being non-adherent to SUD treatment, bed availability pending, or clients becoming incarcerated. For those individuals who experienced a delay in residential admission, ICBHS continued to provide care coordination, medication management, individual counseling, and group counseling in the interim.

The number of residential admissions during FY 23-24 decreased by 22 from the FY 22-23 admissions. A summary of the data for length of time to residential treatment admission is included below:

Table S5.1 Residential Admissions

Adolescents	FY 21-22	FY 22-23	FY 23-24*
ASAM Assessments Determining Residential Treatment	2	2	3
Total # of Residential Admissions	2	2	3
Average Time for Determination of Need to Residential Treatment Admission	18 days	36 days	
Average Time for Authorization Approval to Residential Treatment Admission			6 days
Range (work-days) for Determination of Need to Residential Treatment Admission	17 days	3 days	
Range (work-days) for Authorization Approval to Residential Treatment Admission			9 days
Adults	**FY 21-22**	**FY 22-23**	**FY 23-24***
ASAM Assessments determining Residential Treatment	63	99	76
Total # of Residential Admissions	63	99	76
Average Time for Determination of Need to Residential Treatment Admission	28 days	22 days	
Average Time for Authorization Approval to Residential Treatment Admission			15 days
Range (work-days) for Determination of Need to Residential Treatment Admission	4 days	96 days	
Range (work-days) for Authorization Approval to Residential Treatment Admission			58 days

**Effective FY 23-24, the measurement metric changed from ASAM assessment to residential admission to authorization of residential placement to residential admission.*

Effective February 19, 2024, ICBHS and DHCS executed a program funding agreement (PFA) for the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 5: Crisis and Behavioral Health Program not to exceed $17,285,302 million in grant funding. Funds will be used to establish a local residential facility, which would eliminate barriers and increase access to care. The 16-bed Adult Residential SUD Treatment Facility with Incidental Medical Services (IMS), DHCS/ASAM Level of Care 3.5 Designation and DHCS/ASAM Level of Care 3.2 Withdrawal Management Designation. ICBHS has been meeting with Advocates for Human Potential (AHP) contracted by DHCS to provide consulting and oversight of the PFA to ensure the department is on track with construction milestones and project phases in order to complete construction of the Adult Residential SUD Treatment Facility by June 30, 2027. ICBHS is currently in the stage of Acquisition Complete and working toward the Pre-Development Design. ICBHS is closely working with Public Works Department to begin Environmental Study and Asbestos testing and Requests for Application (RFA) for Project Manager Bids are posted. ICBHS plans on having an Adult Residential SUD Treatment Facility Groundbreaking Ceremony by February 2025. By opening a local residential treatment facility, it is expected that the number of admissions to residential treatment will increase, while the wait time to admission will decrease.

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 entails reviewing the Residential Treatment Services Log, which identifies the date the client is discharged from residential treatment services, to determine if the client received an appointment within the 7-business day timeliness standard.

During FY 23-24, there were 76 clients that were discharged from a residential treatment facility. Of the 76 clients that were discharged, 37 (49 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 below:

Table S5.2 Follow-Up Services After Residential Treatment

Follow-up Services After Residential Treatment	FY 21-22	FY 22-23	FY 23-24
Total number of residential discharges	51	85	76
Total number of follow-up services delivered within 7-days of discharge	30	43	37
Percent of services delivered within 7-days of discharge	59%	51%	49%
Total number of follow-up services delivered within 30-days of discharge	40	53	51
Percent of services delivered within 30-days of discharge	78%	62%	67%

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 has increased when compared with the previous fiscal year. Factors impacting the percentage of clients receiving follow-up services are clients transitioning to sober living facilities (in/outside county), clients transitioning to another

residential facility, unsuccessful attempts to contact clients after discharge, clients becoming incarcerated, and/or no attempts made to follow up.

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 23-24, there were 6 unduplicated admissions into withdrawal management. From the 6 admissions, there were no readmissions that occurred within 30 days of discharge. The annual residential withdrawal management admission and readmission findings are included below:

Table S5.3 Withdrawal Management Admission and Readmissions

WM Readmission Rates within 30 days	FY 21-22	FY 22-23	FY 23-24
Total number of WM admissions	27	12	6
Total number of readmissions within 30 days	1	1	0
Percent of readmission rate within 30 days	4%	8%	0%

Data indicates a continued decline in admissions to withdrawal management, observable over the past three fiscal years. Concurrently, while the number of withdrawal management readmissions within 30 days has remained relatively steady, it has now fallen to zero.

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) to ensure all required medications are made available to beneficiaries. The monitoring process entails collecting data related to the different medications used in the NTP programs 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 23-24, there were 232 clients receiving medication used in the NTP programs. The majority of clients received Methadone as seen below:

Table S5.4 NTP Utilization of Methadone and non-Methadone MAT

NTP - Medications	FY 22-23	FY 23-24
Methadone	218	224
Buprenorphine-Mono	0	3
Buprenorphine-Naloxone Combination	13	5
Disulfiram	0	0
Naloxone- Nasal Spray	0	0
Total	**231**	**232**

Data demonstrates an increase in the overall total of clients that received Methadone and Buprenorphine-Mono medication and a decrease in Buprenorphine-Naloxone Combination from FY 22-23 to FY 23-24. Methadone continues to be the number one medication used in the NTP setting although there has been a slow increase in for clients that are receiving

Buprenorphine-Mono combination. Feedback from the NTP program indicates they continue to offer, when medically necessary, the required non-methadone MAT medications; however, they chose Methadone as their primary treatment medication.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.

- The ICBHS SUD programs will implement interventions to ensure service coordinators collaborate with residential staff throughout treatment, schedule follow-up appointments within 7 days of discharge, and utilize discharge summaries to support beneficiaries in maintaining sobriety.

6. 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. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Care Coordination and Continuity of Care

a. Outreach and Engagement

ICBHS increased outreach activities in the city of Winterhaven where tribal and non-tribal members reside. Community Service Workers engaged in the following activities: outreach and education activities, Imperial Valley Mall Kiosk, ICBHS social media posts, ICBHS re-occurring web events, community presentations, wellness radio show, back to school events, and health fairs. ICBHS continues to conduct outreach and engagement activities in all areas of Imperial County and among key community agencies to address accessibility of services, referral process, and identification of treatment needs.

b. Harm Reduction

As part of its harm reduction efforts, ICBHS assembled and distributed personal hygiene kits designed for both men and women. These kits include essential items such as feminine products, socks, hair ties, toothbrushes, toothpaste, condoms, deodorant, bar soap, hairbrushes, non-alcoholic mouthwash, shampoo and conditioner. They are intended for individuals in the community experiencing homelessness who may lack access to basic personal care items. Additionally, the kits contain informational materials detailing the services provided by ICBHS.

Hygiene kits are available in all four county-operated SUD clinics and are provided during outreach and engagement activities. ICBHS continues efforts to prevent overdoses and remains 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 overdoses. Outreach is conducted in partnership with schools, law enforcement, hospitals, and other community agencies. Furthermore, 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 and distributes fentanyl and xylazine test strips that detect the presence of fentanyl and xylazine in other drugs.

c. *SUD Bridge Collaboration*

ICBHS and El Centro Regional Medical Center (ECRMC) will be entering into a partnership to execute a multi-team system implementation strategy to improve buprenorphine adherence for patients who initiate treatment in the emergency department. This system will be a two-part implementation study that will develop and test an approach for improving care coordination between SUD outpatient clinics and the emergency department for CA Bridge patients who started on buprenorphine in the emergency room. Furthermore, ICBHS and Pioneers Memorial Hospital established a~~n~~ SUD Champions Meeting on a bi-monthly basis to improve care coordination between SUD outpatient clinic and their emergency department for patients receiving MAT inductions in the emergency room. ICBHS mission is to improve referral systems and utilize whole person approach care at both local hospitals to ensure all patients receiving MAT at the emergency rooms are successfully linked to SUD Treatment Programs for MAT follow-up and other SUD outpatient services.

d. *School Partnerships*

The demand for SUD treatment services has increased compared to previous years. This is a result of ongoing meetings and collaboration between ICBHS and school officials. Ongoing meetings take place prior to the end and beginning of the school year to offer and promote SUD treatment and prevention services. This past academic year, 2023, resulted in an influx of referrals received from the different school districts. Additionally, a previous inactive school, Calexico 9th Grade Academy, requested to resume SUD treatment services, for the 2023-2024 academic year. Adolescent SUD treatment services have seen an increase in high-risk cases resulting in youths being assessed at a higher level of care meeting residential services and MAT.

e. *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)*

ICBHS has been working closely with Health Management Associates (HMA) 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. With this collaboration, ICBHS aims to improve and expand SUD and mental health services, enhance the knowledge and awareness of working with individuals with co-occurring disorders, and improve community collaboration, for the implementation of harm reduction strategies to prevent death by overdose and elimination of stigma related to SUDs and treatment. HMA provided in person MAT training Workshops with the goal of improving patient quality of care in Imperial County. The workshops were a success as there was great participation and attendance from key stakeholders from Imperial County such as government/community agencies, law enforcement, primary care providers, and ICBHS staff. Furthermore,

ICBHS and HMA provided two in-person train-the-trainers for ICBHS direct service staff as well as correctional and probation officers to learn about the conceptualization and treatment of substance use disorders and co-occurring disorders, MAT, stigma, and harm reduction. Funding for training events and consultations by HMA was funded though DHCS of State Opioid Response Grants from SAMSHA.

f. Youth Opioid Response Grant 3

ICBHS has been participating in YOR 3 grant for the period of April 2023 to September 2024 with an award amount of $500,000. This is the third round of the State Opioid Response (SOR III) funds ICBHS has received to address increases in youth and adults between the ages 12 to 24 diagnosed and treated for an opioid and/or stimulant use disorder. This funding is through the DHCS administered by the California Institute of Behavioral Health Solutions (CIBHS) in partnership with Advocates for Human Potential, Inc. (AHP). It is part of the SOR III service grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The aim is to address the opioid crisis sweeping the nation by increasing access to medication assisted treatment (MAT), reducing unmet treatment need and reducing opioid overdose related deaths.

On April 2024, ICBHS was provided with additional funding under the YOR 3 grant in the amount of $142,000.00 to enhance outreach and engagement activities in Imperial County. These funds will support efforts to improve accessibility of services and identify treatment needs through outreach. Outreach activities will include resource fair events, presentations, information dissemination, social media campaigns, and advertisements. The intent is to raise community awareness and increase access to services. ICBHS is planning to expand advertising efforts by broadcasting commercials at local cinemas to promote substance use disorder treatment services and harm reduction. It is crucial to raise awareness among youth and young adults with Opioid Use Disorder and Stimulant Use Disorder about the available support services.

g. California Opioid Settlement Funds

Imperial County is a participating subdivision in California that has and will continue to receive opioid settlement funds. ICBHS will manage these funds and will ensure that treatment and remediation activities are implemented. All funds received must be used for future opioid care, treatment and other programs designed to address the misuse and abuse of opioid products, treat or mitigate opioid use or related disorders and mitigate other alleged effects of, including on those injured because of the opioid epidemic. ICBHS will focus on High Impact Abatement Activities (HIAA) to reduce and lessen, or end the opioid crisis by providing care, treatment, outreach, and other services. ICBHS asked the community for feedback on HIAA to focus on rating each activity on a scale from 1 – 6 (1 being the most important and 6 being the least important). The community determined Provision of matching funds or operating costs for the Adult Residential SUD Treatment Facility in Imperial County project. ICBHS plans to use opioid settlement funds to fund media campaigns to prevent misuse and drug addiction by running a billboard media campaign throughout Imperial County.

h. PATH Justice-Involved Round 3

On August 7, 2023, ICBHS was conditionally awarded $1,109,824.00 by DHCS for the implementation of PATH Round 3 Justice Involved Planning and Capacity Building

Program for the period of April 1, 2024, to March 1, 2026. This grant funding will allow ICBHS to provide behavioral health services for justice involved individuals 90 days prior to release and post release from a correctional facility. Pre-release services will include assessment and intensive care coordination services to ensure continuity of care for those individuals who are identified as having a mental health or substance use condition. Additionally, ICBHS, in collaboration with Imperial County Sheriff's Office, will develop an implementation plan to facilitate a secure exchange of medical records of individuals with mental health and substance use disorder treatment history. The implementation plan will streamline the processes for referral, assessment, and care coordination for incarcerated individuals to ensure these individuals are linked and have access to these services prior to and once released. PATH funds will also be available to support investments in personnel, capacity, and/or IT systems that are needed for collaborative planning and implementation of prerelease services.

2) Memorandum of Understanding with Manage Care Plans

As the DMC-ODS Plan for Imperial County, ICBHS is responsible for providing DMC-ODS services to Medi-Cal beneficiaries who meet both access and medical necessity criteria. ICBHS is expected to coordinate with the local Medi-Cal Managed Care Plans (MCP) to coordinate services for Medi-Cal beneficiaries who do not meet criteria for DMC-ODS services. During FY 22-23, Imperial County transitioned from its previous Medi-Cal MCPs, Molina Health Care and California Health & Wellness, to Kaiser Permanente and Community Health Plan of Imperial Valley (CHPIV). As of the beginning of FY 24-25, MOUs with both MCPs are pending to be executed, although agreements have been made as to the language and scope of each MOU.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- ICBHS will increase community outreach and engagement activities in all areas of the county and amongst key community agencies to community awareness of and decrease stigma associated with OUD, StUD and other SUDs among the youth and adult population.

- ICBHS will engage in regular meetings with officials from the local tribe for the purpose of identifying barriers to service delivery, improvement of the quality, effectiveness, and accessibility of services available to Native American community within the county.

- ICBHS will work closely with Imperial County Sheriff's Office to implement pre-release and re-entry to behavioral health services for justice involved individuals 90 days prior to and post relase as part of the CalAIM Justice Involved Inititative.

- ICBHS will continue collaborate with two local hospitals, El Centro Regional Medical Center and Pioneer Memorial Hospital to provide expedited coordination of care for clients receiving MAT in the emergency department and/or urgent outpatient care centers.

7. Provider Complaints and Appeals

The QM Unit monitors provider disputes with concerning the request for authorization or payment for a DMC-ODS service. The QM Unit also monitors provider appeals through the written appeals submitted by DMC-ODS providers for denial of authorization or payment, or modification of requests for authorization.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

During FY 23-24, 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.

The current process for providing services that require prior authorization (residential and inpatient) involve the beneficiary first being assessed by ICBHS. If it is identified that a beneficiary meets the ASAM level of care for residential or inpatient service, ICBHS coordinates referral and admission to an appropriate provider. Therefore, during FY 23-24, there were no requests for authorization of service by a DMC-ODS provider, and subsequently no need for a provider appeal. Likewise, no requests were made by beneficiaries for a service that requires prior authorization. This is a consistent finding over time.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- 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.

8. Hospitalization Monitoring

The QM Unit tracks and monitors the admission and readmission of beneficiaries who are admitted to the hospital for SUD-related concerns in order to identify any potential quality of care issues or trends in occurrences.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

The QM Unit monitoring process consisted of collecting data related to hospitalizations from the ICBHS SUD Hospitalizations Log. The log records the number of hospitalizations, 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 investigate the efforts made to prevent the hospitalization.

During FY 23-24, there were 6 hospitalizations made by SUD treatment programs, which is a significant decrease from prior years, as indicated below:

Table S8.1 Hospital Admissions & Readmissions

Review Period	Adolescent SUD Program		Adult SUD Program		Total	
	Admissions	Readmissions	Admissions	Readmissions	Admissions	Readmissions
FY 23-24	1	0	5	0	6	0
FY 22-23	4	1	11	0	14	1
FY 21-22	0	N/A	11	4	11	4

The average hospitalization timeframe for both the Adult and Adolescent SUD programs was 4 days. After hospitalization, the average timeframe for follow-up care was within 7 days. Data shows that most of the clients received timely follow-up care within the first week after leaving the hospital; however, there was an adult client who, after being discharged from the hospital, did not return to the Adult SUD Program, as there appears to be no indication that care coordination by the Adult SUD Program was conducted.

Current efforts being implemented by the county-operated SUD treatment programs to prevent hospitalizations involve assessing clients in a consistent and timely manner upon admission and throughout the course of treatment as needed. For those individuals engaging in high-risk behaviors, clinical staff provide additional support, such as care coordination, to reduce the risk of emergencies and hospitalizations. Additionally, ICBHS continues to collaborate with local hospitals to effectively coordinate treatment for clients requiring SUD and MAT services.

b. Update on the DMC-ODS objectives and planned activities for FY 24-25:

- The ICBHS SUD programs will continue to assess clients throughout the course of treatment and provide timely interventions to prevent avoidable hospitalizations.

9. No Show Rates

To maximize service delivery capacity and expand the service delivery to DMC-ODS consumers, the QM Unit monitors, tracks, and analyzes the no show rates for ASAM assessment, MAT, and individual counseling appointments. Data related to appointments was collected from the EHR for all clients receiving DMC-ODS services from ICBHS. This assists ICBHS in evaluating client engagement in services and identifying possible barriers to treatment or causes of non-adherence. By effectively monitoring no show appointments, ICBHS can plan and implement interventions to increase client engagement and decrease wait times for services.

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

During FY 23-24, the county-operated SUD treatment programs implemented various strategies and interventions to reduce the rate of missed appointments for SUD treatment services. These efforts included conducting retention calls, arranging transportation for clients, and introducing a Positive Engagement Team (PET) to enhance the treatment experience and encourage clients to attend their scheduled appointments with greater commitment. In addition, clinical staff increased their engagement efforts by conducting frequent home visits for high-risk clients who are prone to miss appointments.

1) No Show Rates to ASAM Assessment Appointments

The overall no show rate for ASAM assessment appointments was 43 percent during FY 23-24, which is an increase from the previous FY, although neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for ASAM assessment appointments are as follows:

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

The results by program are summarized in the table below:

Table M9.1 No Show Rates – ASAM Assessment

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 23-24	133	38%	545	45%	678	43%
FY 22-23	76	33%	267	40%	343	38%
FY 21-22	41	28%	305	34%	346	33%

2) No Show Rates to Individual Counseling Appointments

The overall no show rate for individual counseling appointments was 34 percent during FY 23-24, which is a decrease from the previous FY, although neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

- Adolescent SUD Program – 41 percent
- Adult SUD Program – 50 percent

The results by program are summarized in the table below:

Table M9.2 No Show Rates – Individual Counseling

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 23-24	373	31%	1,645	35%	2,018	34%
FY 22-23	610	41%	2,325	48%	2,935	46%
FY 21-22	245	29%	1,597	38%	1,842	36%

3) No Show Rates to MAT Appointments

The overall no show rate for MAT appointments was 37 percent during FY 23-24, which is an increase from the previous FY. While the Adolescent SUD Program did not exceed its benchmark, the Adult SUD Program did with a 37 percent no show rate. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

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

The results by program are summarized in the table below:

Table M9.3 No Show Rates – MAT

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 23-24	18	33%	774	37%	792	37%
FY 22-23	14	31%	539	34%	553	34%
FY 21-22	6	33%	416	27%	422	27%

Although in most instances the SUD programs met their established benchmarks for no show appointments during FY 23-24, both the benchmarks and the no show rates themselves are exceptionally high, indicating an issue with client engagement that needs to be explored. This is consistent with the high rate of unsuccessful discharges that have occurred within both programs. Although this is not data that is currently accessible by ICBHS, it has been recommended by the EQRO to work on identifying the reasons for high rates of summary exits and high levels of unsatisfactory progress in treatment – an analysis that would go hand-in-hand with exploring the reasons for high no show rates.

b. Overview of the DMC-ODS objectives and planned activities for FY 24-25:

- The QIC will consider adopting a lower no-show benchmark for all appointment types and will aim for incremental improvements of 5 percent until reaching the new no-show benchmark.

- ICBHS will work on identifying reasons for high rates of summary exits and high levels of unsatisfactory progress in treatment and follow with interventions to improve treatment outcomes.

10. Performance Improvement Projects

The QIC oversees the development of clinical and non-clinical Performance Improvement Projects (PIPs). The QIC reviews data indicating the need for quality improvement activities, taking into consideration recommendations made by the QM Unit, and selects the PIPs and the individuals assigned to participate in a PIP taskforce. Members of the PIP taskforce are responsible for developing the PIPs, collecting and analyzing data, developing goals and key performance indicators, implementing interventions, and measuring outcomes. Progress on each PIP is presented during the monthly QIC meetings and to the EQRO during the annual external quality review.

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 was 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. ICBHS submitted its BHQIP PIPs on March 20, 2024, and received a response from DHCS on April 24, 2024, stating that all supporting documents submitted were sufficient for meeting this milestone. Of the three BHQIP PIPs, two are related to DMC-ODS: Pharmacotherapy for opioid use disorder (POD) and Follow-up after emergency department visits for alcohol and drug abuse and dependence (FUA).

a. Update on the DMC-ODS objectives and planned activities for FY 23-24:

1) Decreasing Administrative CalOMS Discharges to Improve Treatment Outcomes

During the FY 22-23 EQRO review, it was recommended for ICBHS to assess administrative discharges and the connection between unsuccessful discharges and the high rate of administrative discharges. This PIP initiated in July 2023 after a review of the data collected from 2022. One of the central issues that emerged during this review was the miscoding of discharges, primarily because the clients have been linked with the wrong discharge codes. This issue became a key focus in the effort to understand the high rate of administrative discharges within the programs. A significant finding of the analysis was the contrast between Adult and Adolescent SUD programs. Specifically, the data revealed that the Adult SUD program had a higher percentage of CalOMS administrative discharges when compared to the Adolescent SUD program.

The goal of this PIP is to improve retention and engagement with evidence of satisfactory progress and outcomes in treatment and decreasing the number of unsuccessful administrative discharges. Decreasing unsuccessful administrative discharges will show clients' adherence and commitment to treatment and staff's effort for engagement and retention.

The PIP's intervention consisted of training the SUD staff every three months along with monitoring of the discharges on a monthly basis. The SUD programs provided three separate trainings throughout the fiscal year to all SUD program staff on CalOMS forms and proper coding for all discharges. Staff were trained on the importance of consistent engagement and follow-up throughout the course of treatment. Furthermore, staff were educated on completing standard discharge from for the purpose of treatment

The aim/goal of this PIP is as follows*: Upon the completion of the CalOMS training by SUD staff from both Adults and Adolescents programs, the SUD anticipates a 10 percent decrease in administrative discharges, with the goal of improving the current rate of 76 percent.*

During FY 23-24, the SUD programs were able to decrease the percentage in administrative discharges; however, PIP members agreed to continue this PIP for second year to show the ability to sustain this improvement over time and implement new strategies for improvement.

2) Pharmacotherapy for Opioid Use Disorder

During FY 22-23, ICBHS implemented measures to enhance performance related to the HEDIS measure for Pharmacotherapy for Opioid Use Disorder (POD). The PIP taskforce met with the County's NTP provider, starting in November 2022, to discuss information exchange in support of the POD measures. These meetings continued regularly to monitor intervention progress, tracked in the Imperial PIP Progress Tracker and the DHCS PIP template. The transition to a new EHR in February 2023 initially complicated data exchange, causing delays in monitoring; however, after resolving these issues, the QM Unit successfully extracted data from the EHR regarding NTP's submitted claims.

In FY 23-24 this PIP moved forward for a second year. The PIP Taskforce and the NTP program continued to meet regularly to monitor the progress of the interventions which are tracked in the DHCS PIP Template.

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 the NTP program and ICBHS. The goal is to enhance treatment adherence, improve clients' outcomes, and increase the overall effectiveness of the program.

The PIP's intervention consisted of the NTP program implementing a comprehensive approach to monitor and address treatment absences, to improve patient safety engagement and treatment outcomes. Patients who miss three consecutive days of treatment are flagged for review by their primary counselor, who conducts an engagement call to discuss reason(s) for the treatment absences. For patients who miss more than four consecutive days, a notification about potential consequences is sent, and telehealth options are utilized to re-engage them in treatment. The NTP program also introduced a report mechanism to track missed appointments.

Additionally, ICBHS planned to extend similar interventions to county-operated MAT clinics, implementing a flagging protocol, providing staff training, and initiating monthly monitoring and engagement calls to improve treatment experiences and outcomes. ICBHS Information Systems created a client flag tracking system to identify clients who agreed to be referred to MAT services. Another flag was created to identify clients who attended the initial MAT appointment and continue to receive MAT services. Execution of both MAT flags began November 2023, and a MAT flag report was developed to monitor the first 90 days of treatment and identify two consecutive missed follow-up appointments.

Due to the limitation in the EHR for tracking the data for county-operated programs, challenges in compiling data, and limited data availability, the QM Unit was unable to measure two of the key performance indicators (KPI); however, key performance indicators from the NTP program were obtained.

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.*

In September 2023, the first KPI for the NTP program showed that 16.01% of beneficiaries followed up for missed treatments. By March 2024, the first KPI results showed a decrease with only 12.78% of the beneficiaries followed up for missed treatment. Additionally, three additional KPIs were introduced in March 2024.

The second KPI for the NTP program indicates that 50% of the beneficiaries received an engagement call, resulting in client engagement.

The first milestone was submitted on September 29, 2023, and a second on March 20, 2024. Despite efforts to address barriers, the aim statement's target remains unmet, highlighting the need for continued improvements in data management and service delivery. PIP task force members agreed to concentrate on county-operated SUD programs only for the upcoming fiscal year.

3) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

During FY 22-23, ICBHS implemented measures to address follow-up after emergency department visits for alcohol and other drugs or dependence (FUA). In October 2022, ICBHS met with El Centro Regional Medical Center (ECRMC) to discuss information exchange for FUA measures. Due to technological constraints with ECRMC's current EHR in their Emergency Department (ED), secure direct messaging could not be utilized.

As an interim solution, ICBHS used SUD staff from the California Bridge Program stationed at ECRMC's Emergency Department (ED) and created a designated email to serve as a centralized receiving point for incoming referrals from ECRMC. The SUD Staff worked from 8:00 a.m. to 5:00 p.m., Monday through Friday, linking and completing referrals to ICBHS for SUD-related conditions. If unavailable, the ECRMC ED Case Manager would send a referral via the designated email address, ensuring better follow-up care.

During FY 23-24 this PIP moved forward for a second year. The PIP intervention consisted of several elements, including care coordination with the ED, screening in the ED, real-time referrals coordination from the ED, and post-ED discharge care coordination. To streamline this process, SUD staff from the California Bridge program are assigned to quickly assess beneficiaries' needs and provide appropriate services to address any urgent conditions.

The AIM Statement for this PIP is as follows: *To improve the follow-up percentage of individuals with alcohol use disorders or other drug use disorders after visiting the emergency room in Imperial County from 12% to 25% by implementing care coordination practices and streamlined data exchange processes by March 2024.*

The first KPI showed that 47.27% of beneficiaries successfully transitioned to follow-up after care. Out of 110 beneficiaries assessed, 52 were transitioned to follow-up care.

The second KPI showed that 61.54% of beneficiaries kept their scheduled appointment after ED visit. Out of the 52 beneficiaries scheduled, 32 kept their appointment.

In March 2024, the results for the first KPI showed that 50% of beneficiaries successfully transitioned to follow-up care. Out of the 2 beneficiaries accessed, one was transitioned to follow-up care. The second KPI showed that 50% of beneficiaries kept their scheduled appointment after ED visit.

Implementing the FUA PIP has proved challenging due to preexisting financial and systemic challenges faced by hospitals in Imperial County that have been further aggravated by the economic strain brought by the COVID-19 pandemic. ICBHS has struggled to establish effective communication with both ECRMC and Pioneers Memorial Hospital (PMH) due to the existing challenges associated with healthcare. Despite this, ICBHS continued efforts to improve relations with both hospitals. Additionally, ICBHS's Information Systems Unit contacted local Medi-Cal Managed Care Plans (Molina and California Health & Wellness) about data exchange capabilities. Meetings were held with both Managed Care Plans to discuss data exchange processes.

Despite these efforts, in September 2023, ECRMC terminated partnerships with ICBHS as their California Bridge Program concluded. Simultaneously, ICBHS has been collaborating

with PMH as they implement the California Bridge Program within their ED. In November 2023, ICBHS met with PMH's California Bridge program staff and the ED Medical Director to discuss and develop a referral process. ICBHS agreed to provide a SUD Counselor onsite in the ED Monday through Friday to assist with SUD Navigation to ensure successful linkage to MAT Outpatient services.

Due to the terminated partnership with ECRMC which was beyond the control of the County it impacted the ability to measure the aim statement progress sufficiently. For this reason, the aim statement remains inconclusive as there is no data; however, ICBHS is formalizing its relationship with PMH to execute a MOU in terms of care coordination and establishing a data exchange workflow to ensure clients are assessed and successfully linked to outpatient treatment and to monitor follow-up outcomes.

The first milestone was submitted on September 29, 2023, and a second on March 20, 2024. The PIP concluded as of March 2024; however, despite efforts to address barriers, the aim statement's target remains unmet, highlighting the need for 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 and planned activities for FY 24-25:

- The county-operated SUD programs will continue to implement interventions to increase client engagement and retention, reducing the rate of unsuccessful, administrative CalOMS discharges.

- The count-operated SUD programs will continue to implement interventions to increase adherence to MAT for clients diagnosed with an opioid use disorder.

- ICBHS will continue to work with the local MCPs to establish data exchange processes in order to better coordinate care for Imperial County Medi-Cal beneficiaries who are accessing the local EDs for a substance use disorder.

CULTURAL AND LINGUSITIC COMPETENCE

ICBHS utilizes 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. Overview of the ICBHS objectives and planned activities for FY 23-24:

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 23-24. 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
The QM 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, audience, and proposed schedule. 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
The QM Unit produced an annual Cultural Competence Training Report summarizing training activities for the fiscal year for mental health and SUD program staff. The data 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 23-24, the QM Unit monitored ICBHS compliance with the requirement of attending at least one cultural competence training per year. Out of 595 ICBHS employees, 100 percent completed a cultural competence training as required, although it should be noted that 5 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
ICBHS provided the Client Culture Training and the Client Culture Refresher Course accordingly to 221 mental health and SUD program staff during FY 23-24. These trainings provide staff with an understanding that consumers of behavioral 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. 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 23-24, 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 23-24, one interpreter training took place via Zoom on March 11-14, 2024, for 17 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 ICBHS Center for Clinical Training continued to implement an eLearning cultural competence training course for new hires during FY 23-24. 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 23-24, 130 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 207 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 23-24, the CCTF continued its work toward achieving its CY 2024 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 2024 Annual Cultural Competence Plan. Some of the CCTF achievements include:

- The QM Unit conducted random test calls, during business and after hours, in both English and Spanish, the County's threshold language. During FY 23-24 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 23-24, the QM Unit for mental health services conducted a total of 49 test calls, 26 during business hours and 23 after-hours. The Access Unit was 100 percent compliant when providing services, including language capabilities.

- During FY 23-24, the translation subcommittee reviewed four documents to ensure the accuracy of translation and cultural appropriateness. The following documents were reviewed and approved: SmartCare Forms (Consent for email, Service Notes, Coordinated Care Consent, and Mental Health Exam). The CCTF subcommittee reviewed the forms and recommendations were provided to the appropriate program.

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 23-24, the QM Unit prepared a CCP Update, which included the activities conducted by ICBHS CCTF. The CCP is updated annually 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, 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 86 percent of the workforce is bilingual and 80 percent is proficient in the Spanish language.

During FY 23-24, the Access and Benefits Workers continued to identify clients' primary language when scheduling appointments and logging if interpreter services were needed in languages other than the established threshold language, Spanish. To monitor if services are being offered to clients, the Access Unit supervisor reviews the Access Log to ensure that language assistance services are being offered to clients requesting them. The QM Unit conducts random test calls to assess if the Access Unit staff offers interpreter services.

Interpreter Services Contracts

In order to facilitate timely access to services, ICBHS contracts for interpreter services for in-person and over the phone interpreter services. ICBHS contracts with Deaf Communities of San Diego and Hanna Interpreting Services, independent contractors, for sign language translation and interpretation. In addition, the ICBHS allocates funds for the Language Line Solutions annually to provide interpreters services in languages not spoken by ICBHS staff.

Quality Improvement Committee

The CCTF chairperson participates in the QIC and attends on a monthly basis. The CCTF chairperson reports on activities, any issues/concerns, and progress towards meeting objectives under CLAS Standards on behalf of the CCTF and makes recommendations, as appropriate.

Mental Health Service Act Steering Committee

The CCTF chairperson and other members of the CCTF are members of the Mental Health Services Act (MHSA) Steering Committee. The members actively participate in the planning of MHSA services, ensuring the inclusion of cultural competency, and provide input and make recommendations, as appropriate.

2) Capacity of Service

A profile of the County of Imperial reflects that Hispanics account for 86.0 percent of the population and 73.3 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 SMHS 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:

Table C2.1 SMHS – Children Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Southern Services	0.71	full-time equivalent psychiatrists	18% Hispanic	17% Spanish	18% Hispanic
	3.80	full-time equivalent clinicians			
	1.57	full-time equivalent nurses			
	6.43	full-time equivalent mental health rehabilitation specialist/technicians			
Central Services	1.79	full-time equivalent psychiatrists	64% Hispanic	67% Spanish	53% Hispanic
	9.36	full-time equivalent clinicians			
	3.41	full-time equivalent nurses			
	18.79	full-time equivalent mental health rehabilitation specialist/technicians			
Northern Services	0.68	full-time equivalent psychiatrists	18% Hispanic	16% Spanish	22% Hispanic
	1.58	full-time equivalent clinicians			
	1.71	full-time equivalent nurses			
	9.05	full-time equivalent mental health rehabilitation specialist/technicians			
Eastern Services	0.03	full-time equivalent psychiatrists	100% Hispanic	100% Spanish	42% Hispanic
	0.22	full-time equivalent clinicians			
	0.04	full-time equivalent nurses			
	0.48	full-time equivalent mental health rehabilitation specialist/technicians			

Table C2.2 SMHS – Youth & Young Adults Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Southern Services	0.61	full-time equivalent psychiatrists	25% Hispanic	16% Spanish	15% Hispanic
	3.00	full-time equivalent clinicians			
	0.77	full-time equivalent nurses			
	3.41	full-time equivalent mental health rehabilitation specialist/technicians			

Central Services	1.37	full-time equivalent psychiatrists	64% Hispanic	68% Spanish	80% Hispanic
	6.57	full-time equivalent clinicians			
	3.09	full-time equivalent nurses			
	13.29	full-time equivalent mental health rehabilitation specialist/technicians			
Northern Services	0.57	full-time equivalent psychiatrists	100% Hispanic	16% Spanish	24% Hispanic
	3.28	full-time equivalent clinicians			
	1.06	full-time equivalent nurses			
	4.48	full-time equivalent mental health rehabilitation specialist/technicians			

Table C2.3 SMHS – Adults Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Southern Services	1.31	full-time equivalent psychiatrists	17% Hispanic	20% Spanish	19% Hispanic
	1.02	full-time equivalent clinicians			
	1.79	full-time equivalent nurses			
	3.86	full-time equivalent mental health rehabilitation specialist/technicians			
Central Services	2.97	full-time equivalent psychiatrists	66% Hispanic	61% Spanish	62% Hispanic
	4.68	full-time equivalent clinicians			
	4.78	full-time equivalent nurses			
	9.48	full-time equivalent mental health rehabilitation specialist/technicians			
Northern Services	1.54	full-time equivalent psychiatrists	17% Hispanic	19% Spanish	19% Hispanic
	1.92	full-time equivalent clinicians			
	2.00	full-time equivalent nurses			
	5.45	full-time equivalent mental health rehabilitation specialist/technicians			
Eastern Services	0.11	full-time equivalent psychiatrists	100% Hispanic	100% Spanish	42% Hispanic
	0.15	full-time equivalent clinicians			

	0.04	full-time equivalent nurses			
	0.00	full-time equivalent mental health rehabilitation specialist/technicians			

Table C2.4 SMHS – Mental Health Triage & Engagement Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Central Services	2.57	full-time equivalent psychiatrists	100% Hispanic	100% Spanish	100% Hispanic
	5.90	full-time equivalent clinicians			
	3.30	full-time equivalent nurses			
	23.41	full-time equivalent mental health rehabilitation specialist/technicians			

Table C2.5 DMC-ODS – Adolescent SUD Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Southern Services	2.00	full-time equivalent SUD counselor	89% Hispanic	67% Spanish	56% Hispanic
	2.40	full-time Licensed Practitioner of the Healing Arts (LPHA)			
Central Services	1.00	full-time equivalent SUD counselor	67% Hispanic	33% Spanish	67% Hispanic
	1.40	full-time Licensed Practitioner of the Healing Arts (LPHA)			

Table C2.6 DMC-ODS – Adult SUD Services

Service Region	Average of full-time equivalent staff		Ethnicity	Language Capabilities	Cultural Awareness
Southern Services	3.00%	full-time equivalent SUD counselor	100% Hispanic	100% Spanish	100% Hispanic
	1.45%	full-time Licensed Practitioner of the Healing Arts (LPHA)			
Central Services	6.00%	full-time equivalent SUD counselor	75% Hispanic	75% Spanish	50% Hispanic
	4.85%	full-time Licensed Practitioner of the Healing Arts (LPHA)			

During FY 23-24, ICBHS direct service staff was 78 percent Hispanic with 69 percent fluent in Spanish. In addition, 49 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 23-24, the MHP provided services to 7,401 unduplicated beneficiaries. Of these, 80 percent were Hispanic and 34 percent were Spanish speaking. The distribution by division is included below:

Table C2.7 MHP Distribution of Beneficiaries by Division

Division	Number of Beneficiaries FY 23-24	Ethnicity		Language	
Children Services	2,082	81%	Hispanic	49%	Spanish
Youth and Young Adult Services	1,376	85%	Hispanic	31%	Spanish
Adult Services	2,841	79%	Hispanic	34%	Spanish
Mental Health Triage & Engagement	1102	76%	Hispanic	27%	Spanish

Children Services: 89 percent of Children Services direct services staff were Hispanic with 77 percent fluent in Spanish. In addition, 63 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Youth and Young Adults Services: 80 percent of Youth and Young Adults Services direct services staff were Hispanic with 63 percent fluent in Spanish. In addition, 61 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adults Services: 87 percent of Adults Services direct services staff were Hispanic with 70 percent fluent in Spanish. In addition, 69 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Mental Health Triage & Engagement Services: 93 percent of MHTES Services direct services staff were Hispanic with 66 percent fluent in Spanish. In addition, 70 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.
In FY 23-24, the DMC-ODS Plan provided services to 771 unduplicated beneficiaries. Of these, 83 percent were Hispanic and 18 percent were Spanish speaking. The distribution by division is included below:

Table C2.8 DMC-ODS Distribution of Beneficiaries

Division	Number of Beneficiaries FY 23-24	Ethnicity		Language	
Adolescent SUD	162	94%	Hispanic	21%	Spanish
Adult SUD	609	81%	Hispanic	18%	Spanish

Adolescent SUD Services: 78 percent of direct services staff were Hispanic with 69 percent fluent in Spanish. In addition, 49 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adult SUD Services: 78 percent of Adult Services direct services staff were Hispanic with 69 percent fluent in Spanish. In addition, 49 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ICBHS ensures that beneficiaries have access to SMHS 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.

3) Staff Cultural Competence and Linguistic Capabilities

In FY 23-24 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 2024 for all ICBHS staff and contract providers.

472 surveys were completed by staff, which represents a 90 percent response rate. The total number of surveys includes:

- 57 in administrative services
- 91 in direct services-licensed (includes licensed/registered interns)
- 90 in direct services-unlicensed, and;
- 234 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 86 percent of the population, while the second highest race, White, accounted for 19 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 29 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 the cultural needs of the clients they served, and 80 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 LGBTQ.

91 surveys were completed by contract providers, which represents a 38 percent response rate. The total number of surveys includes:

- 46 in direct services-licensed (includes licensed/registered interns), and;
- 45 in support services.

The survey results indicate that of the completed surveys, Hispanic/Latino population continues to be the largest portion representing 49 percent of the population, while the second highest race, White, accounted for 10 percent. When addressing the language that the staff is competent enough to provide services to clients beside English, Spanish (18%) 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 24 percent of the staff reported that they provided interpretation services for clients in the last year.

b. Overview of the ICBHS objectives and planned activities for FY 24-25:

- ICBHS will ensure the Cultural Competence Plan is updated annually and contains an assessment of the department's overall cultural competence and ability to meet the cultural needs of beneficiaries, including goals for improving cultural competence and access to care.

- The QM Unit will monitor the cultural and linguistic activities of the Department to ensure the cultural and linguistic needs of beneficiaries are met.