FY15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Sacramento

Conducted on

August 4 – 6, 2015

Prepared by:

Behavioral Health Concepts, Inc.
400 Oyster Point Blvd., Suite 124
South San Francisco, CA 94080
www.caleqro.com

TABLE OF CONTENTS

INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Beneficiaries served in CY14—20,005
  - MHP Size—Large
  - MHP Region—Central
  - MHP Threshold Languages—English, Spanish, Cantonese, Russian, Hmong, Vietnamese
  - MHP Location—Sacramento

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Sacramento mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

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

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark.
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Sacramento MHP submitted two PIP's for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

Utilizing the Information Systems Capabilities Assessment (ISCA) protocol, the EQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included review of the MHP's reporting systems and methodologies for calculating Performance Measures (PM).

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

The EQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP or its subcontractors.

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

(5) KEY COMPONENTS, SIGNIFICANT CHANGES, ASSESSMENT OF STRENGTHS, OPPORTUNITIES FOR IMPROVEMENT, RECOMMENDATIONS

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

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

---

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY14-15

- Recommendation #1: Develop a performance improvement project tracking Phase A implementation of the initiative with Triage/Navigator staff to improve access and service engagement.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP developed a PIP that will track implementation to improve access and service engagement and increase capacity. There are two distinct elements to the PIP: Phase A implementation and the Triage/Navigator Grant.
  - Phase A implementation is part of a Community Services and Supports Expansion Planning Process that used MHSA funds to the Regional Support Teams (RSTs) to increase timeliness, expand capacity and incorporate new design elements to further address the MHSA principles. See Recommendation #2 for details.

- The Triage/Navigator program is funded under a grant awarded by the Mental Health Services Oversight and Accountability Commission for the purpose of providing crisis intervention, system navigation, peer support and linkages to individuals living with mental illness or serious emotional disturbance who are experiencing a crisis**.**
- The MHP has contracted for 20.8 FTE Navigator positions to support the Navigator program. The Navigators will be field-based and some personnel will be located at Emergency Rooms (ERs), of which there are nine in Sacramento County.
- The Triage Navigator Program and Community Care Teams are still in development stage pending staff hiring, and therefore not complete in implementation. This allows for a "partially addressed" to this recommendation.
- The RSTs will collaborate with triage/navigator staff which is one of the strategies in the PIP.
  - Navigators will also support individuals in other acute facilities to support "warm hand-off" to RST improve engagement and access to services.
  - It is expected that Navigators will use web-based mobile devices to submit electronic service requests to Access Unit for treatment authorizations.

- Recommendation #2: Develop a performance improvement project to improve timeliness of first access including both non-psychiatric and psychiatric contact.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has established an adult Performance Improvement Project (mentioned above) to address the issues of timeliness, access to services, and capacity.
  - A collaborative workgroup, consisting of MHP program staff, quality management, research and evaluation, cultural competence, consumer/family advocates and provider representatives have been meeting since March 2015 to operationalize the Performance Improvement Project (PIP).
  - The expectation is to utilize the new Community Care Teams at the RSTs to engage the client after access authorization and continue the engagement until the client has his or her first appointment.
  - The Community Care Teams will be working on the back door issues by assessing clients for transition to lower levels of care**.**

- Recommendation #3: Develop a metric that will allow tracking of the missing timeliness data elements:

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has made the following progress on metrics:
  - Children's first psychiatric service – The MHP has added this to its quarterly benchmark report and the MHP began reporting it in the 4th quarter of the CY2014 Report.
  - No-show rates – The MHP stated that it will start reporting No Show and cancellation rates starting with the first Quarterly Timeliness (Benchmark) report that covers July – September 2015. The MHP is currently educating providers on the importance of tracking no shows in relation to their timeless to services. They have communicated with providers at provider meetings and through contract monitors. The issue has been placed on an upcoming agenda to discuss breaking out cancellation into staff and consumer cancellation and it is anticipated that this change will take place in the near future so that both of those elements can also be tracked.
  - Current re-hospitalization rates – The MHP has tracked hospital recidivism rates as part of their annual reporting for many years. They provided CalEQRO FY13-14 Recidivism report for this year's review.

- Recommendation #4: Continue to collaborate with Netsmart Technologies to create a provider integration product which will advance coordinated and integrated care by the sharing of information across providers.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - Quality Management has worked with the Avatar team to create a clinical data elements requirement document to share with providers that have their own Electronic Health Record (EHR) systems. This document is scheduled be shared with providers in the coming months in preparation for provider integration.
  - Currently there is one Legal Entity (LE) with an EHR that is ready to exchange data with the MHP. There are four additional LE's with plans to implement their own EHR systems but are not yet ready to exchange data with the MHP. The MHP currently contracts with 48 LE's, which use direct data entry into the MHP's Avatar System.
  - Provider EHR integration project is expected to begin during FY15-16. The MHP Avatar team will continue to work with Netsmart technologies in the development of a satisfactory product.

- Recommendation #5: To enhance MHP's communication with contract provider organizations, reinstitute the consistent process of taking and distributing notes from the bi-monthly Avatar Forum meetings.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - Meeting minutes from both the Clinical and Practice Management (PM) User Forums held after the EQRO visit in November 2014 have been posted on the

Avatar website (December 2014, February 2015, April 2015). At the time of the on-site review, the MHP was finalizing the June 2015 minutes for posting.

- It is the goal of the Avatar team to continue to consistently post the minutes from both the Clinical and PM User Forums moving forward.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

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

- Access to Care
  - The MHP has successfully implemented the electronic Access Service Request (SR) and has merged the once separate Children's and Adult Access Teams into a single centralized Access Unit. The Access Unit is creating new business and processes for the MHP to more efficiently identify contracted census and provider capacity at contract sites.
  - To improve monitoring of access to care and consumer engagement, the MHP installed a call center telephone system that better provides the capability to produce management and usage reports to measure Access Unit activities.
  - To increase capacity, reduce level of care (LOC), and improve access/scheduling,–the MHP has expanded Full Service Partnerships (FSPs) for all ages, implemented two mobile crisis teams with law enforcement, implemented one crisis residential facility and is planning three more, and is implementing both the Triage/Peer Navigator and Community Care Teams(CCT) programs.
  - *Katie A.* Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) are successfully being billed. The Demonstration Project Identifier (DPI) is used for all sub-class members who receive other MHP services. The MHPS participated in developing a joint MHP/Child Protective Services (CPS) screening form used by CPS to make referrals to the MHP. The form is scanned into the Avatar EHR.
  - Collaboration with the four Medi-Cal Geographic Managed Care Plans in the county is currently a major challenge to the MHP particularly in light of the large numbers enrollment of new Medicaid Expansion consumers.
  - The MHP has implemented and is currently testing geo-mapping/Geographic Information System (GIS) functionality that can map provider and enrollee locations.
- Timeliness of Services

- Implementation of Mobile Crisis Teams (which may be used by Triage, CCT programs among others) as well as he "Mobile Crisis Go Live" in Avatar may increase timeliness of services.
- The above mentioned merged Children's and Adult Access Teams into a single centralized Access Unit is expected to increase timeliness of services, although no data has been gathered at this point.

- Quality of Care

- The Avatar EHR now includes the language in which services are provided.
- The MHP has not as yet developed manual or electronic data sharing with their four Medi-Cal Geographic Managed Care (GMC) Plans or primary care providers. Collaboration with GMC's in the county is currently a major challenge to the MHP to serve the huge enrollment of new Medicaid Expansion consumers and to successfully refer consumers with "mild" to "moderate" impairments to the GMC's and primary care providers.
- Avatar continues to provide the MHP with robust reports which include many quality indicators.
- The ICD-10 Implementation is in process with implementation scheduled to meet compliance date of October 1, 2015. System Readiness review and testing in progress, with "Super User" training complete. Provider training with full access to ICD-10 is projected for mid-August 2015.

  Sacramento Superior Court in collaboration with the MHP, Public Defender, District Attorney and the Probation Department secured grant funding to address treatment needs of individuals diagnosed with a co-occurring SMI and Substance Use Disorder who are participating in a Co-Occurring Mental Health collaborative court. The MHP provides a liaison to this court and the MHP providers deliver treatment services to support this Mental Health Co-Occurring collaborative court.

- Consumer Outcomes

- The MHP has added performance measures requirements to all provider contracts. This will allow tracking and trending of hospital rates, timely access, re-hospitalization rates, patient satisfaction, CANS and other outcomes. This began in 2015.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

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

Table 1—Sacramento MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

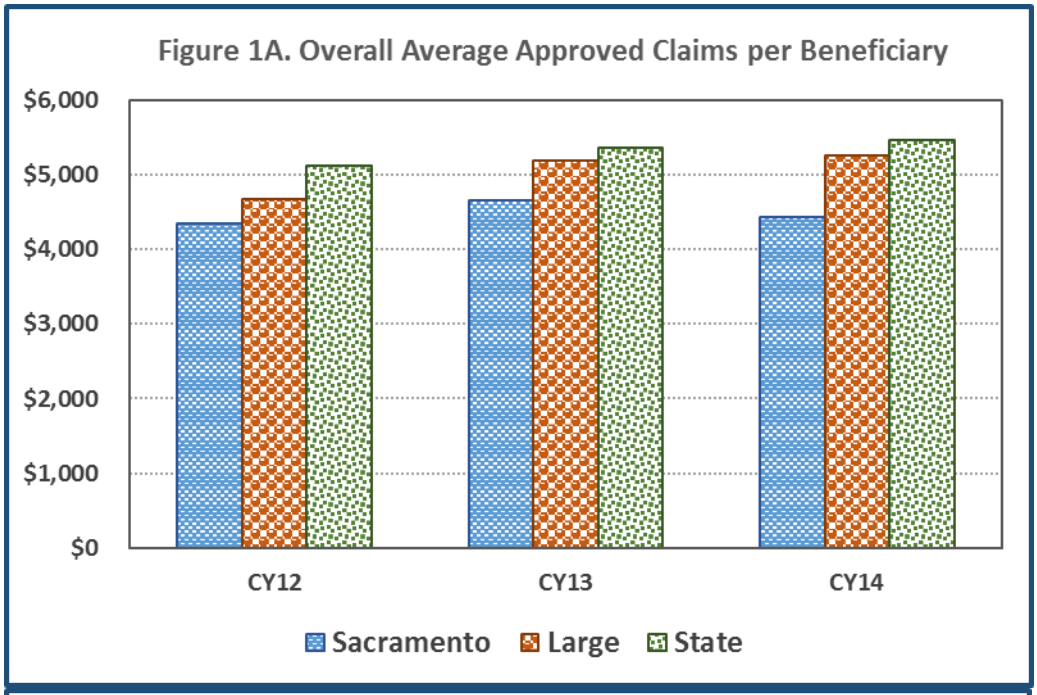
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	104,315	7,205
Hispanic	94,653	3,321
African-American	68,367	4,635
Asian/Pacific Islander	67,493	1,494
Native American	3,123	216
Other	65,396	3,386
Total	403,346	20,257

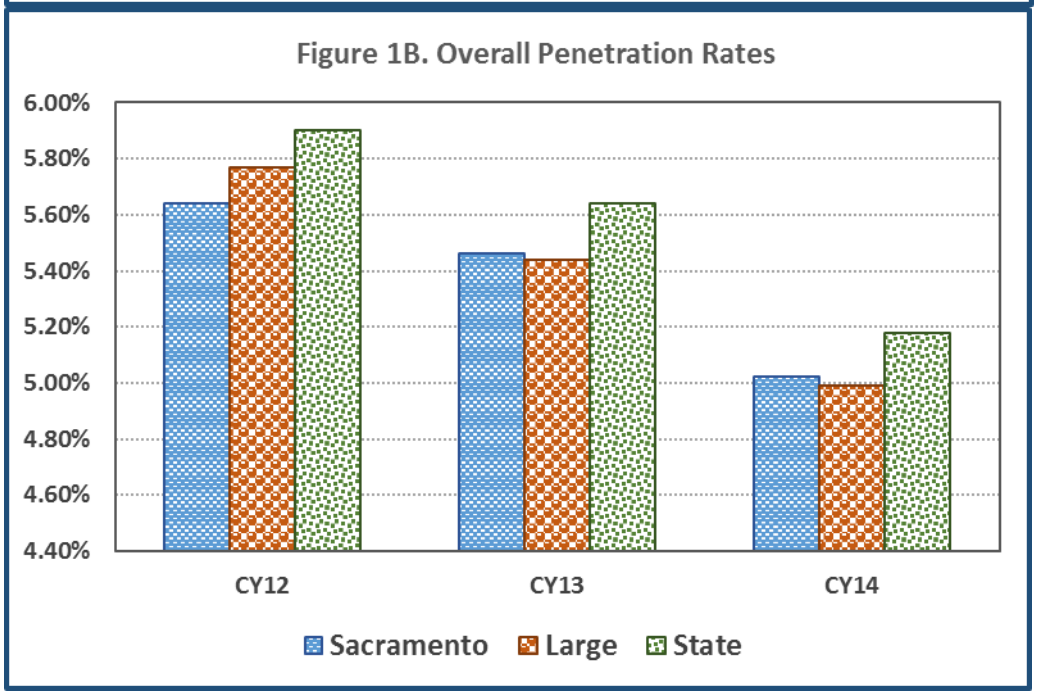
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

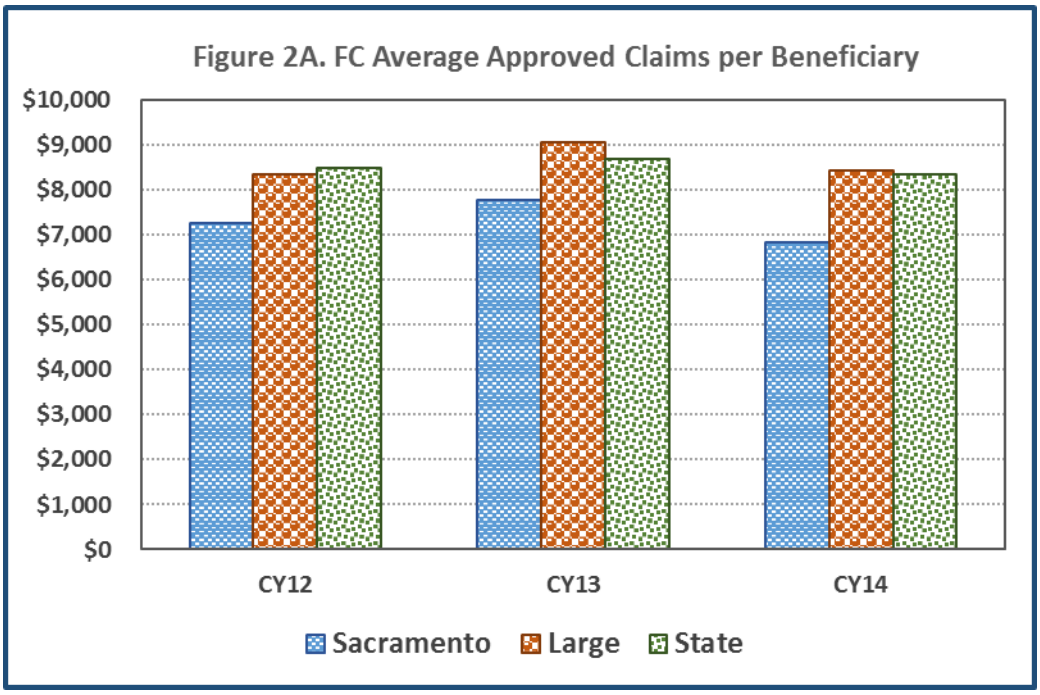
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

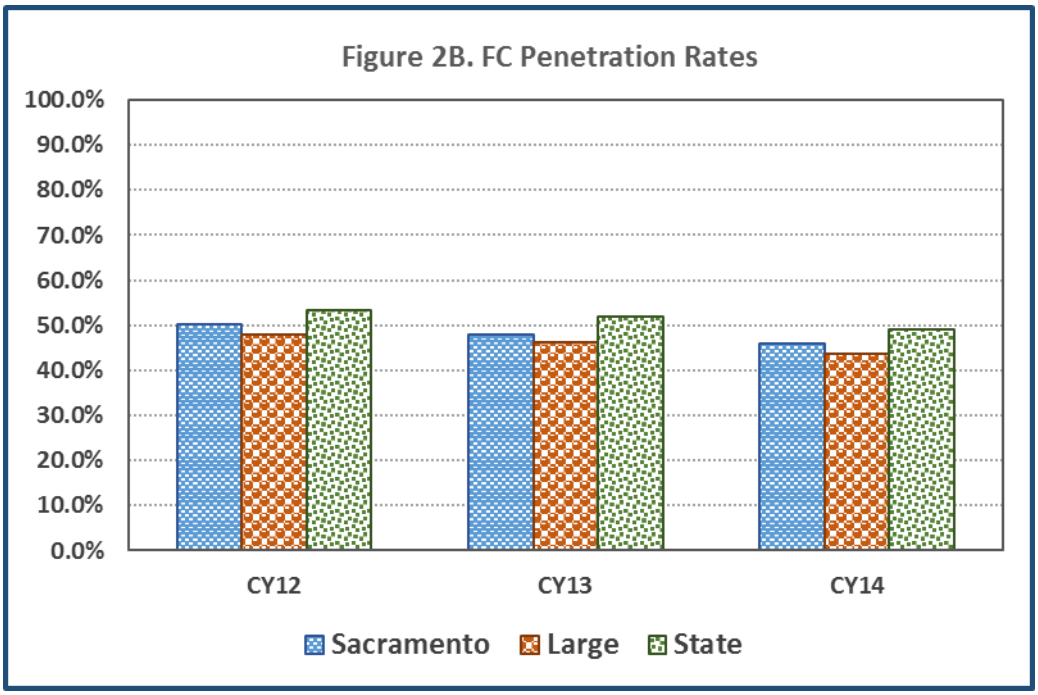
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



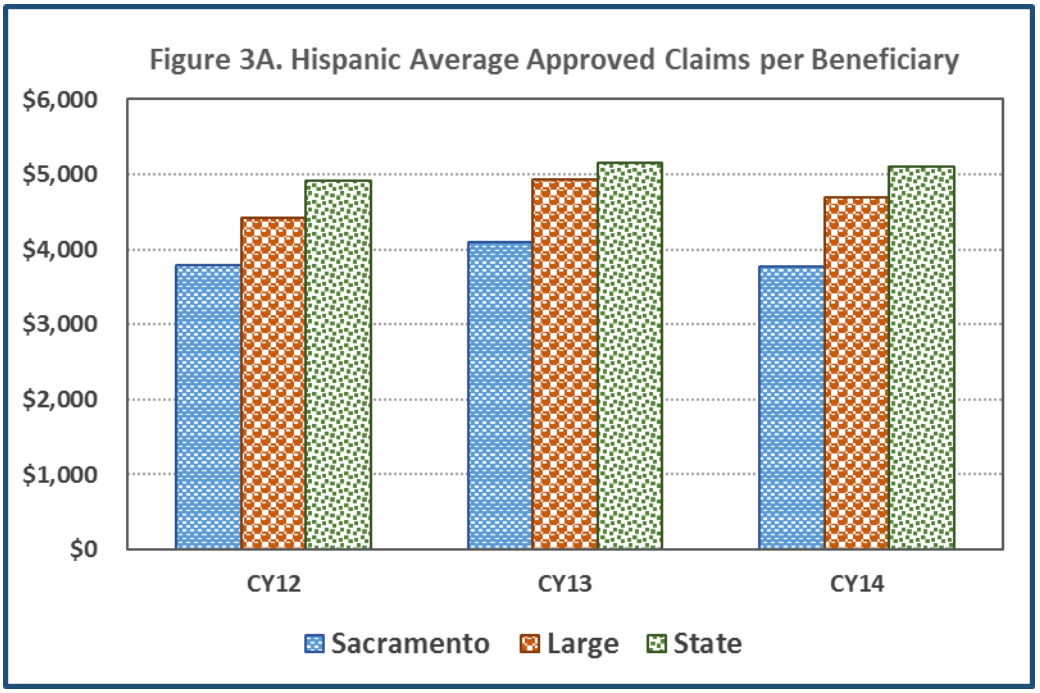


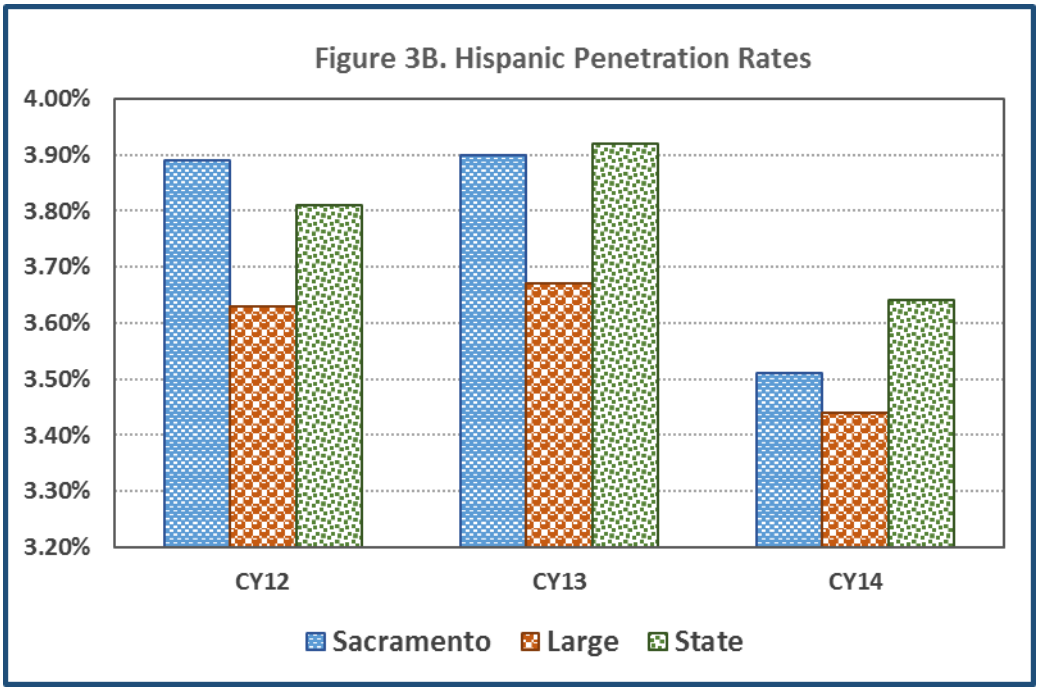
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





Figures 3A and 3B show 3-year trends of the MHP's Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





HIGH-COST BENEFICIARIES

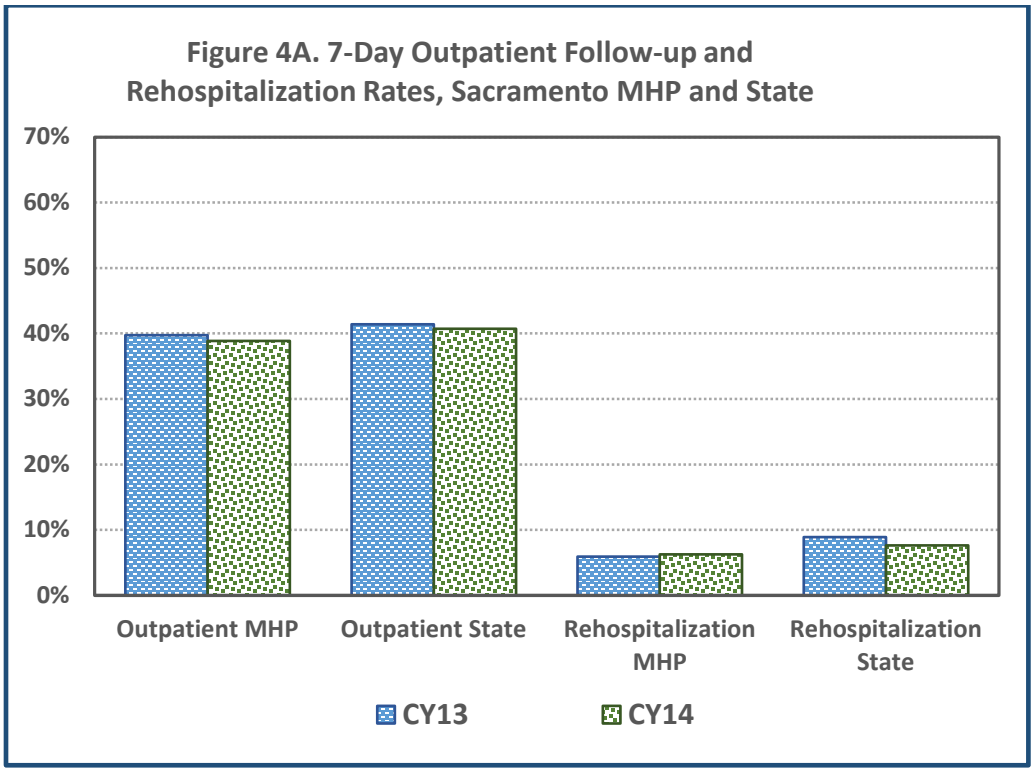
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

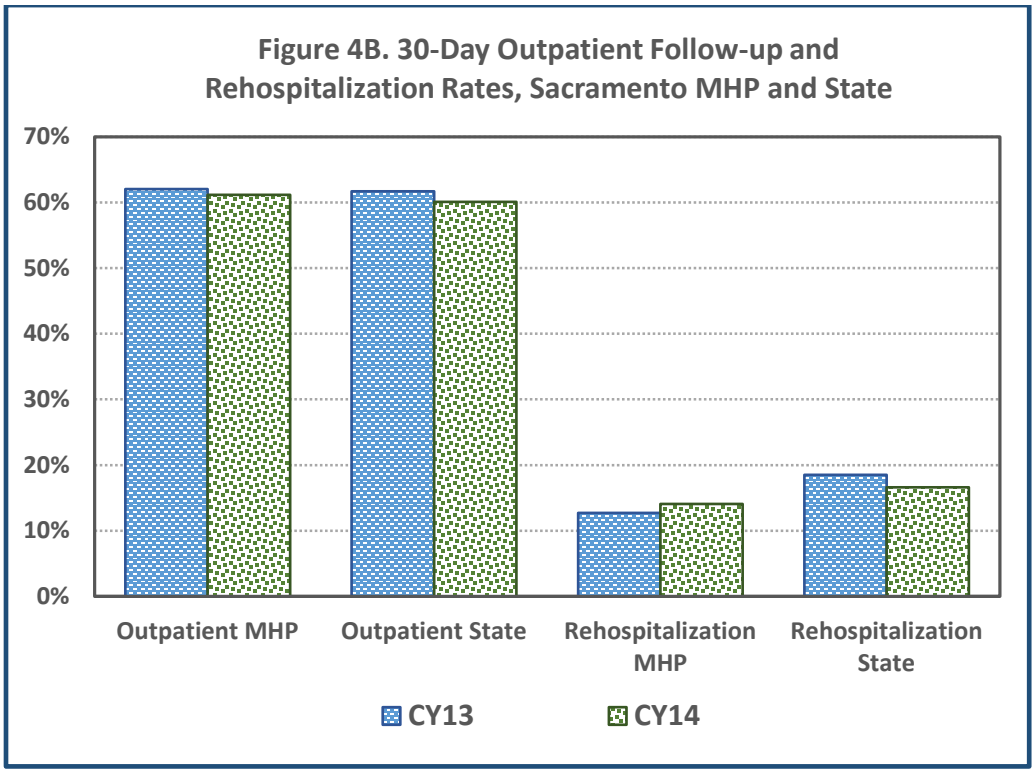
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Sacramento	CY14	250	20,151	1.24%	$42,987	$10,746,759	12.74%
	CY13	326	19,746	1.65%	$45,084	$14,697,284	16.01%
	CY12	268	18,988	1.41%	$44,033	$11,800,721	14.31%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

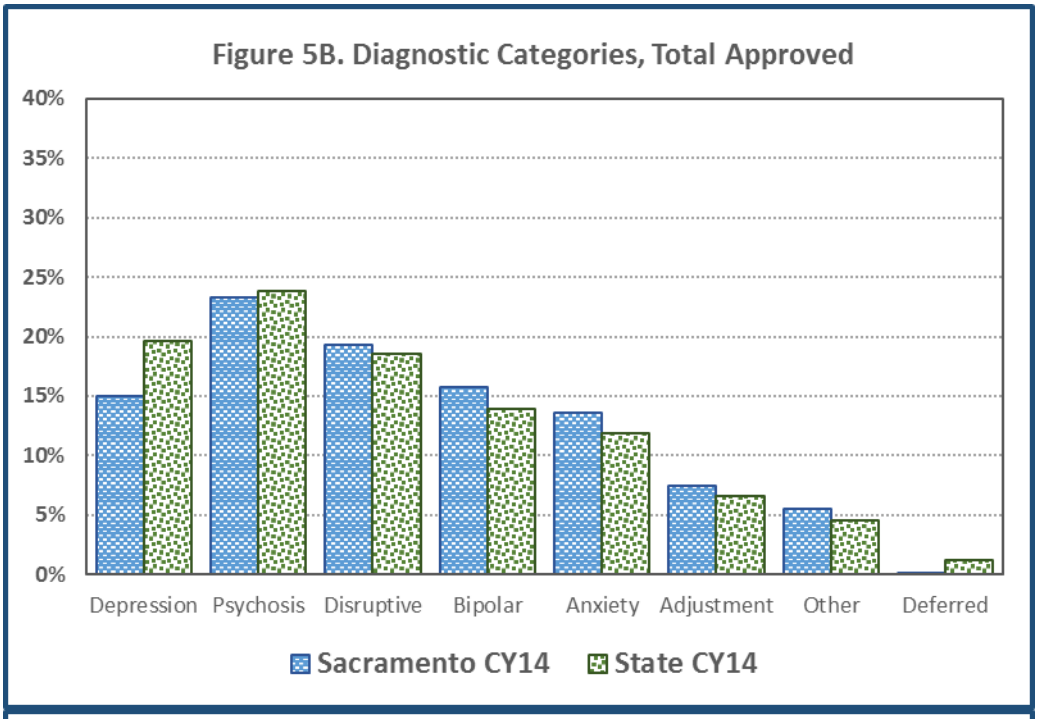
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and re-hospitalization rates for CY13 and CY14.

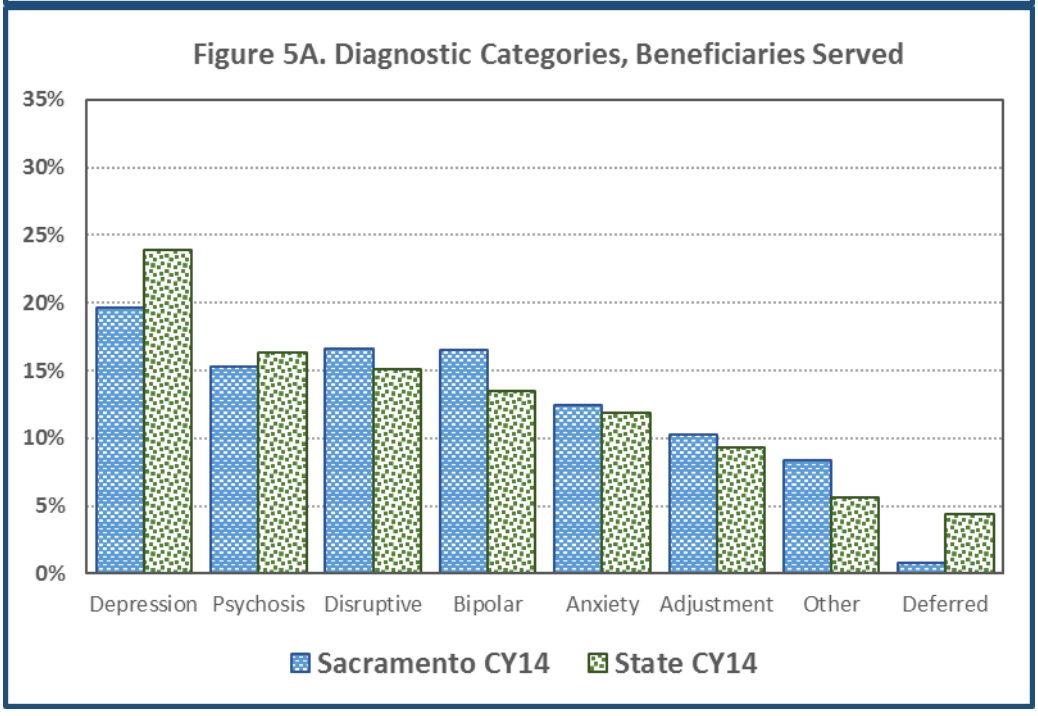




DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - While the MHP penetration rate has been lower than the statewide rates during the same time period, during the last two calendar years the MHP penetration rate has been slightly higher than the large MHP rates.
  - The MHP's foster care penetration rate is slightly higher than the large MHP average and slightly lower than that statewide. There has been a small downward trend in foster care rate statewide and for the MHP.
  - The MHP's Hispanic penetration rate is higher than the large MHP average, but lower than the statewide average. Hispanic penetration rate appears to have declined across the board for both the MHP and statewide.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from psychiatric inpatient episodes were similar to its rate in CY13 and similar to those statewide.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries was half that statewide and showed a decrease from its CY13 percentage. Its percentage of total HCB claim dollars was also almost half that statewide and lower than its own CY12 and CY13 percentages
  - The MHP's average approved claims per beneficiary served have been consistently lower than the large MHP and statewide averages for three years between CY12 and CY14.
  - The MHP's lower than statewide and large MHP average approved claims per beneficiary figures are also reflected in its corresponding figures for foster care and Hispanic beneficiaries.
  - Like statewide, a primary diagnosis of Depressive Disorders accounted for the largest of number of beneficiaries served by the MHP. However, the percentage was lower than that statewide. Instead, the MHP had a higher percentage of beneficiaries with primary diagnosis of Bipolar Disorders than statewide.
  - Also similar to statewide, the total approved claims for individuals with Psychotic Disorders were higher than that for any other diagnostic category.
  - The MHP appears to use Deferred Diagnoses for a very low percentage of its beneficiaries compared to statewide.
- Consumer Outcomes

- The MHP 7 and 30-day psychiatric rehospitalization rates in CY14 were similar to those rates in CY13.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

SACRAMENTO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Sacramento MHP submitted two PIP's for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Improving Timely Access to Outpatient Services.
Non-Clinical PIP	Increasing Collaboration Between Mental Health (MH) and Children Protective Services.

Table 4A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	PM
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	M	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NA	M
		7.2	Interim data triggering modifications as needed	NA	M
		7.3	Data presented in adherence to the plan	NA	M
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NA	M
		7.5	Interpretation of results and follow-up	NA	M

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	M
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	M
		8.3	Threats to comparability, internal and external validity	NA	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	M
		9.3	Improvement in performance linked to the PIP	NA	M
		9.4	Statistical evidence of true improvement	NA	M
		9.5	Sustained improvement demonstrated through repeated measures.	NA	PM

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	15	28
Number Partially Met	1	2
Number Not Met	0	0
Number Applicable (Maximum = 30)	16	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	97%	97%

CLINICAL PIP—IMPROVING TIMELY ACCESS TO OUTPATIENT SERVICES

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

- "Does creating a Care Coordination Team with strategies to engage and provide timely access to outpatient services increase engagement and mental health treatment and increase overall client satisfaction?"
- Date PIP began: July 2015
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

The Clinical PIP focus is evidence based and utilizing the MHP's own data to address core issue of access, timeliness, and continued engagement in outpatient services. The Sacramento MHP has historically struggled with timeliness and service engagement, and this PIP is an effort to address and correct these issues. Service Authorization and Utilization data will be used to determine engagement and timeliness to services. Regional Service Teams admissions and discharges, psychiatric hospitalization and client satisfaction data will be collected and analyzed. The Clinical PIP utilizes a variety of stakeholders for input. Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of a discussion during the PIP session of the review that resulted in the MHP redesigning its study question to ensure that the clinical aspects of this Clinical PIP is documented as it continues forward.

NON-CLINICAL PIP—INCREASING COLLABORATION BETWEEN MENTAL HEALTH (MH) AND CHILD PROTECTIVE SERVICES

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

- "Does applying a standard set of expectation for involvement and coordination with Child Protective Services (CPS) in Intensive Care Coordination–Child and Family Teams (ICC-CFT) result in better outcomes for children/youth and their families?"
- Date PIP began: March 2014
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

The Non-Clinical PIP engages collaboration between Mental Health and CPS in effort to increase access, timeliness and quality of service delivery. The MHP will continue to utilize strategies that it has put in place and implement continuous quality improvement strategies for the future. Ongoing business practices have been implemented as result of the success of this PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of encouragement to continue to develop a plan to measure outcomes of the PIP, to continue quality improvement. There was also a discussion about the development of the next PIP for review in FY2016-17 CalEQRO site visit.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The Clinical PIP addresses issues regarding access to outpatient services.
  - The Non Clinical PIP addressed collaboration between Mental Health and CPS to facilitate access to care. This was successful and has resulted in new business practices that carry forward the successful interventions of the PIP.
- Timeliness of Services
  - The Clinical PIP addresses issues of timeliness to outpatient services.

  - The Non clinical PIP addressed timeliness through creation of new communication schedule coordination techniques that facilitated timely referrals. The CPS/MH Katie A. Steering Committee insured elimination of barriers at systems level.

- Quality of Care
  - The Clinical PIP addresses issues of appropriate engagement in outpatient services in a timely manner, and at an appropriate provider location.
  - The Non Clinical PIP addressed Sub class issues of timeliness and fidelity to the Core Practice Model. To insure completion of quality of services training in the Core Practice Model across providers, the MHP implemented coordination expectations in contracts for Intensive Level Service Providers, as well as ICC-CFT documentation standards to promote consistency between providers.
- Consumer Outcomes
  - The Clinical PIP has no consumer outcomes at this time as it is in the early phase of implementation. The hypothesis expects an increase in quality of service delivery through more timely and appropriate delivery of services.
  - The Non Clinical PIP has resulted in Katie A subclass beneficiaries receiving more appropriate treatment with Core Practice Model fidelity and interagency collaboration.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management—an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs—are discussed below.

Access to Care

As shown in Table 5, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	MHP provided Cultural Competency Plan. 91% of the MHP's providers are contractors, inclusive of many culturally-specific providers.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The electronic referral of consumers from the MHP's centralized Access unit to contract providers reduces number of inappropriate referrals to wrong region for client or provider; Access Units (Children & Adult) consolidated; new Call Center phone system June 2015; system captures call volume data, reports will be available to measure daily/monthly capacity.
1C	Integration and/or collaboration with community based services to improve access	FC	Outreach and services are targeted to cultural language sub-populations through the County. 91% of the MHP's services are provided through contract providers who represent a broad-spectrum of the county's community-based organizations. Additionally, the MHP partners with other community based organizations to strengthen and increase collaboration and integration with culturally, racially, ethnically and linguistically diverse communities in Sacramento County to improve access to services.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 6, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	The MHP timeliness standard is 14 days for both Adult and Children. Adults meet target between 13% - 28.2%; Children 32.4% - 52.7%.As the MHP data indicates they generally meet the 14 day standard less than 50% of the time. Therefore, a Partially Compliant score is supported. The MHP plans to address timeliness from initial contact to first appointment in upcoming implementation of Community Care Teams.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	MHP timeliness standard is 28 days for both Adult and Children. Adults meet target between 14.7-34%; Children, 4th quarter 2014 - 38.6%. The MHP reported data indicates them meeting the28 day standard less than 50% of the time. Therefore a Partially Compliant score is supported. Community Coordination Teams within Regional Support Teams are still at planning/implementation phase. The purpose of these teams is to enhance engagement and timely access to services.
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP began tracking time to urgent services in CY 2015. MHP states that consumer with urgent conditions are seen on a timely basis through presentation at emergency rooms (ERs), the MHP's Crisis Stabilization Unit(s) (CSUs),the Mental Health Treatment Center (MHTC), etc. Navigator Staff and Community Care Teams remain in program development phase.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP intends to utilize their EHR to develop a way that tracks date of first offered appointment in addition to tracking of first "completed" appointment. Target is 7 days for Adult and Children. Adult meets 47.2% - 50.4%, children 60.4% - 76.3%.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2E	Tracks and trends data on re-hospitalizations	PC	The MHP has set a performance standard to measure re-hospitalization that is tracked and trended quarterly with the Division Dashboard Summary. It is recommended the MHP measure those consumers with two or more acute psychiatric admission during a 12 month period and report results quarterly. The MHP tracks hospital recidivism rates within 30-days. The MHP does extensive data analysis of hospital recidivism trends (i.e. tracking 30-day recidivism by hospital, age, race/ethnicity, total number of re-admissions per year, total number of hospital days for readmissions, etc.).
2F	Tracks and trends No Shows	NC	The MHP began tracking No-show rates in July 2015. MHP does not currently have data from tracking "No Shows" to present.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 7, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP produces many annual, semi-annual or quarterly reports which include quality data.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	FC	The MHP produces reports to include MHP's Quarterly Dashboard Summary Report; the Child and Adolescent Needs and Strengths (CANS) Annual Report; the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan
3C	Evidence of effective communication from MHP administration	FC	Multiple levels of routine staff meetings to disseminate information; email blasts; supervision discussions.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Some Consumer Family Members have been invited to serve on committees focused on addressing improvement of service delivery.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	91% of the MHP's services are provided through contract providers who represent a broad-spectrum of the county's community-based organizations. The MHP is implementing the Triage/Peer Navigator and Community Care Teams (CCTs) within their Regional Services structure. The MHP continues its Respite Partnership program.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	MHP produces the annual CANS Report; Dashboard Summary and many other reports on a quarterly to annual basis. Completed PIP addressing Katie A., "Increasing Collaboration Between Mental Health and Child Protective Services" and is implementing a new Clinical PIP to improve referral, access and engagement of consumers in outpatient services.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	Consumer Perception Survey data included in MHP's Annual Dashboard Report. Aggregate consumer responses are compared for most recent four (4) years.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP and contractor providers employ many peer support workers who are of specific cultural/language groups.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	TCORE and Crossroads employs consumers and family members in line and supervisory positions. TCORE has 5 designated peer positions, 1 for each service team. At TCORE 60% of the staff have lived experience.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The number of beneficiaries served has increased over the past three years. While the MHP has increased contract capacity in different programs through MHSA, Clinical, MD positions and contract providers have not increased in proportion to the increase in beneficiaries served. This may impact consumer access to providers.
  - The implementation of the electronic Service Request has addressed process-related impediments that may have contributed to creating contract provider backlogs in scheduling appointments. Once Access Unit authorizes and opens the client to a provider that provider is immediately able to schedule an appointment.
  - The new Call Center phone system captures call volume data, allowing reports to be available to measure by daily/monthly volume.
  - The consolidation of Access Units (Adult and Children) allows for a more efficient response to request for services.
  - The MHP is challenged to reduce the number of inappropriate referrals.
- Timeliness of Services
  - The lack of data on response to urgent conditions has not allowed the MHP to adjust staffing capacity in a meaningful way to address this need.

- The MHP historically has not tracked no shows. No shows tracking and trending are expected to begin July 2015. This will allow the MHP to assess timeliness in a manner that is open to program adjustments as needed.
- The consolidation of Access Units (Adult and Children) will allow a more timely delivery of services due to efficient access and referrals.

- Quality of Care
  - The completed PIP addressing Katie A., "Increasing Collaboration Between Mental Health and Child Protective Services" was successful and has resulted in change in business practices which increase quality of care for this group.
  - Difficulty in the transition from Specialty Mental Health to a Moderate or Mild level of care due to capacity issues of the Managed Care entities (GMCs) creates "backdoor" issues which are barriers for some beneficiaries receiving appropriate level of care.
- Consumer Outcomes
  - Some Consumers and Family Members have been invited to serve on various committees that focus on improving service delivery.
  - The MHP contracts with Mental Health America for 3 positions that sit on the MHPs Management Team. These positions are a Consumer, Family Member and Child/Family liaison. These 3 positions report to the MH Director.
  - TCORE and Crossroads employs consumers and family members in line staff and supervisory positions.
  - Difficulty in the transition from Specialty Mental Health to a Moderate or Mild level of care due to capacity issues of the Managed Care entities (GMCs) creates "backdoor" issues which are barriers for some beneficiaries receiving the appropriate level of care.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups, which included the following participant demographics or criteria:

- Focus Group 1: a culturally diverse group of 8 – 10 Adult beneficiaries and family members, including both high and low utilizers of MHP services in the previous 12 months.
- Focus Group 2: 8 – 10 Hispanic/Latino parents/caregivers of child/youth beneficiaries, culturally diverse group including both high and low utilizers of MHP services in the previous 12 months.
- The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

Focus Group 1 Description: 13 participants, culturally and linguistically diverse, including both high and low utilizers of services from Sacramento County MHP. All participants had been receiving services for 2 -15 years. Two interpreters were present, one for two Hmong speaking participants and one for a Russian speaking participants. This group was held at T-Core Program, 3737 Marconi Avenue, Sacramento.

Overview: All participants had positive experiences with services. Participants reported that they were able to receive non English services if they needed them. All participants had psychiatrist visits for medication management ranging from every one to three months. They were not aware of any provider capacity issues. One participant shared that she had been told her services needed to be changed to come from her primary care managed care group. There was no one available to her for mental health treatment there and she expressed concern for treatment follow up. For some in the group, transportation to treatment was an ongoing issue. Three were aware of volunteer opportunities, and two served as warm line volunteers. Participants reported that they find out what is going on with the Mental Health Department through fliers in waiting areas as well as from peer partners, therapists, psychiatrists and front office staff. All agreed that they get ample information. All stated that they were aware of avenues to give suggestions or make complaints about programs and services. This group agreed that T-Core was a positive environment in which to receive Mental Health Services.

- There were no participants who had initiated treatment within the past year.

- Recommendations arising from this group include:
- This group did not have any specific recommendations and all concurred that they felt that the MHP was doing a good job with the resources available.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		13
Number/Type of Participants	Consumer Only	11
	Consumer and Family Member	2
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	11
	Older Adult (60+)	2
Preferred Languages	English	10
	Spanish	0
	Bilingual_____/_____	0
	Other(s) Hmong -2; Russian -1	3
Race/Ethnicity	Caucasian/White	7
	Hispanic/Latino	1
	African American/Black	1
	Asian American/Pacific Islander	3
	Native American	1
	Other(s)	0
Gender	Male	6
	Female	7
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreters (2) used for focus group 1: ☐ No ☒ YesLanguage(s): Hmong; Russian

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

Focus Group Description: 13 participants who were a mixture of consumers and family members, parents, caretakers of children/youth, culturally diverse and including both high and low utilizers of services from Sacramento County MHP. All participants utilized the Spanish interpreter for this group. This group was held at River Oaks Center for Children, 8412 Big Horn Blvd, Elk Grove.

Overview: All participants were female and there was a mixture of consumers and family members, with two people being both consumers and family members. There were three participants who began services within the past year, and also two participants who had at one time received services but were there as family members. Most participants received services at La Familia and a few went to Weave for their services. All except for one participant reported there was no problem receiving services in Spanish.

For participants who entered services within the past year, the experience was described as

- Access to services was without issue, although one person said she waited a long time (no specific timeframe given).
- All three participants who initiated services in the past year expressed feeling that they/their family members were benefiting from receiving services.
- Transportation was not an issue for anyone in the group.

Recommendations arising from this group include:

- One participant suggested that the counselor speak English with bi-lingual children and youth who were fluent in English.
- Participants all agreed that services were already quite good.
- One participant recommended that services be delivered in English for their children who spoke English.

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		13
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	0 2 11
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	0 2 10 1
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	2 11 0 0
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	0 13 0 0 0 0
Gender	Male Female Transgender Other Decline to state	0 13 0 0 0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - All participants report access to care was not difficult, although at times it felt slow.
  - Two participants talked about not being able to transfer to a lower level of care because the managed care provider they were with did not have psychiatrist availability.

- Timeliness of Services
    - Some participants felt timeliness was an issue in that they could not always get an appointment to see the psychiatrist and/or therapist as soon as they would like.
- Quality of Care
    - Participants have been able to receive services and materials in their preferred language.
    - The majority of participants in both groups have case managers who they endorse as very helpful in navigating treatment.
    - All participants are aware of what to do in case of a psychiatric urgent or emergency situation. They were aware of the hotline telephone number.
- Consumer Outcomes
    - Participants valued wellness and recovery and observed that it was practiced in the locations at which they received services.
    - Participants in both groups believed that they were benefiting from the services they received.
    - Several participants in each group had been made aware of and became involved in volunteer positions within the MHP.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 9 shows the percentage of services provided by type of service provider:

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	7.98%
Contract providers	91.65%
Network providers	.37%
Total	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☐ More than 1x month ☒ Weekly ☐ More than 1x weekly

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses:

26.1%

- MHP self-reported average monthly percent of missed appointments:

21.5%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- While the MHP tracks missed appointments by consumer no-shows, they do not track appointments that staff cancel or may otherwise miss.
- The MHP continues to conduct its own penetration rate analysis based upon Medi-Cal eligibles as well as those at 200% Federal Poverty Level (FPL).

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar information system from Netsmart Technologies in the Application Service Provider (ASP) model. The MHP has over 1,200 users who have been trained and given individual user accounts giving them access to Avatar.
- A large percentage of services are provided by contract providers, 91.65%. County-operated/staffed clinics provide 7.98% of services. 72.75% of services are billed to Medi-Cal.
- While some turnover and hiring has occurred, the MHP states the IS staffing level has remained stable over the past year at approximately nine full-time equivalent (FTE) positions.
- Avatar trainings continue to be offered. The following highlights these trainings:
    - ▷ Avatar applications, including PM, CWS and OrderConnect.
    - ▷ Privacy and security training required annually.
    - ▷ Avatar Forums conducted bi-monthly which are a venue for communication on system implementations and/or modifications.
    - ▷ ICD-10 and CPT Code trainings.
- The Access Team continues to use the electronic Access Service Request (SR). The MHP has merged the once separate Children's and Adult Access Teams into a single Access Unit. While the support staff are fully integrated, the clinical staff are being cross trained to handle either child or adult requests.
- The Mental Health Treatment Center (MHTC) continues its use of the Avatar CWS, OrderConnect and document imaging.
- *Katie A.* Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) are being billed. The Demonstration Project Identifier (DPI) is used for all sub-class members who receive other MHP services. The MHP has created a Katie A. designation

form in Avatar that identifies Katie A. class/sub-class membership and changes in membership status.

- The MHP has been certified for Medicare production claims, but has not yet begun production billing.

MAJOR CHANGES SINCE LAST YEAR

- Implementation of Electronic Utilization Review.
- Implementation of Mobile Crisis Go Live.
- Increased access to medication monitoring and allergy information.
- Improved workflow for inpatient doctors related to completing treatment plants.
- New CPT Code implementation.

PRIORITIES FOR THE COMING YEAR

- Continue the Avatar implementation of Provider Integration.
- Implementation of the Personal Health Record Planning.
- Implementation of the Avatar Electronic Lab Orders and results module.
- Implementation of ICD-10.

OTHER SIGNIFICANT ISSUES

- The Access Unit is creating new business processes for the MHP to more efficiently identify contracted census and provider capacity at contract sites. However, these new business processes for the new centralized Access function are currently creating some challenges for the MHP to identify open slots and provider capacity at contract sites. The MHP is aware of these issues. The MHP is trying to meld centralized Access and electronic SRs with use of the MHP's other access points, the new Triage Navigator Program, Care Coordination/Community Care Teams (CCTs) and other initiatives to achieve flexible and appropriate access.
- Rather than having a common EHR scheduler available to both the county MHP and contract providers, the Access Unit is limited in its ability to determine the capacity of contract providers due to a labor and time intensive process used to identify "capacity" at any given point in time. To improve access may require further brainstorming to develop mechanisms to further improve referral and scheduling of appointments.

- The MHP has not yet implemented Medicare production billing, which is resulting in the MHP not being able to receive this Medicare reimbursement funding source.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar CWS	EHR	Netsmart Technologies	4	MHP/Netsmart Technologies
Avatar PM	EHR	Netsmart Technologies	6	MHP/Netsmart Technologies
Infoscriber/Order Connect	e-Prescribing	Netsmart Technologies	4	MHP/Netsmart Technologies

PLANS FOR INFORMATION SYSTEMS CHANGE

- There are no plans to replace the current Avatar system. The MHP is in the sixth year of a multi-year implementation. The project completion date remains 2016.
- The Avatar functionalities to be implemented in the next year are Electronic Lab Orders (e-lab) and Provider Integration.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Avatar CWS (Netsmart)	X			
Clinical decision support					X
Document imaging	Netsmart	X			

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Electronic signature—client	Topaz	X			
Electronic signature—provider	Topaz	X			
Laboratory results (eLab)				X	
Outcomes	CANS		X		
Prescriptions (eRx)	Netsmart	X			
Progress notes	Avatar CWS (Netsmart)	X			
Treatment plans	Avatar CWS (Netsmart)	X			
Summary Totals for EHR Functionality		7	1	2	

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- As described in "Other Significant Issues" above, the centralized Access Team and SR policies and procedures continue to be developed and fine-tuned as required in this early stage of implementation.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP has successfully implemented the electronic SR, however the process remains complex: 1) electronic referral of consumers from Access to contract providers; 2) need for providers to determine whether they have open slots and that consumers can benefit from their programs; and 3) need for providers to send SRs back to Access for approval prior to providers' scheduling appointments; all create backlogs in scheduling appointments. The MHP indicated their intent to streamline the SR process to eliminate these multiple steps by November, 2015.
  - The current Access/SR "access point" does not allow for "walk-ins". There are some service locations where direct "walk-in" services are provided, but these are limited and the MHP is working to increase this component.
  - The MHP has implemented Geo-mapping/Geographic Information System (GIS) functionality that can map provider and enrollee locations. The MHP is currently testing this functionality through developing draft reports of different programs' enrollee and provider distributions.
  - The MHP does not monitor productivity standards as over 91% of the provider network is contractors.

- Timeliness of Services
  - The first two findings enumerated in "Access to Care" above may negatively impact timeliness.
  - Implementation of "Mobil Crisis Go Live" and improved workflow for in-patient doctors to complete treatment plans may increase timeliness of services.
  - The MHP would like to implement a data element in the SR/Avatar EHR for first offered appointment.
- Quality of Care
  - Implementation of "Mobil Crisis Go Live" and improved workflow for in-patient doctors related to completion of treatment plans may increase coordination of care.
  - The MHP has fully implemented Katie A. in their EHR. County CPS provides regular data reports on all "open" child welfare cases via Business Objects query of the county's Child Welfare System (CWS)/County Management System (CMS) relational database.
  - The Avatar EHR includes the language in which services are provided.
  - The MHP has not as yet developed manual or electronic data sharing with managed care plans or primary care providers for consumers who need "mild" or "moderate" services.
  - The Avatar CWS continues to provide the MHP with robust management report production capabilities. The MHP produces many annual, semi-annual or quarterly reports which include quality data including the: i) MHP's Annual Dashboard Summary Report; ii) the Child and Adolescent Needs and Strengths (CANS) Annual Report; iii) the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan, and many other reports.
- Consumer Outcomes
  - The MHP was previously considering implementing the Level of Care Utilization System (LOCUS), (used for intensive placement teams), for all adults. Various tools are also used for Full Service Partnership (FSP) adults. However, the MHP has not yet implemented a universal level of care/level of service/consumer outcome tool for adults. The MHP is weighing the advantages and disadvantages of various adult tools, weighing issues of simplicity versus complexity, the specific purposes of each tool (e.g., level of care determination versus consumer functioning/outcome reporting), and interoperability with contract providers who use many different adult tools.
  - The MHP produces the Annual CANS Report.
  - The MHP includes analysis of Consumer Perception Survey data in the Annual Dashboard Summary Report.

- The Draft MHSA FY14-15 – 16-17 Three-Year Program and Expenditure Plan posted for public review and comment includes outcome data for FSP consumers on: i) mental health emergency room (ER) visits; ii) number of hospitalizations and total hospital days; iii) physical health ER visits; iv) homeless occurrences and total homeless days; v) arrests, jail occurrences and incarcerations; and vi) FSP consumers employed; and vii) FSP consumers with primary care physicians.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers or conditions that significantly affected CalEQRO's ability to prepare for and/or to conduct this review.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP has successfully implemented the electronic Access SR form and has merged the Children's and Adult Access Teams into a single centralized Access Unit.
  - The Triage/Navigator program is being established to provide crisis intervention, system navigation, peer support and linkages to individuals experiencing a crisis at the county's 9 hospital emergency rooms (ERs), the main jail and other crisis settings.
  - The MHP is establishing four Community Care Teams (CCTs) within the four Regional Service Teams (RST's) to engage clients after Access Unit authorization until the client's first appointment.
  - The MHP has expanded FSPs for all ages, implemented two mobile crisis teams with law enforcement, and has aggressive plans to implement additional crisis residential programs in the next year.
  - For the purpose of facilitating access to services, the MHP has implemented the Commercially Sexually Exploited Children (CSEC) Steering Committee and is increasing outreach to the newly arriving refugee populations from the Middle East, primarily from Iraq, Iran and Afghanistan.
  - The MHP has included in the new Transition Age Youth (TAY) FSP and in some other MHP programs a component to reach lesbian, gay, bi-sexual, transgender and questioning (LGBTQ) consumers.
- Opportunities:
  - The Affordable Care Act resulted in increased demands for services. This expanded benefit creates new opportunities for collaboration between the Mental Health Plan and four Geographic Managed Care (GMC) Plans.

- The centralized Access Unit has historically provided great single-point of access to a large geographical area via phone and fax referrals, allowing the MHP to authorize access to care. The new centralized Access Unit based on electronic SRs maintains this single point of access. However the many steps currently involved in transmission and approval of SRs, poses challenges for the MHP to develop sufficient points for direct access to ensure that all clients who request a service are scheduled for an initial service.
- The Access Unit currently includes approximately 14 clinical and 7 support staff. This staffing is 50% below Access Unit staffing in 2009. Staffing comparable to earlier years and to current beneficiary enrollment level may be necessary to fairly support the capacity of the Access Unit.

Timeliness of Services

- Strengths:
  - The MHP stated that it will begin reporting "No Show" and Cancellation rates starting with the first Quarterly Timeliness (Benchmark) report that covers July 2015- September 2015. This "No Shows" data point has been difficult for the MHP to collect due to variable and inconsistent practices among its providers
  - The MHP has developed multiple systems intended to increase engagement and timeliness of services. These include: 1) "Mobile Crisis Go Live; 2) planned for implementation of Triage/Peer Navigator Teams; and 3) Community Care Teams (CCT's).
- Opportunities:
  - The MHP stated that it will begin reporting "No Show" and Cancellation rates starting with the first Quarterly Timeliness (Benchmark) report that covers July 2015- September 2015. This "No Shows" data point has been difficult for the MHP to collect due to variable and inconsistent practices among its providers.
  - The MHP intends to develop a way to track the date of first offered appointment utilizing the EHR.
  - Timeliness is greatly impacted by the fact that the four Medi-Cal GMC Plans and PCPs/FQHSs currently have limited capacity to serve consumers with "mild" to "moderate" mental health impairments.

Quality of Care

- Strengths:
  - Avatar and the Research and Evaluation Unit provides the MHP with robust clinical and management reports which include many quality indicators.
  - The MHP completed a Non-Clinical PIP on Katie A. which showed measurable improvement in collaboration between Mental Health (MH) and Child Protective

Services. This increased collaboration between MH and CPS resulted in plans to incorporate this into their ongoing business practices.

- The MHP uses deferred diagnoses sparingly compared to statewide, a good practice toward providing appropriate care.

- Opportunities:
  - The Affordable Care Act resulted in increased demands for services. This expanded benefit creates new opportunities for collaboration between the Mental Health Plan and four Geographic Managed Care (GMC) Plans.
  - The MHP does not have a standard for re-hospitalizations within 30 days.

Consumer Outcomes

- Strengths:
  - The MHP continues to monitor and conduct in-depth analyses of their re-hospitalization rates.
  - The MHP has a Consumer/Family Member employees at several levels of the organization and Consumer/Family Members report being offered opportunities for volunteer positions within the MHP.
- Opportunities:
  - The MHP has not yet selected a universal adult consumer outcome tool.

RECOMMENDATIONS

- Investigate communication and collaboration with Geographic Managed Care's (GMC's) to serve Medi-Cal consumers with "mild" to "moderate" mental health impairments, as well as receive referrals from them of "seriously mentally ill" (SMI) beneficiaries.
- Implement Medicare Part B production billing as soon as practical.
- Explore ways to implement flexibility in the centralized Access Unit function and staffing to improve access and timeliness.
- Explore further opportunities to improve access and timeliness, such as mobile crisis teams to support local law enforcement, peer navigator program to improve linkage with hospital and outpatient services, and Community Care Teams (CCT's) to support the four regional service support teams.
- Complete implementation of the full spectrum of timeliness data elements including tracking "No Shows" and cancellations, tracking time to urgent services, and tracking time of first offered appointment.

ATTACHMENT A—REVIEW AGENDA

Click on the text below to open the MHP On-Site Review Agenda:

Sacramento County
MHP CalEQRO Agenda

Unless otherwise indicated, all conference rooms are located at MHP Main office at 7001A East Parkway, Sacramento, CA 95823

Day 1 August 4, 2015

Time	Activity Please note location of sessions
8:30 am – 9:00 am	**Opening Session** • Introduction to BHC • MHP Team Introductions **Participants:** MHP Leadership, Quality Management Staff, Key Stakeholders **BHC EQRO Participants:** Lynda Hutchens, Bill Ullom, Richard Hildebrand, Walter Shwe **Location: Room 1 (Large room outside locked double doors)**
9:00 am- 10:30am	**Review of Past Year** • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • Use of Data in the Past Year **Participants:** MHP Leadership, Quality Management Staff, Cultural Competence Staff, Key Stakeholders **BHC EQRO Participants:** Lynda Hutchens, Bill Ullom, Richard Hildebrand, Walter Shwe **Location: Room 1**
10:30am – 10:45am	**Break**
10:45 am – 12:00 pm	**Quality Management Activities** • Quality, Access, Timeliness, Outcomes **Participants:** Lisa Sabillo, Dawn Williams, Rolanda Reed, Alex Rechs, Pam Gardner, Mary Nakamura **BHC EQRO Participants:** Lynda Hutchens, Bill Ullom, Richard Hildebrand, Walter Shwe **Location: Room 301**

Sacramento 3 day EQRO Agenda Final_7-29-15_LH

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT, Lead Quality Reviewer - lynda.hutchens@bhceqro.com
Bill Ullom, Chief Information Systems Reviewer - bill.ullom@bhceqro.com
Richard Hildebrand, Information Systems Reviewer - richard.hildebrand@bhceqro.com
Walter Shwe – Consumer/Family Member Consultant

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

Sites of MHP Review

MHP SITES

7001A East parkway, Sacramento, CA 95823

CONTRACT PROVIDER SITES

HRC TCORE, 3737 Marconi Avenue, Sacramento, CA 95821

Participants Representing the MHP

Name	Position	Agency
Adrea Crook	Client Advocate	NorCal MHA
Adrienne Williams	MHC	BHS – Children
Alex Rechs	Program Coordinator	BHS
Amanda Divine	Clinical Director	El Hogar
Andrea Maestas	Youth Advocate	Mental Health of America
Angela Chalmers	Senior Admin Analyst	BHS – Admin
Ann Mitchell	ASOIII	DHHS
Anthony Madariaga	Executive Director MHTC	BHS
Barb Hale	Lead Service Coordinator	El Hogar Regional Spt. Team
Barbara Oleachea	Program Planner	Child Protective Services
Blia Cha	Adult Family Advocate Liaison	BHS/ NorCal MHA
Carol Wallace	CPM & Clinical Supervisor	Stanford Youth Solutions

Caroline Bentley	Senior MH Consultant	ACCESS
Christine Baker	Program Coordinator	BHS
Cindy Yang	SOA	BHS/QM
Dawn Williams	Program Manager	BHS – REPO
Dr. Sherri Heller	Director	DHHS
Elaina Garrido	Team Leader	HR Consultants
Iris Johnson	Admin Services Officer	BHS
Jane Ann LeBlanc	Health Program Manager	BHS
Jennifer Benson	CPM	River Oak
Judi Kiestzman	Senior MH Counselor	County MH
Kacey Vencill	Program Manager	BHS
Karen Brockopp	Assoc. Director for Program Services	TLCS
Karisa Hyppolite	Program Planner	BHS
Kathy Burlingame	MH Program Coordinator	ACCESS
Kelli Weaver	Health Program Manager	BHS
Lakshmi Malroutu	COO	APCC
Laura Heintz	CEO	Standford Youth Solutions
Lisa Harmon	Program Planner	BHS
Lisa Sabillo	Division Manager	BHS
Lynn Place	Executive Director	HR Consultant TCORE
Magdalena Mustafa	Clinician – Therapist	River Oak Ctr for Children
Mai Thor	Peer Partner	HWHA
Marlyn Sepulveda	Program Director	TLCS – TCORE
Mary Nakamura	Program Planer – Acting for Health Plan Mgr JoAnn Johnson	BHS
Matt Quinley	Health Program Manager	BHS
Melissa Jacobs	Health Program Manager	BHS
Michael Lazar	Executive Director	TLCS
Michele Omelas-Knight	Clinical Supervisor/Assoc. Director	UCD CAARE

Michelle Callejas	Deputy Director	Child Protective Services
Michelle Schuhmann	Program Planner	BHS
Molly McGurk, LCSW	Senior MH Counselor/Early Intervention	HUK, Cty CH
Nerkesia Swanjan	Lead Therapist	Stanford Youth Solutions
Nicole Cable	Program Coordinator	BHS/QM
Pamela Gardner	Program Coordinator	BHS/QM
Pangcha Vang	Peer Partner	APCC
Rachel Rios	Executive Director	LaFamilia Counseling Center
Rob Kesselring	Program Coordinator	BHS
Rolanda Reed	Program Coordinator/QM	BHS
Ronit Aviv, LMFT	MH Therapist	UCD CAARE Center
Sandena Bader	Youth & Family Liaison	NorCal MHA
Sarah Boyett	Clinician – Therapist	TCORE/HRC
Shannon Taylor	Administrator	Telecare Corp SOAR
Sheila Brush	Program Planner	BHS/REPO
Sheri Reynolds	Program Coordinator	APSS Stockton (Sac Cty)
Sue Chow	Clinical Supervisor	APCC – TWC
Tricia Watters	Program Coordinator	DHHS – BHS –CAPS
Uma Zykofsky	County BH Director	BHS
Zang Fang	Community Support Coordinator	CST

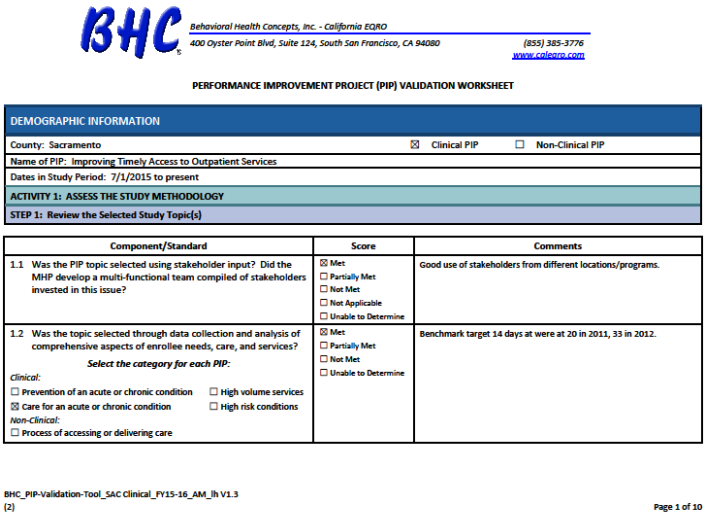
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Click on the text below to open the PIP Validation Tools:

Clinical PIP:



Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

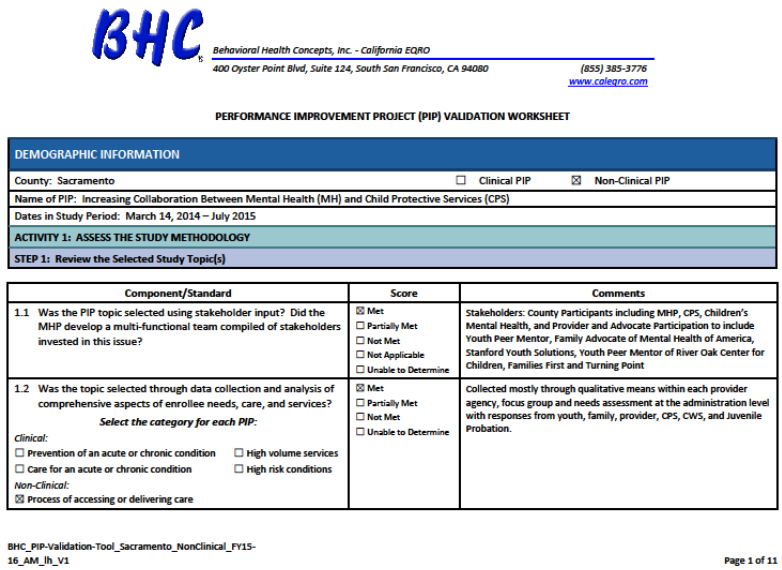
DEMOGRAPHIC INFORMATION		
County: Sacramento	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Improving Timely Access to Outpatient Services		
Dates in Study Period: 7/1/2015 to present		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Good use of stakeholders from different locations/programs.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☐ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Benchmark target 14 days at were at 20 in 2011, 33 in 2012.

BHC_PIP-Validation-Tool_SAC Clinical_FY15-16_AM_lh V1.3 (2)

Page 1 of 10

Non-Clinical PIP:



Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Sacramento	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Increasing Collaboration Between Mental Health (MH) and Child Protective Services (CPS)		
Dates in Study Period: March 14, 2014 – July 2015		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Stakeholders: County Participants including MHP, CPS, Children's Mental Health, and Provider and Advocate Participation to include Youth Peer Mentor, Family Advocate of Mental Health of America, Stanford Youth Solutions, Youth Peer Mentor of River Oak Center for Children, Families First and Turning Point
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Collected mostly through qualitative means within each provider agency, focus group and needs assessment at the administration level with responses from youth, family, provider, CPS, CWS, and Juvenile Probation.

BHC_PIP-Validation-Tool_Sacramento_NonClinical_FY15-16_AM_lh_V1

Page 1 of 11