FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Sacramento

Conducted on

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TABLE OF CONTENTS

INTRODUCTION **5**

PRIOR YEAR REVIEW FINDINGS, FY13-14 ..... **9**

STATUS OF FY13-14 REVIEW RECOMMENDATIONS 9
Assignment of Ratings *9*
Key Recommendations from FY13-14 ..... *9*
CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS 11

PERFORMANCE MEASUREMENT **13**

TOTAL BENEFICIARIES SERVED 13
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY 14
HIGH-COST BENEFICIARIES 17
THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED 17
TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE 18
DIAGNOSTIC CATEGORIES 19
PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS 20

PERFORMANCE IMPROVEMENT PROJECT VALIDATION **21**

SACRAMENTO MHP PIPS IDENTIFIED FOR VALIDATION 21
CLINICAL PIP—CHANGING THE CULTURE OF MENTAL HEALTH TO INCREASE COORDINATION WITH PRIMARY CARE 24
NON-CLINICAL PIP—INCREASING COLLABORATION BETWEEN MENTAL HEALTH AND CHILD PROTECTIVE SERVICES 25
PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS 26
PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS 26
Access to Care *27*
Timeliness of Services *28*
Quality of Care *29*
KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS 31

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S) **33**

CONSUMER/FAMILY MEMBER FOCUS GROUP 1 33
CONSUMER/FAMILY MEMBER FOCUS GROUP 2 34
CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS 35

INFORMATION SYSTEMS REVIEW **37**

KEY ISCA INFORMATION PROVIDED BY THE MHP 37
CURRENT OPERATIONS 38
MAJOR CHANGES SINCE LAST YEAR 38
PRIORITIES FOR THE COMING YEAR 39
OTHER SIGNIFICANT ISSUES 39
PLANS FOR INFORMATION SYSTEMS CHANGE 40
ELECTRONIC HEALTH RECORD STATUS 40
INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS 41
Findings *41*

SITE REVIEW PROCESS BARRIERS **43**

CONCLUSIONS **45**

STRENGTHS AND OPPORTUNITIES 45
Access to Care *45*
Timeliness of Services *45*
Quality of Care *46*
Consumer Outcomes *46*
RECOMMENDATIONS 47

ATTACHMENTS 49

ATTACHMENT A—REVIEW AGENDA 51
ATTACHMENT B—REVIEW PARTICIPANTS 55
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA 61
ATTACHMENT D—PIP VALIDATION TOOL 65

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 Independent 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 CY13—19,746
  - MHP Size—Large
  - MHP Region—Central
  - MHP Threshold Languages—Spanish, Cantonese, Hmong, Russian, Vietnamese
  - MHP Location—Sacramento

This report presents the fiscal year 2014-2015 (FY 14-15) 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 PM rates.

(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 one 90-minute focus group 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.

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[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, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 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 FY13-14

- Recommendation #1: Conduct an analysis that determines the actual capacity of the current system to serve beneficiaries, particularly in the adult system which is severely impacted. Identify true staffing needs that can help inform the stakeholder processes that will drive decisions for additional MHSA funds.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP analyzed and reported services data on access, engagement and timeliness to the MHSA Steering Committee that resulted in focusing on expansion of Community Services and Supports (CSS) component of MHSA. The MHP presented all data reports demonstrating thorough analysis of service capacity and access.
  - The CSS expansion focus is on improving access and timeliness of services.

  - A three phase planning process is currently underway – Adult Outpatient Regional Support Teams, Full Service Partnerships, other system priorities. The first phase has been completed and the second phase is underway.

- Recommendation #2: Begin an initiative to improve timely access to services system-wide, given long wait times (some of the longest wait times in the state). This may require adapting models for existing service access – separating more urgent requests from routine – and other aspects of service provision and level of care adjustments for long-term consumers.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP produces timeliness benchmark reports quarterly. The FY 13-14 benchmark reports continue to show that the average first face-to-face appointments was longer than 28 calendar days for most of CY13-14.
  - The MHP will be adding 21 triage/navigators at key access points to improve timely access to services (See response to Recommendation #5 for details).
  - The MHP will be adding Mobile Crisis Support Teams in partnership with the police and sheriff's department to provide immediate response to individuals experiencing psychiatric emergencies.
  - The MHP is in the process of establishing a Memorandum of Understanding (MOU) with all Geographic Managed Care plans in the county to enhance services to individuals in need of behavioral health services. Both sides are committed to ensuring services are timely and seamless.
  - Further tracking is needed to assess the effectiveness of these and other efforts to improve timeliness throughout the system.

- Recommendation #3: Evaluate the feasibility of using electronic assessment forms for TARs to automate the process between contract providers and Access Team to improve processing time and eliminate paper-processing errors.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - Access Team internal business processes to accomplish a paperless system were identified in preparation for the design and implementation of the electronic service request (SR).
  - Access Teams went live with the electronic SR in October 2014. Contract providers were then trained on the new process prior to their implementation.
  - Policies and procedures continue to be developed and fine-tuned as required in this early stage of the electronic SR implementation.

- Recommendation #4: Investigate the feasibility to implement Netsmart Technologies CareConnect application earlier than currently planned in order to reduce or eliminate the need for double data entry by some contract providers.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

- Netsmart Technologies Care Connect does not currently meet the County's needs for health information exchange (HIE). Provider Integration is an IS priority for the coming year and the MHP is working with Netsmart on the development of a satisfactory product.

- Recommendation #5: Examine the system's ability to provide urgent services. Develop a comprehensive plan so that consumers' urgent needs can be met at the clinic sites rather than hospital emergency rooms.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP received two grants under SB 82 , Investment in Mental Health Wellness Act to improve urgent care and emergency service access:
  - Mental Health Oversight and Accountability Commission (MHSOAC) grant - The MHP will be adding 21 triage/navigators at key access points to improve timely access to services. These access points include the County Jail, designated locations to serve the homeless population, the hospital emergency departments and the Intake and Stabilization Unit. The objective of this program is to help address gaps and better meet the needs of individuals experiencing a mental health crisis, while reducing unnecessary emergency room visits, psychiatric hospitalization and incarceration.
  - The California Health Facilities Financing Authority (CHFFA) grant - The MHP will be adding two Mobile Crisis Support Teams (MCST) in partnership with the Sacramento Police Department and Sacramento County Sheriff's Department. The teams are designed to provide immediate response to individuals experiencing a psychiatric emergency and linking them to appropriate supports.
- Additionally, under MHSA funding for Innovation projects, Sacramento has funded the Respite Partnership Collaborative which added two programs in 2013:
  - TLCS Crisis Respite Center, a 24/7 crisis center for those experiencing a mental health crisis but not to the degree of need needing hospitalization.
  - St John's Shelter for 'Women and Children which provides brief respite (up to 30 days) for women and children in a mental health crisis.

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 taken several steps to improve its Crisis and Urgent Care access and response system:
    - Triage/Navigator staff at key access points
    - Two Mobile Crisis Support Teams
    - Two new Respite Partnership Collaborative programs
  - The paperless electronic service request system went live in October 2014 which will facilitate contract providers' treatment authorization requests throughout the system.
- Timeliness of Services
  - The MHP is tracking and trending timeliness of first face-to-face appointments.
  - FY 2013-14 timeliness data show the need to undertake performance improvement projects in this regard.
- Quality of Care
  - Mental Health for Crisis Responder Training continues to provide training for Sacramento Sheriff's Department. Since January 2014, trainers have conducted 20 Advanced Officer Trainings (AOT).
  - Screening, Assessment, and Brief Treatment Program, part of the Prevention and Early Intervention (PEI) Integrated Health and Wellness Project funds five Federally Qualified Health Care Centers to integrate medical and behavioral health services in a community health care setting.
  - The MHP has been offering Katie A. services to families since December 2013. Beginning January 2014 MH began working with CPS to pilot a screening tool to be used for CPS referrals to MH. The screening tool was implemented by CPS on July 1, 2014.
- Consumer Outcomes
  - The MHP mandates Child and Adolescent Strengths and Needs (CANS) for all children and youth services. Provider staff uses the CANs for clinical decision making. The MHP produces an annual report that uses the CANs data to look at system wide outcomes.

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 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, 2015.

TOTAL BENEFICIARIES SERVED

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

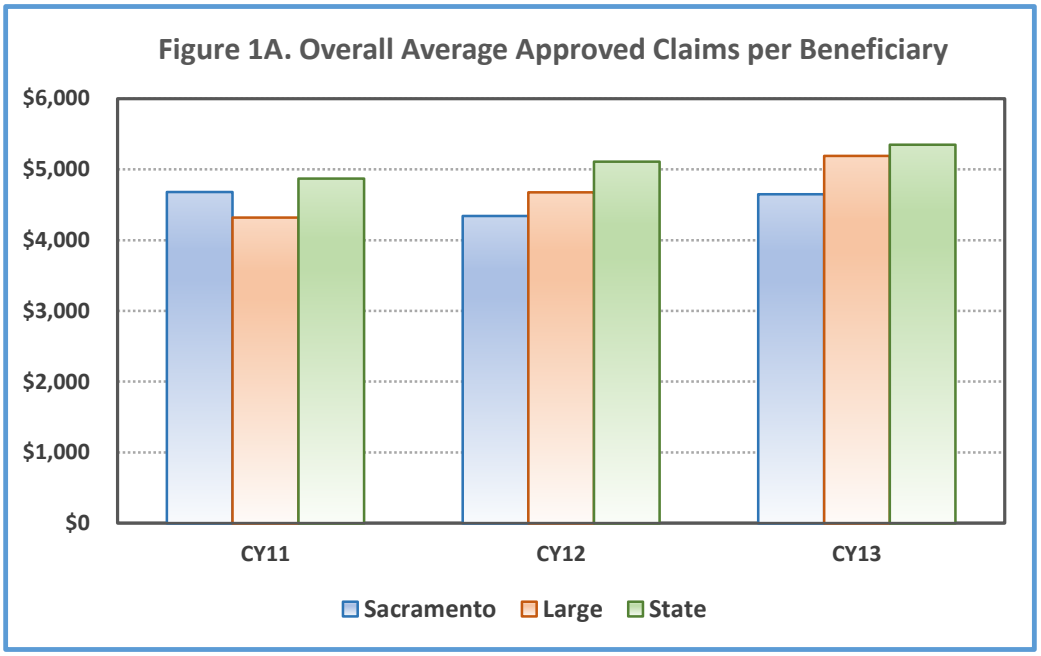
Table 1—Sacramento MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

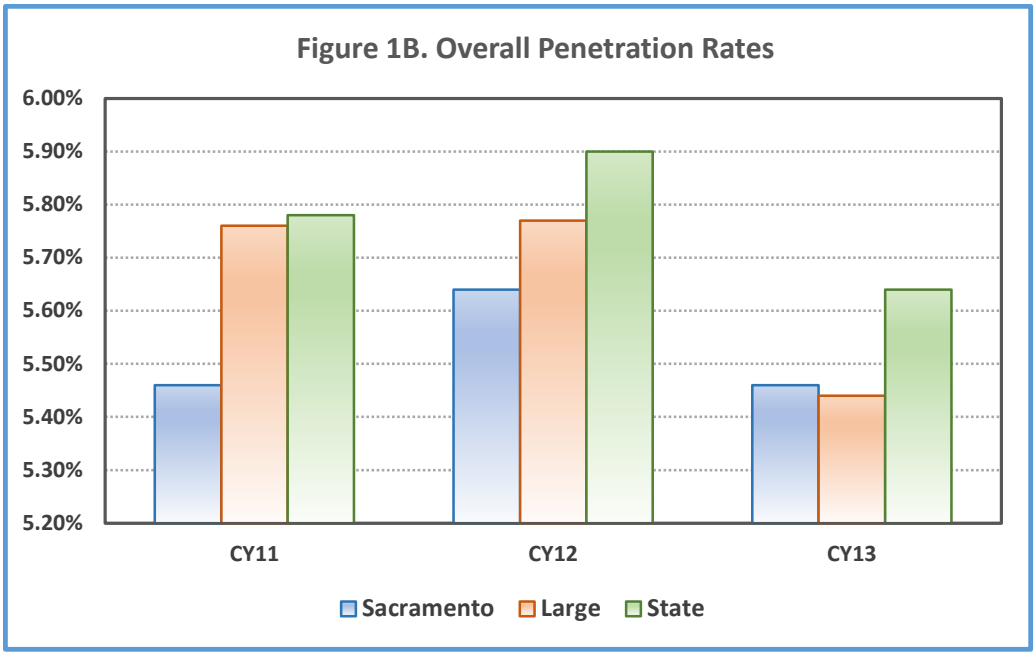
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	94,656	7,303
Hispanic	88,108	3,432
African-American	65,361	4,911
Asian/Pacific Islander	55,771	1,414
Native American	3,060	219
Other	54,693	2,467
Total	361,646	19,746

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

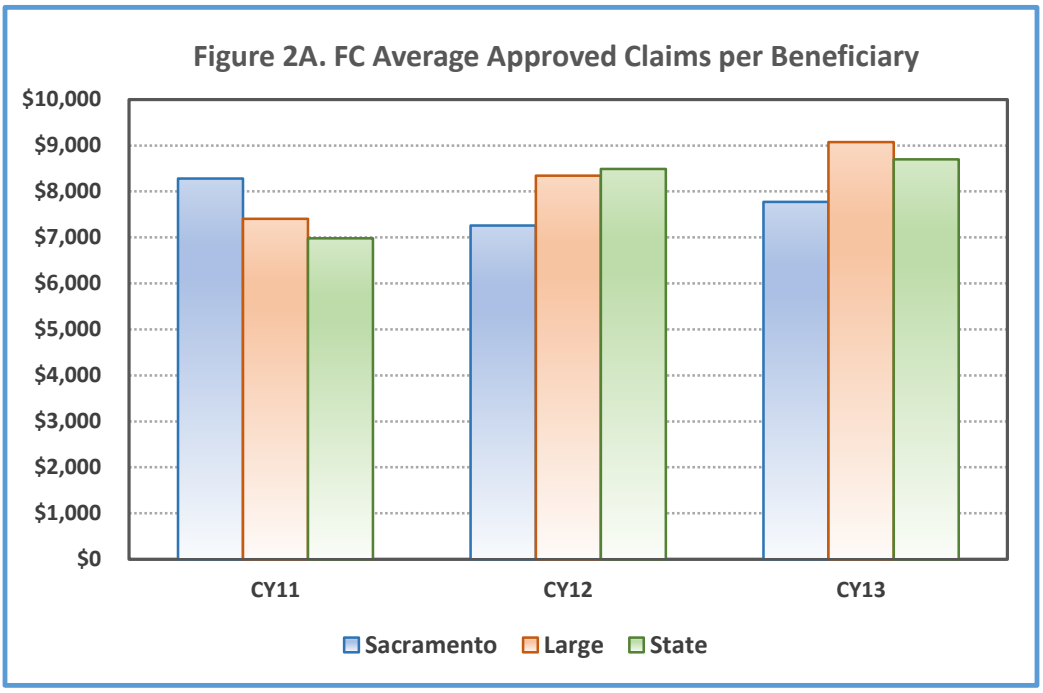
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

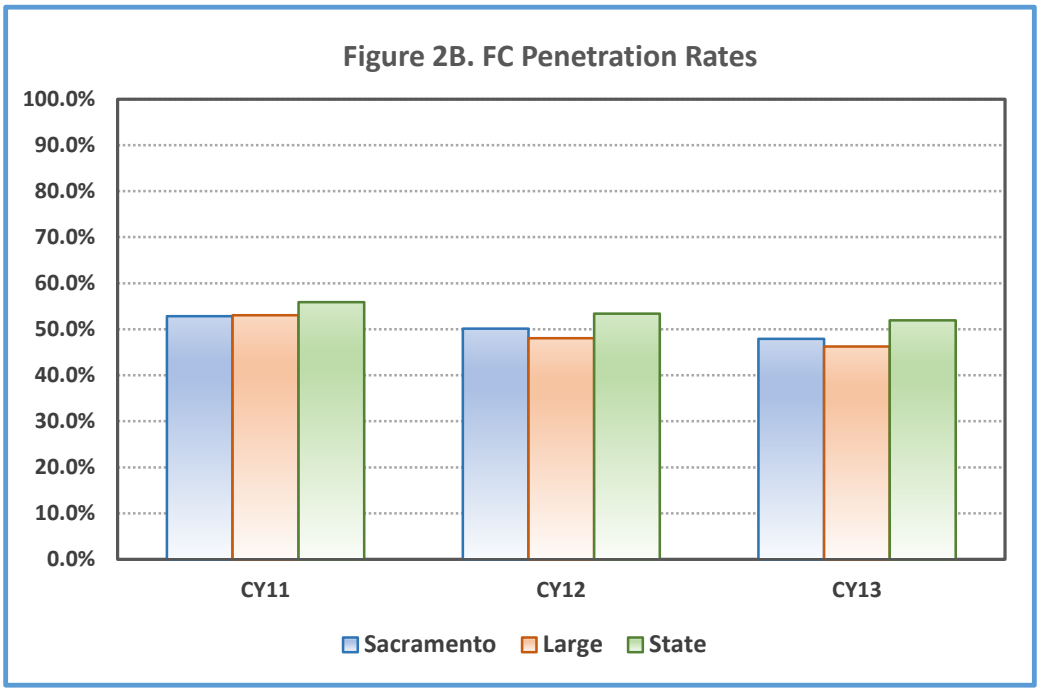
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



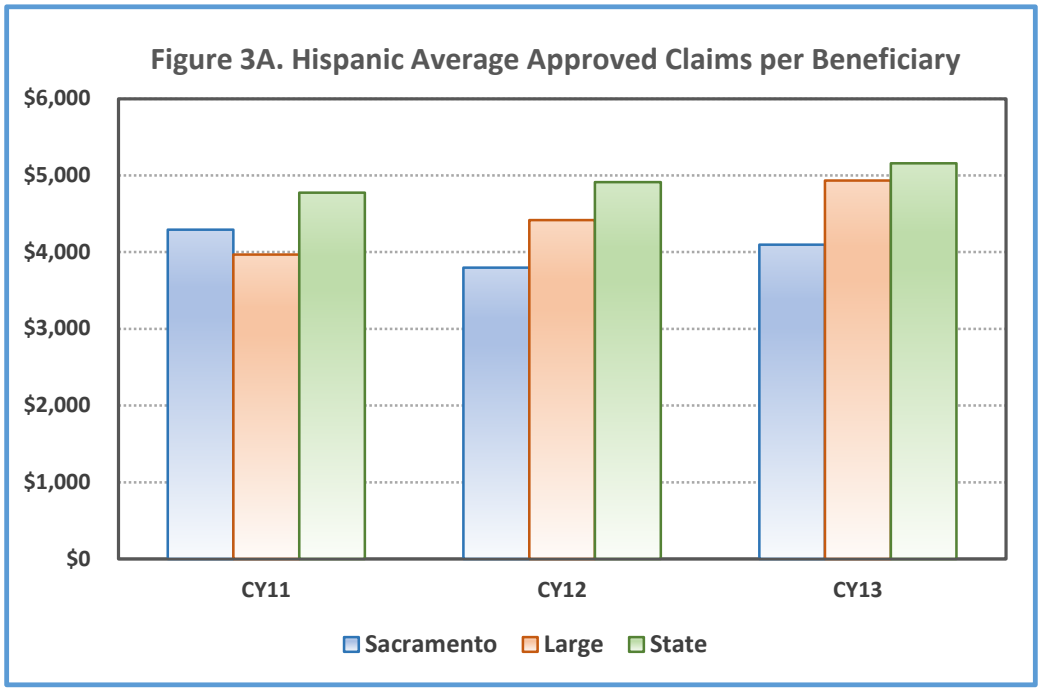


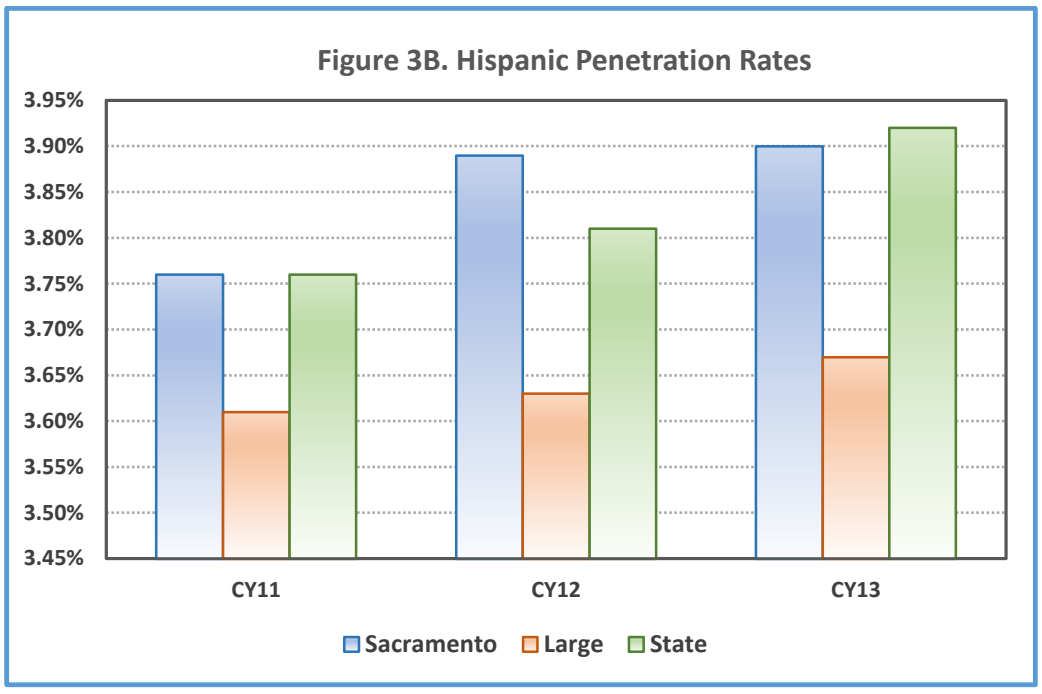
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





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 CY13 with the MHP's data for CY13, 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 Number	Total Beneficiaries	% of Total	Average per HCB	HCB Total Claims	% of Total Claims
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Sacramento	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%
	CY11	296	18,029	1.64%	$45,382	$13,433,180	15.84%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

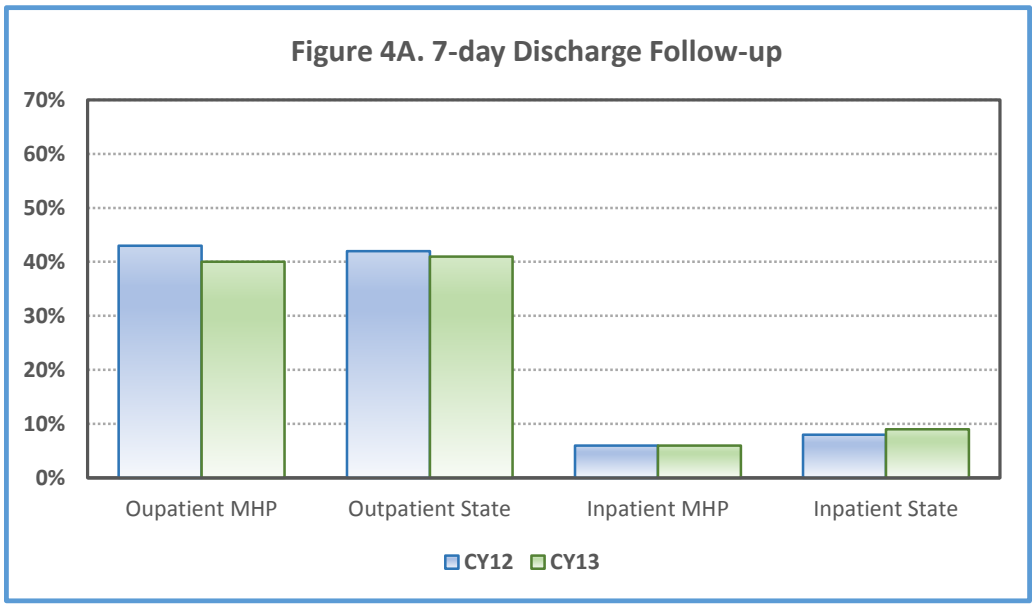
Table 3 compares the CY13 statewide data for TBS client count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

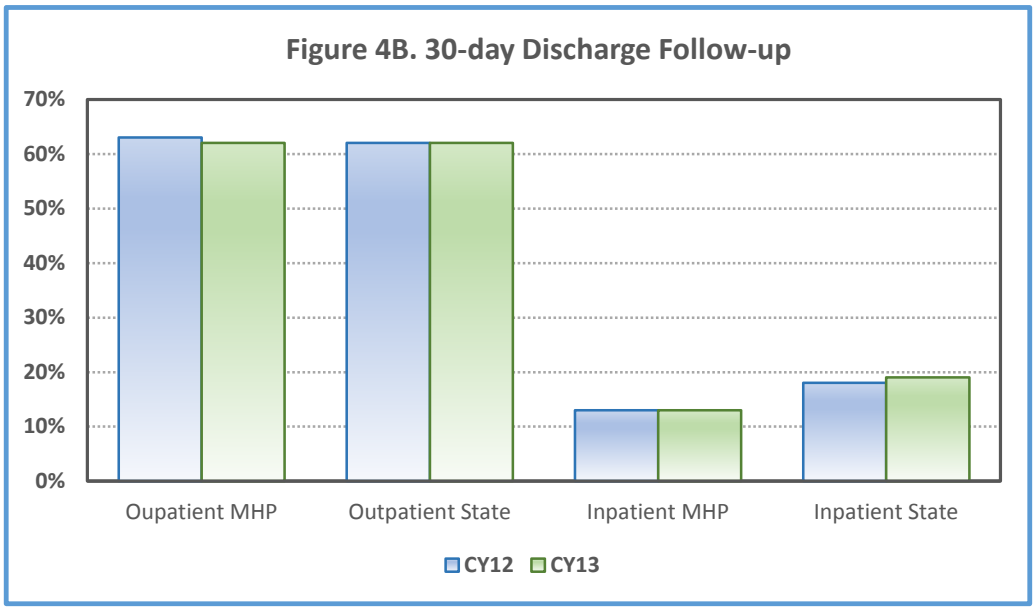
Table 3—TBS Client Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Client Count	TBS Client Count	TBS Penetration Rate
Sacramento	Yes	10,181	319	3.13%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

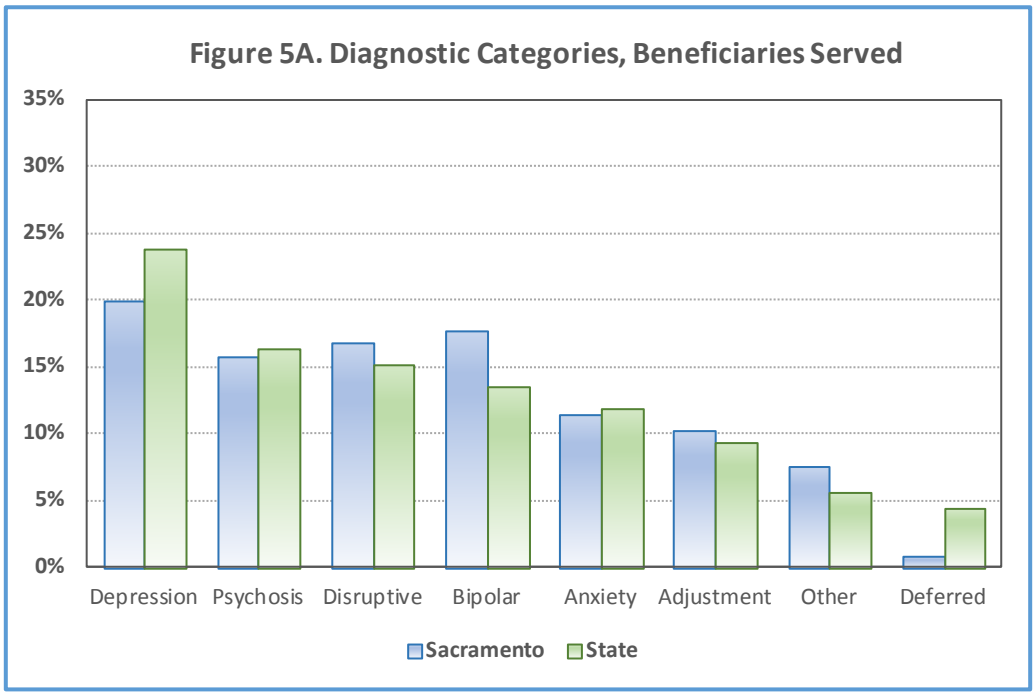
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

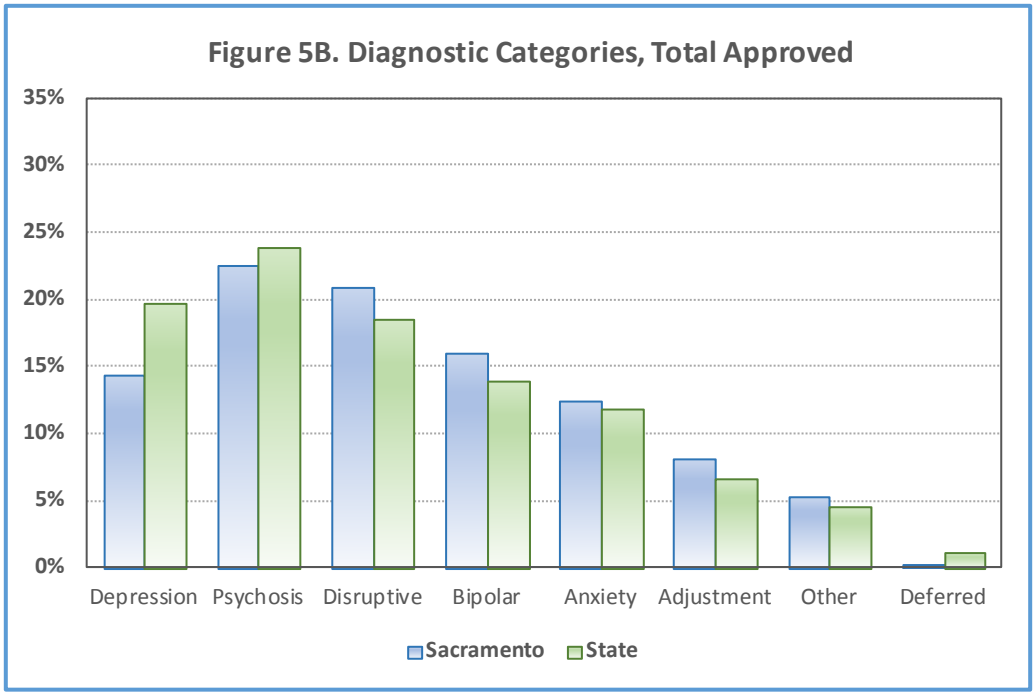




DIAGNOSTIC CATEGORIES

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 CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate is similar to the large MHP average and slightly lower than the statewide penetration rate.
  - The MHP's foster care penetration rate is very similar the large MHP and statewide averages.
  - The MHP's Hispanic penetration rate is similar to the statewide rate and slightly higher than the large MHP average.
- Timeliness of Services
  - The MHP's 7 and 30-day outpatient follow-up rates after psychiatric inpatient discharge are very similar to the statewide rate.
  - The MHP's 7 and 30 day inpatient recidivism rates are slightly lower than the statewide rate.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are both significantly lower than statewide.
  - The MHP's overall, foster care and Hispanic average approved claims per beneficiary are all lower than the corresponding averages for large MHPs and statewide.
  - The MHP's distribution of diagnostic categories is very similar to the statewide distribution. The MHP has a slightly higher percentage of bipolar disorder diagnosis than statewide and slightly lower percentage of depressive disorder diagnosis that statewide.
  - The MHP has very few individuals with deferred diagnoses compared to statewide. This is a good practice for appropriate care delivery.
- Consumer Outcomes
  - None noted.

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 2013.

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	Changing the culture of Mental Health to increase coordination with Primary Care. Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	Increasing Collaboration Between Mental Health (MH) and Child Protective Services (CPS). Onsite technical assistance was provided to identify future PIP topics.

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	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	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	PM	M
		6.4	Plan for consistent and accurate data collection	M	PM
		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	M	NA
		7.2	Interim data triggering modifications as needed	NM	NA
		7.3	Data presented in adherence to the plan	M	NA
		7.4	Initial and repeat measurements, statistical significance, threats to validity	M	NA
		7.5	Interpretation of results and follow-up	M	NA

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	M	NA
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	M	NA
		8.3	Threats to comparability, internal and external validity	M	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	PM	NA
		9.3	Improvement in performance linked to the PIP	M	NA
		9.4	Statistical evidence of true improvement	M	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NM	NA

**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	24	15
Number Partially Met	4	1
Number Not Met	2	1
Number Applicable	30	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	86.66%	97%

CLINICAL PIP—CHANGING THE CULTURE OF MENTAL HEALTH TO INCREASE COORDINATION WITH PRIMARY CARE

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

- "Will implementation of staff training on physical health issues, wellness groups for clients and establishment of collaboration with a primary health care provider result in increased coordination of care, leading to improved primary care access and treatment for mental health clients?"
- Date PIP began: October, 2012
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

This PIP had originally started as a project to improve documentation of physical health status and primary care physician identification in mental health records. Over time as it became clear that both staff and consumers had difficulties discussing physical health issues and often lacked knowledge to properly record the necessary health information, the project evolved to improve collaboration with primary care providers through staff training and wellness groups for consumers.

The PIP included the Regional Service Team staff and consumers who account for approximately 50% of adult non-residential beneficiaries served in the system. At the end of the PIP, while there were positive movements in all indicators, statistically significant improvements were found in consumer awareness of their physical health issues and staff roles in getting physical healthcare needs met. The PIP committee staff stated that improvements across more domains will be a longer term process.

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 assessing longer term impact of the project with a select cohort over time and with further positive evidence, expansion of the interventions system wide in the adult system of care.

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

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

- "Does applying a standard set of expectations 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

  ☐ No PIP submitted

This PIP arose from the statewide Katie-A court settlement requirements to provide better coordinated and specific modality of services in conjunction with the county social services department to foster care children belonging to the Katie-A class and sub-class. The MHP determined that standardizing the expectations and procedures for coordinating with the Child Protective Services is needed in order to provide Katie-A mandated Intensive Care Coordination (ICC) services and developing Child and Family Teams (CFT).

The PIP is limited to the Katie-A sub-class members who are all eligible to receive ICC (n=693 in the first six months of 2014). At the time of the on-site visit, only baseline data had been compiled and presented to EQRO.

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 understanding how to methodologically include the beneficiaries who become eligible for services as the PIP progresses. Currently, the MHP proposes to track the initial cohort over time and collect functional status outcomes using CANS every six months.

The MHP should consider continuing this PIP as the clinical PIP in 2015 since it has extensive individual clinical outcomes tracking mechanism in place.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The adult clinical PIP has not demonstrated any improvement in access to care, either for mental health services or for physical health care services.
  - From the MHP's current strategic initiatives to improve access to services, there are at least two efforts that can be considered for non-clinical PIP development around access and timeliness of services:
    - Tracking the effectiveness of Triage/Navigators in improving timely access from key locations where these new staff will be located.
    - The impact of the electronic Service Request (SR) on timeliness.
- Timeliness of Services
  - See second bullet above under Access.
- Quality of Care
  - The clinical PIP showed statistically significant positive change according to MHP's own analysis presented in the PIP submission in improving mental health staff's role in identifying physical health care needs.
  - The non-clinical PIP had not reached a stage at the time of the review whereby its impact on quality of care for Katie-A subclass members can be determined.
- Consumer Outcomes
  - The clinical PIP showed slight improvement according to the PIP submission documents in all indicators and in qualitative data. However, statistically significant improvement was noted in the PIP documents only in consumer awareness of their physical health care needs.
  - The non-clinical PIP had not reached a stage at the time of the review whereby its impact on Katie-A subclass members' functional outcomes or overall processes can be determined.

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	The MHP has a strong cultural competence unit and the monthly meeting minutes indicate strategy identification and follow-up actions and evaluation. During FY13-14, one such notable effort was the addition of targeted intervention development for refugee mental health including victims of human trafficking. The MHP has five threshold languages in addition to English– Spanish, Chinese (Cantonese), Hmong, Russian and Vietnamese. The MHP website provides all forms and informational materials in all threshold languages.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP measures its capacity extensively and continually. The number of beneficiaries served increased by 9% in the past 3 years. It started producing benchmark reports measuring access, inpatient and crisis aftercare and satisfaction among others. There are new efforts that were put in place in 2014 to improve crisis after care as noted in MHP strategic initiatives. The impact of these initiatives is not fully understood at this time. Over 90% of MHP services are delivered through contract providers making it one of the MHPs with most contracted out services as opposed to county operated services.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP has collaborative efforts with other County and City agencies such as law enforcement, probation, Child Protective Services, schools, as well as with a number of community organizations including faith-based ones, homeless outreach, and those serving refugees.

**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 consistently collects quarterly timeliness data overall, by program, ethnicity and language. The last three quarterly data show significant delay (14 calendar day standard) s in first appointments, especially in the Adult system of care (consistently over 30 days for the last three quarters for which data were available). This is not measured from initial contact. Rather, it is measured from the episode opening time.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP does not track this indicator for children. The Adult system tracking data shows more than two months of wait as opposed to MHP standard of 28 days from first outpatient visit.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP has strategic initiatives to improve timeliness of after care services but does not measure timeliness to crisis services themselves.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP meets its target of psychiatry follow-up of 30 calendar days (20 business days) for more than 70% of the time for adults and more than 80% for children. The first face-to-face other appointments take over 2 weeks against the MHP standard of 1 week.
2E	Tracks and trends data on re-hospitalizations	PC	The latest data submitted was from FY12-13.
2F	Tracks and trends No Shows	NC	The MHP does not track no-shows. On site it stated that they are working on defining No Shows better and how to capture them. In the ISCA, the percentage of missed appointments was listed as 9% by the MHP staff. The IS staff reported tracking no-shows and consumer cancelled appointments.

**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 services. 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 has an integrated Quality Management (QM) and Performance Outcomes structure with a single manager overseeing both QM and Research, Evaluation and Performance Outcomes (REPO) unit that takes the lead in all performance improvement projects, assessing access, timeliness and outcomes.
3B	Data are used to inform management and guide decisions	FC	On site, the MHP presented a number of reports detailing access, timeliness and other performance measures by program, program types and funding sources. These included benchmark reports on timeliness and dashboard reports on critical indicators such as crisis follow-up, hospitalization that are rated by the degree of meeting the MHP established targets.
3C	Evidence of effective communication from MHP administration	FC	Quarterly reports including benchmarks to the providers. Quarterly reports to the program monitors. Annual FSP reports to all providers that includes any changes from baseline, comparison across providers. Annual dashboard report is vetted by management, QIC and CCC. Phase A planning report for Regional Service Teams. Plus the providers can run their own reports off of Avatar including demographics, census, and hospitalization.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Stakeholder engagement during FY 13-14 is evidenced in MHSA CSS planning with the Regional Service Team providers in the 3 phase planning process to improve access and engagement post-crisis episodes.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The non-clinical PIP seeks to enhance collaboration with CPS to properly implement Katie-A. Cultural competency initiative started planning and working in 2014 with community partners to improve refugee mental health.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP uses CANS throughout the Children's system. Other tools are in use for specific populations or specialized treatment programs.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP has incorporated consumer satisfaction and perception of better functioning as critical elements in its dashboard during FY2013-14.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Consumer and family member advocates are employed by the MHP at several levels to plan and guide recovery oriented service delivery system.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	There are three consumer driven advocacy programs one of which is funded through realignment dollars and the other two through MHSA.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - As noted in responses to FY 13-14 EQRO recommendations, the MHP has undertaken a three-phase process to improve access and service engagement through the use of triage/navigator staff located at key access points and two mobile crisis service teams to improve crisis response system.
  - The MHP presented data on beneficiary trends that showed a 9% increase in the number of beneficiaries in the previous 4 years.
    - Contract provider supervisors and clinical line staff focus group participants stated that this has created a negative impact on their service access and frequency.

    - However, the MHP leadership attributed the increase to an effort to improve client flow through a more wellness and recovery oriented system.
  - The MHP assesses its capacity by demographics, location, and specific populations such as foster care children, homeless adults, refugees, and those with law enforcement contacts.

- Timeliness of Services
  - While the MHP tracks timeliness to first appointment on a quarterly basis, the findings demonstrate significant lag in comparison to the MHP standard of 10 business days or 14 calendar days. The lag is particularly acute in the adult system of care.
  - The MHP's first psychiatric appointment after an initial service encounter also lags behind its own standards in the adult system. The MHP does not track this indicator for the children's system.
  - The MHP's hospital discharge follow-up for non-psychiatric encounters averages at 14 days, twice the MHP's own standard of 7 days.

- Quality of Care
  - The MHP has a number of collaborative arrangements with other county agencies and community based organizations.
  - The MHP tracks and addresses its beneficiaries' cultural needs and undertakes strategic initiatives to address specific groups of individuals' needs. During FY2013-14, one such initiative involves addressing the mental health needs of refugees including human trafficking victims.
  - Family advocates and peer partners are employed throughout the system by contract providers.
  - The contract providers' line staff (n=3 of 3 in the focus group) report having less time for actual service delivery due to increased paper work, specifically the service verification forms.

- Consumer Outcomes
  - The MHP collects and utilizes CANS throughout the Children's system of care..
  - The MHP collects and includes consumer satisfaction data among its key elements in the management dashboard.
  - Contract provider staff reports that several other outcomes tools are used specifically for the populations they serve such as How I Think (HIT) for probation youth, UCLA PTSD for TF-CBT screening and Core Elements or Practice Wise for Flexible Integrated Treatment Program (FITP).

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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 a focus group which included the following participant demographics or criteria:

- Hispanic/Latino consumers and family members.
- A mix of high and low utilizers of the system in the previous 12 months.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, 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

This focus group of Hispanic/Latino consumers and family members was held at La Familia and included 5 participants.

This focus group had to be held in two smaller sessions as only two participants had shown up at the time of the review. Three others joined later and all questions had to be repeated for them.

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

- Only 1 participant reported receiving services for themselves or for their family members for less than one year, and that began receiving services in the children's section within 1 week since receiving a referral.

Recommendations arising from this group include:

- Adult education classes at La Familia (n=2)
- Legal services (n=2)
- Activity classes for kids on specific topics such as bullying (n=1)

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		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	1 1 3
Ages of Participants	Under 18 Young Adult (18-24) 25–59 Older Adult (60+)	0 1 3 1
Preferred Languages	English Spanish Bilingual Other	3 2 0 0
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	0 5 0
Gender	Male Female	1 4

Interpreter used for focus group 1: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group of culturally diverse adult consumers was held at Adult Psychiatric Support Services Clinic (APSSC) and included 14 participants.

This focus group had significant positive feedback about services received through the MHP. At least 12 of the 14 participants expressed satisfaction with psychiatrists, case managers, obtaining medication, respect for their culture, linguistic services and the ability to reach someone whenever needed.

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

- Not Applicable – All participants reported receiving services for longer than 1 year. The reported range of the length of service among participants was from 2 to27 years.
- Services were much better than what experienced at private providers (n=3)
- Felt respect for cultural and linguistic needs (at least 2)

Recommendations arising from this group include:

- Job development and career counseling services (n=3)
- Bus fare to Department of Rehabilitation (n=2)
- English as a Second Language (ESL) classes (n=2)
- Provision of primary care physician co-location at MH clinics (n=1)
- Help in getting disability benefits

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		
Number/Type of Participants	Consumer Only	14
	Consumer and Family Member	0
	Family Member	0
Ages of Participants	Under 18	0
	Young Adult (18-24)	0
	25–59	7
	Older Adult (60+)	5
Preferred Languages	English	11
	Spanish	1
	Bilingual	0
	Other	2
Race/Ethnicity	Caucasian/White	7
	Hispanic/Latino	1
	Other	3
Gender	Male	4
	Female	8

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Hmong

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care

  - All participants except one in the first focus group have been receiving services from the MHP and none identified any problems with access to care.

- Timeliness of Services
  - All participants except one in the first focus group have been receiving services from the MHP and none identified any problems with timeliness of services.

- Quality of Care
  - All participants except one in the first focus group have been receiving services from the MHP and none identified any problems with quality of care.

- Consumer Outcomes
  - None identified

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	7.81%
Contract providers	91.79%
Network providers	0.40%
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:

27.6%

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

9%

- 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-show and consumer called and cancelled, staff cancelled/unavailable appointments are not tracked.
- The MHP continues to conduct its own penetration rate analyses based upon Medi-Cal eligibles as well as 200% of the Federal Poverty Level (FPL).

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar information system from Netsmart Technologies in an Application Service Provider (ASP) model. The Practice Management module went live in May 2009 and Avatar Clinician Workstation (CWS) and Infoscriber/Order Connect were implemented in September 2011. The MHP reports having 1,414 Avatar user licenses.
- A large percentage of services are provided by contract providers, 91.79%. County-operated/staffed clinics provide 7.81% of services. Approximately 74% of services are billed to Medi-Cal.
- While some turn over and hiring has occurred, the IS staffing level has remained stable over the past year and includes nine full-time equivalent (FTE) positions with no current vacant positions.
- Avatar trainings continued to be offered. The following highlights the trainings that are provided:
    - Avatar applications, including PM, CWS and OrderConnect.
    - Privacy and security training is required annually.
    - Avatar Forums are conducted bi-monthly and are a venue for communication on system implementations and/or modifications.

MAJOR CHANGES SINCE LAST YEAR

- The Access Teams went live with the electronic Access Service Request.
- The Mental Health Treatment Center (MHTC) went live with Avatar CWS, OrderConnect and document management.
- The first Katie A billings were submitted in February 2014 and Katie A tracking has been set up.

- The MHP has been certified for Medicare production claims by Meridian and is in the final testing phase.

PRIORITIES FOR THE COMING YEAR

- Continue the Avatar implementation with Provider Integration.
- Implementation of the Avatar Electronic Lab Orders and results module.
- Complete Avatar setup for Navigator and Mobile Crisis.
- Finalize testing and implement Medicare Part B billing and claims submission.

OTHER SIGNIFICANT ISSUES

- As noted last year, a limited number of contract providers (five) who have chosen to maintain their own EHR systems must also enter data directly into Avatar. These contract providers conduct transaction reconciliation between the systems to ensure data integrity.
- Notes from the bi-monthly Avatar Forum have not been regularly distributed. Contract providers find these notes to be of great value in the sharing of information within their organizations, as a reference tool and in the event that they miss a meeting.
- Contract providers noted some initial slowdown in the response of the Access Teams during the electronic SR implementation. They felt this would likely be limited to the initial rollout period of the new electronic SR.

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 PM	Practice Management	Netsmart Technologies	5	MHP/Netsmart Technologies

Table 10—Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar CWS	EHR	Netsmart Technologies	3	MHP/Netsmart Technologies
Inforscriber/Order Connect	e-Prescribing	Netsmart Technologies	3	MHP/Netsmart Technologies

PLANS FOR INFORMATION SYSTEMS CHANGE

- There are no plans to replace the current Avatar system. The MHP is in the fifth 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 (eLab) 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					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	Avatar CWS	X			
Clinical decision support			X		
Document imaging			X		
Electronic signature—client		X			
Electronic signature—provider		X			
Laboratory results (eLab)				X	
Outcomes	CANS, LOCUS		X		
Prescriptions (eRx)		X			
Progress notes	Avatar CWS	X			
Treatment plans	Avatar CWS	X			
Summary Totals for EHR Functionality		6	3	1	

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

- In the last year, the MHTC has gone live with CWS, OrderConnect and document management.
- Access Teams went live with the electronic SR. Policies and procedures continue to be developed and fine-tuned as required in this early stage of implementation.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

Findings

- Access to Care
  - The newly implemented electronic Service Request should largely eliminate the use of paper and faxing Treatment Authorization Request forms from outpatient contract providers to the Access Teams.
- Timeliness of Services
  - The electronic service request has the potential to improve timeliness of access by eliminating delays associated with paper/fax transmittal.
- Quality of Care
  - The implementation of Avatar CWS provides the MHP with more quality management report production capabilities.
  - A limited number of contract providers (five) who have chosen to maintain their own EHR systems must also enter data directly into Avatar. Double data entry requires transaction reconciliation between the systems to ensure data integrity.
- Consumer Outcomes
  - None noted.

SITE REVIEW PROCESS BARRIERS

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

- There was no significant barrier to conducting this review.

CONCLUSIONS

During the FY14-15 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 undertaken a three-phase process to improve access and service engagement through the use of triage/navigator staff located at key access points and two mobile crisis service teams to improve crisis response system.
  - The MHP assesses its capacity by demographics, location, and specific populations such as foster care children, homeless adults, refugees, and those with law enforcement contacts.
  - The MHP presented data on beneficiary trends that showed a 9% increase in the number of beneficiaries in the previous 4 years.
  - The newly implemented electronic Service Request should largely eliminate the use of paper and the faxing of Treatment Authorization Request forms from outpatient contract providers to the Access Team.
- Opportunities:
  - The MHP has not adequately assessed the impact of increase in the number of beneficiaries on its service access.
  - Foster Care penetration rates have continued to decline for a fourth consecutive year to 47.85%, below the current statewide average of 51.89%.

Timeliness of Services

- Opportunities:
  - While the MHP tracks timeliness to first appointment on a quarterly basis, the findings demonstrate significant lag in comparison to the MHP standard of 10 business days or 14 calendar days. The lag is particularly acute in the adult system of care.

- The MHP's first psychiatric appointment after an initial service encounter also lags behind its own standards in the adult system. The MHP does not track this indicator for the children's system.
- The MHP's hospital discharge follow-up for non-psychiatric encounters averages at 14 days, twice the MHP's own standard of 7 days.

Quality of Care

- Strengths:
  - Consumer focus group participants were generally satisfied with the quality of care received.
  - The MHP has a number of collaborative arrangements with other county agencies and community based organizations.
  - The MHP tracks and addresses its beneficiaries' cultural needs and undertakes strategic initiatives to address specific groups of individuals' needs. During FY2013-14, one such initiative involves addressing the mental health needs of refugees including human trafficking victims.
  - Family advocates and peer partners are employed throughout the system by contract providers.
- Opportunities:
  - Notes from the bi-monthly Avatar Forum have not been regularly distributed. Contract providers find these notes to be of great value in the sharing of information within their organizations, as a reference tool and in the event that they are unable to attend a meeting.

Consumer Outcomes

- Strengths:
  - The MHP collects and utilizes CANS throughout the Children's system of care..
  - The MHP collects and includes consumer satisfaction data among its key elements in the management dashboard.
  - Contract provider staff reports that several other outcomes tools are used specifically for the populations they serve such as How I Think (HIT) for probation youth, UCLA PTSD for TF-CBT screening and Core Elements or Practice Wise for Flexible Integrated Treatment Program (FITP).
- Opportunities:
  - The MHP has not consistently started using any adult outcome tools in a system wide manner.

RECOMMENDATIONS

- Develop a performance improvement project tracking Phase A implementation of the initiative with Triage/Navigator staff to improve access and service engagement. .
- Develop a performance improvement project to improve timeliness of first access including both non-psychiatric and psychiatric contact.
- Develop a metric that will allow tracking of the missing timeliness data elements:
    - Children's first psychiatric service.
    - No-show rates.
    - Current re-hospitalization rates.
- 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.
- 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.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the on-site review agenda:

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

Sacramento County MHP
CalEQRO On-Site Review Agenda

(Unless otherwise noted, all conference rooms are located at MHP Main Office at 7001 East Parkway, Sacramento, 95823)

Monday, November 17, 2014

Time	Activity
9:00 am - 9:30 am	Opening Session • Introduction to BHC • MHP Team Introductions **MHP Participants:** **Uma Zykofsky, Lisa Sabillo, Kathy Aposhian, Bob Hales, MD, Robert Horst, MD, JoAnn Johnson, Jeff King, Robert Gillette, Andrea Crook, Anthony Madariaga, Sandena Bader, Kelli Weaver, Matt Quinley, Melissa Jacobs, Steve Davidson, Jane Ann LeBlanc** **BHC EQRO Participants:** **William Holcomb, Ph.D. Saumitra SenGupta, Samantha Fusselman, Cyndi Eppler, Susan Roberts, Lisa Farrell** 7001 East Parkway, Sacramento, 95823, Conference Room 1
9:30 am- 10:00am	**Review of Past Year** • Significant Changes and Key Initiatives • Use of Data in the Past Year **MHP: Lisa Sabillo, Kelli Weaver, Melissa Jacobs, Matt Quinley, JoAnn Johnson, Alex Rechs, Kathy Aposhian** **BHC: All** Conference Room 2
10:15 am- 11:00am	**Performance Improvement Projects** • Adult Clinical PIP • Technical Assistance **MHP Participants:** **Michelle Schuhmann, Lisa Sabillo, Kathy Aposhian, Jesus Cervantes, JoAnn Johnson, Alexis Lyon, Sherri Mikel, Cindy Lopez, Wendy Hoffman-Blank** **BHC Participants: All** Conference Room 2

Sacramento Agenda FINAL FY14-15 SSG

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Ph.D., CalEQRO Deputy Director, Lead
Samantha Fusselman, LCSW, CalEQRO Site Review Director, Quality Reviewer
Cyndi Eppler, LCSW, LPCC, CalEQRO Quality Reviewer
Susan Roberts, LCSW, CalEQRO Quality Reviewer
Lisa Farrell, CalEQRO IS Reviewer
Walter Shwe, CalEQRO 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

MHP Administration, 7001 East Parkway, Sacramento, CA 95823

CONTRACT PROVIDER SITES

La Familia, 5523 34th Street, Sacramento, CA 95820
APSSC Bowling, 7171 Bowling Dr., Suite 700, Sacramento, CA 95823
T-CORE, 3737 Marconi Ave, Sacramento, CA 95821

Participants Representing the MHP

Name	Position	Agency
Adam Simmons	LCSW Clinician	APSS Stockton
Alex Rechs	Program Coordinator	DBHS
Alexis Lyon	Program Director	TPCP
Alfredo Orozco	Clinician	ACAC
Alicia Blanco	Planner	CPS
Amanda Divine	Clinical Director	El Hogar
Andrea Crook	Consumer Advocate	MHANCA
Ann Mitchell	ASO II	DHHS - MHTC
Anne-Marie Rucker	Planner	CPS
Anthony Madariaga	DBHS / MHTC	Treatment Center DBHS
Billie Willson	Planner	BHS
Blia Cha	Adult Family Advocate	MHANCA

Name	Position	Agency
Carrie Harper	Executive Director	Cross Creek
Christine Waligora	LPHA / Clinician	TCORE
Craig Harris	Clinic Manager	Dignity Health
Daniela Zambros	Clinician	DHHS, CAPS
David Brown	Clinical Supervisor	Visions
Dawn Williams	Program Manager	DBHS
Deborah Bennett	Program Director	Stanford
Diana White	COO	TPCP
Elaina Garrido	Clinician	HRC
Elene Spitzer	Admin Director	Security Mental Health Treatment
Gina Mertz	Managing Clinical Supervisor	SJUSD/White House
Graciela Medina	Family Advocate	MHA of Northern CA
Grainger Brown	Manager	Dignity Health
James Marrely	Team Lead / LMFT	Telecare Soar
Jane Ann LeBlanc	Program Manager	DBHS
Janelle Grant	Senior Accountant	BHS
Jennifer Reiman	Clinical Program Manager	EMQFF
Jo Ann Johnson	Program Manager	DBHS
John Mike D'Agostino	MHRS	TLCS
John Sawyer	IT Analyst	DBHS
Joseph Barth…	Adult Psychiatric Support Service	MHA of Northern CA
Judy Cooperrider	Planner	CPS
Kacey Vencill	Project Manger	BHS
Karen Adrian	Clinical Psychiatric Counselor	DH RCCC
Kat Waitz	Consumer Warm Line	MHA of Northern CA
Kathleen Heggum	Clinical Director	TP Northgate RST
Kathy Aposhian	Health Program Manager BHS QM	DBHS
Katie Beattie	Clinical Director	ACAC
Kelli Weaver	Health Program Manager	DBHS
Kerry Payton	PSC III / LPHA	NGP RST
Krystal Reichert	Service Coordinator	HRC
Latika Alganani	Clinical Director	TLCS
Laura Heintz	CEO	Stanford Youth Solutions
Lisa Harmon	Program Planner	DBHS

Name	Position	Agency
Lisa Sabillo	QM/REPO Division Manager	BHS
Lorna Khoo	Peer Partner Specialist	MHA of Northern CA
Lyla Vang	Peer Partner Specialist	HWHA
Lynn Place	Executive Director	Human Resource Consultants, Inc
Matt Quinley	Program Manager	BHS
Melissa Jacobs	Program Manager	DBHS
Melony Ibarra	Admin Service Officer	BHS
Michael Lazar	Executive Director	TLCS
Michelle Schuhmann	Program Planner	DBHS
Mindy Edwards	LPHA / Clinician	TCORE
Moacho	Peer Partner Specialist	HWHA
Mutsumi Hartmann	Quality Assurance Manager	Asian Pacific Community Council
Nicole Hill	Admin Associate	DHMF Center
Pat George	Program Manager	SJUSD
Patrick Yamamoto	PSC II / MFT1	Telecare
Rob Kesselring	Program Director	El Hogar Guest House
Robert Gillette	Accounting Manager	DHHS
Robin Skalsky	Clinical Director	APSS C Bowling
Roland Udy	COO	River Oak
Rolanda Reed	Program Coordinator	QM
Romeal Samuel	Program Planner	DBHS
Sandena Badeu	Youth and Family Adovocate	MHANCA & BHC
Sandi Snelgrove	Executive Director	ACAC
Sara Collette	Clinical Director	HRC & TCORE
Sevina Lewis	Program Planner	DBHS-REPO
Shannon Taylor	Administrator	Telecare corp.
Sheri Reynolds	Clinical Director	Sac County Adult Clinic
Sherri Mikel	Program Coordinator	HRC-RST
Sherri Z Heller	Director	DHHS, Sacramento County
Shirley Telep	Clinical Supervisor	San Juan Unified School District
Stephen Davidson	Health Program Manager	DBHS
Victoria Roberts	Peer Liaison	TCORE
Vince Giocamelli	LMFT, SMHC	APSS
Uma Zykofsky	Behavioral Health Mental Health Director	DBHS

Name	Position	Agency
Wendy Hoffman-Blank	Clinical Program Director	Visions

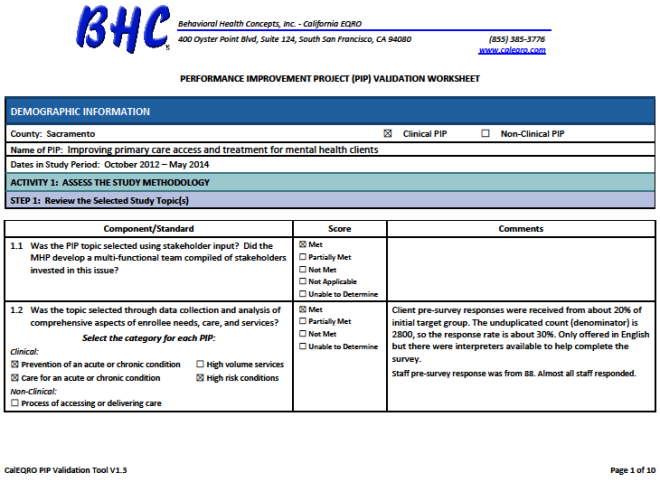
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

This data will be provided to the MHP separately in a HIPAA compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:



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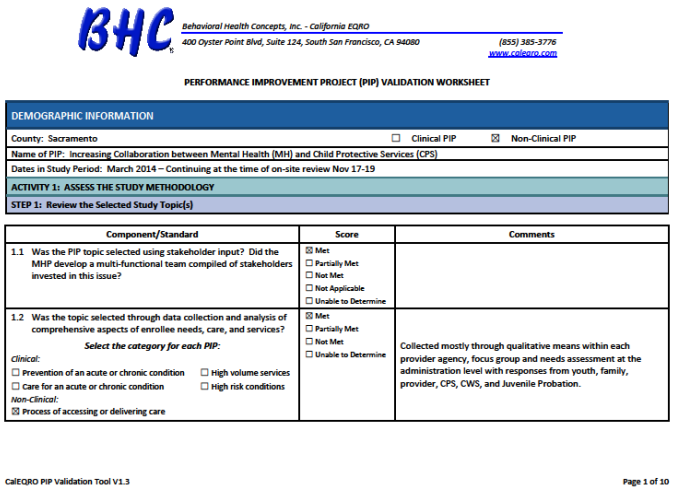
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Sacramento	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Improving primary care access and treatment for mental health clients		
Dates in Study Period: October 2012 – May 2014		
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	
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	Client pre-survey responses were received from about 20% of initial target group. The unduplicated count (denominator) is 2800, so the response rate is about 30%. Only offered in English but there were interpreters available to help complete the survey. Staff pre-survey response was from 88. Almost all staff responded.

CalEQRO PIP Validation Tool V1.3 Page 1 of 10

Non-Clinical PIP:



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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 2014 – Continuing at the time of on-site review Nov 17-19		
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	
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.

CalEQRO PIP Validation Tool V1.3 Page 1 of 10