FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Yolo

Conducted on

February 22-23, 2016

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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—1,802
    - MHP Size—Medium
    - MHP Region—Central
    - MHP Threshold Languages—Spanish, Russian
    - MHP Location—Woodland

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Yolo 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

[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.

- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- 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; Yolo MHP submitted one PIP for validation through the EQRO review. The PIPs 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:

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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.

- 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.
- 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: The MHP needs to overcome operational barriers to hiring sufficient Informational Technology (IT) staff to support in a reasonable manner its EHR for clinical, QI and state mandates. Current levels are insufficient to the task.

    ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

    - The MHP filled two analyst positions on the Quality Management team. In the absence of additional IT staff, the MHP reports that these analysts will support the data requirements of Quality Management, including generating Crystal Reports.
    - IT continues to be under-resourced as evidenced by the delayed implementation of the Avatar Managed Services Organization, document imaging and e-Lab modules during the past year. Insufficient staffing has also hindered expeditious implementation of the Health Information Exchange (HIE) initiatives.

- Recommendation #2: The MHP should conduct a quantitative analysis of the capacity of its psychiatric service providers to identify gaps and explore possibilities for practical and affordable remediation.

  ☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP did not provide evidence that they had conducted any analyses on psychiatric staffing relative to gaps in service provision. The MHP appears to continue to be understaffed in psychiatry.
  - The MHP plans to implement mobile telepsychiatry. However, this new modality is limited to an older adult population who are located remotely or are homebound. At present, telepsychiatry will not have any appreciable impact on psychiatric access for the majority of the MHP consumers.

- Recommendation #3: The MHP should support and implement a plan to shift the management, leadership and running of its Wellness Center to a consumer run/lead Wellness Center focused on wellness, recovery, and peer support encompassing program planning and implementation and evaluation. This includes robust TAY participation in improvement of the existing Wellness Center or the re-institution of a TAY specific Wellness Center.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has made strides in developing a consumer-run and consumer-lead Wellness Center in West Sacramento. Consumers reiterated that the Wellness Center was staffed by consumers; consumer provide input on group topics, consumers conduct/facilitate groups, and consumers participate on mental health advisory panel/board. The MHP's goal is to have peer staff during all operating hours of the Wellness Center.
  - The MHP provides training to peer support specialists to help them be more effective when working with consumers. All peer support are trained in group facilitation. The MHP also trains them in Wellness Recovery Action Plan (WRAP).
  - The MHP provides TAY programming one day each week at the new Wellness Center. MHP has plans to expand TAY programming.

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 opened a Wellness Center in West Sacramento that will increase consumer's engagement in wellness and recovery.
    - The MHP has had vacancies in two key positions: Medical Director and Child Psychiatrist. The MHP had recently hired bilingual (Spanish-speaking) Medical Director who had not yet started at the time of the review. The MHP contracts out child psychiatrist.
- Timeliness of Services
    - The MHP continues to have challenges with data, including tracking of appointments and services. The MHP cannot, or is not in a position to, make an impact on timeliness of services because they do not have a reliable means to assess timelessness.
- Quality of Care
    - The MHP and social services departments (and previously the public health department) were integrated, forming one Health and Human Services Agency. The Health and Human Services Agency (HHSA) has central leadership and coordinated/collaborating departments, which has the ability to improve the quality of care.
    - The Quality Management department of the MHP had a four-fold increase in staff. This increase in staff puts the MHP in a better position to (1) monitor, (2) evaluate, and (3) use data to make decisions and improve quality of services.
- Consumer Outcomes
    - Following the integration and new leadership, HHSA has adopted a results-based accountability framework to look at performance measures. All the units of the MHP (e.g., Moderate Intensity and Children, Youth & Family Branch) are implementing one or another outcome measure.
    - With the increase in Quality Management personnel, the MHP was able to facilitate greater—nearly 400 percent increase—consumer participation in the semi-annual satisfaction surveys. The MHP can use the additional resources to then conduct their own assessments of consumer 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 TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- 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, 2016.

TOTAL BENEFICIARIES SERVED

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

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

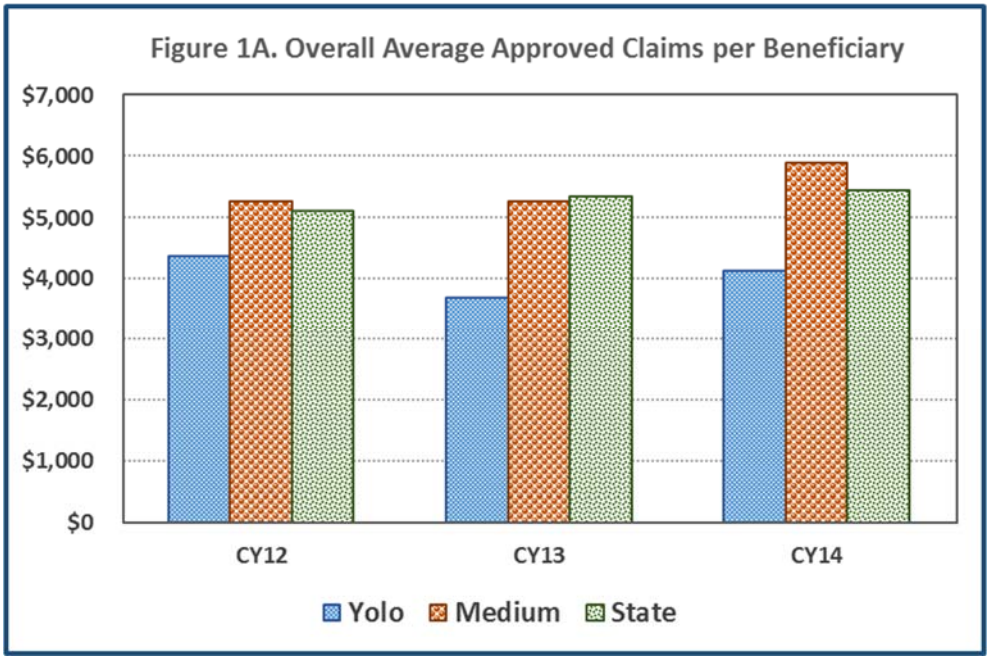
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	11,266	883
Hispanic	19,072	460
African-American	1,742	126
Asian/Pacific Islander	3,764	73
Native American	316	18
Other	5,123	242
Total	41,280	1,802

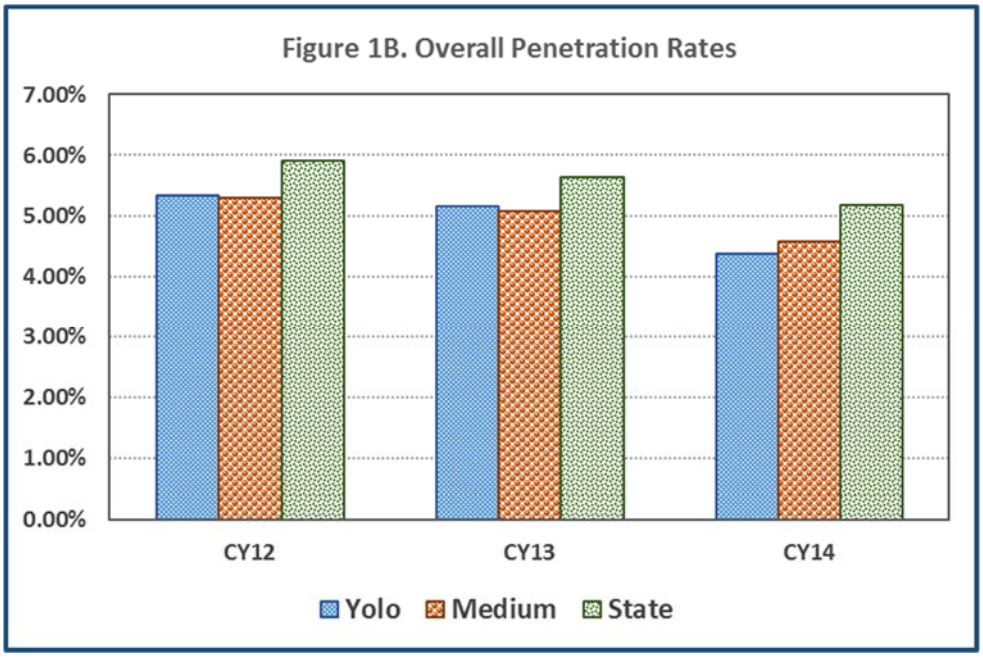
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

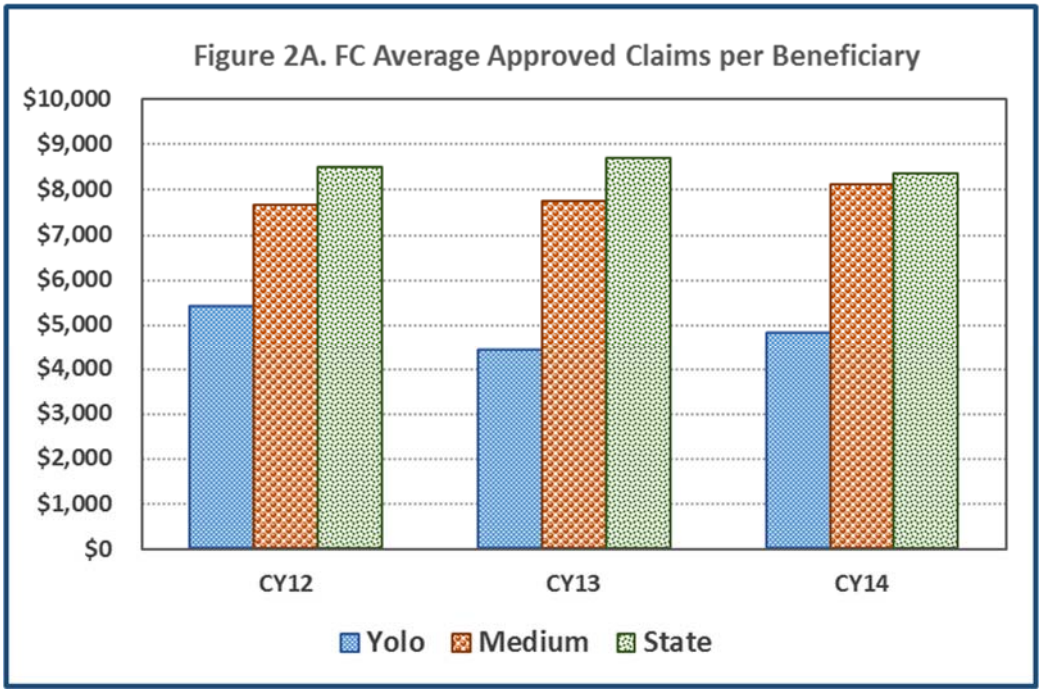
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

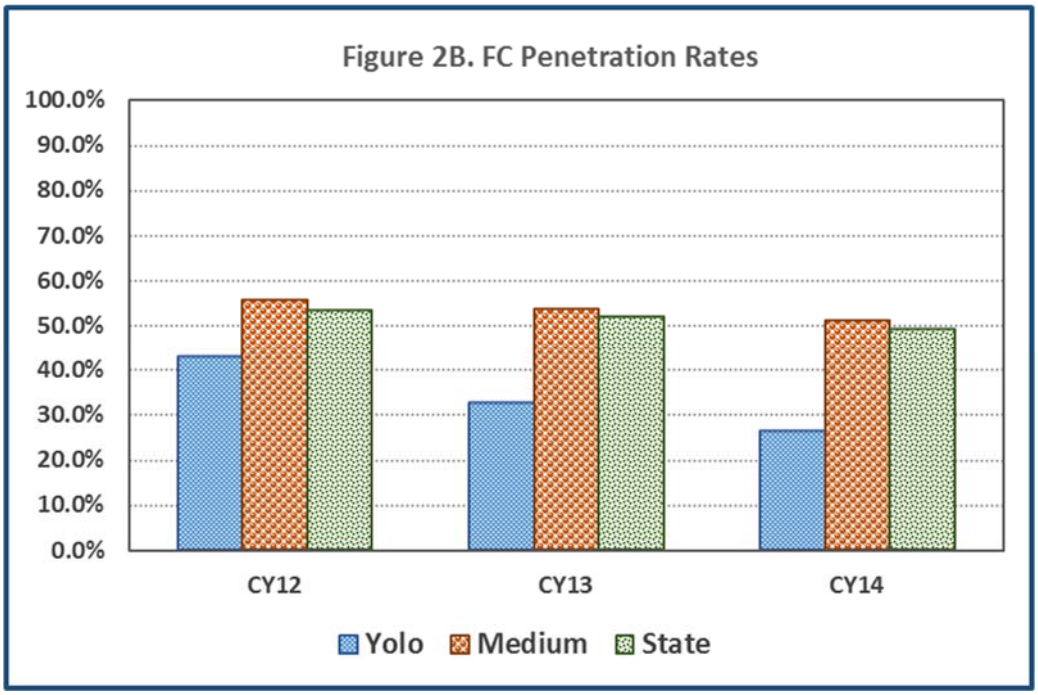
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Medium MHPs.



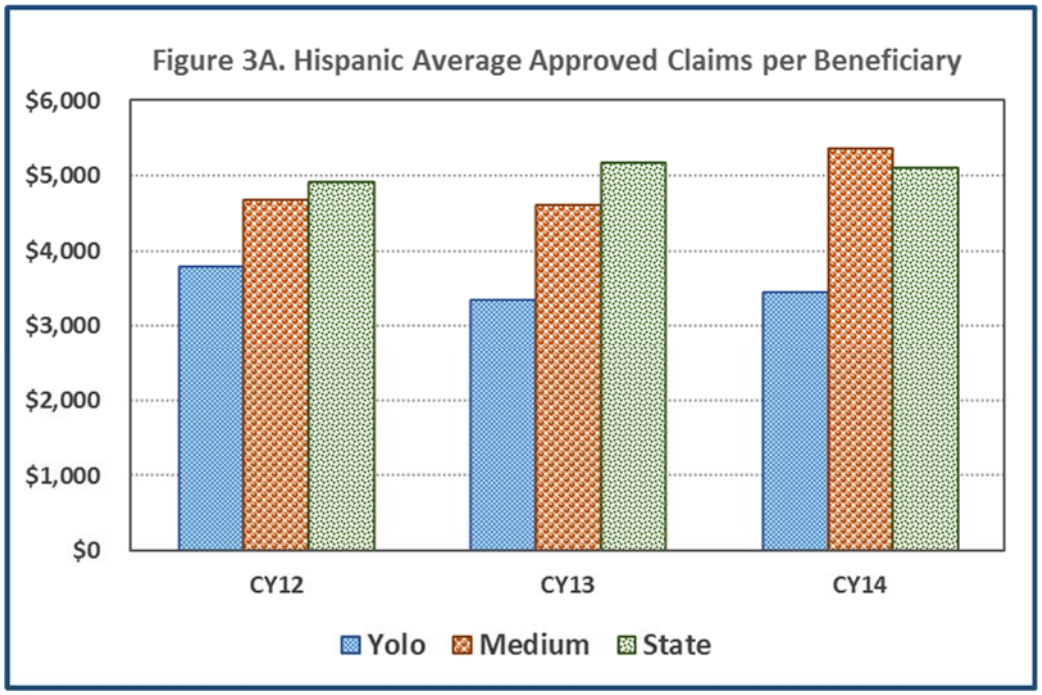


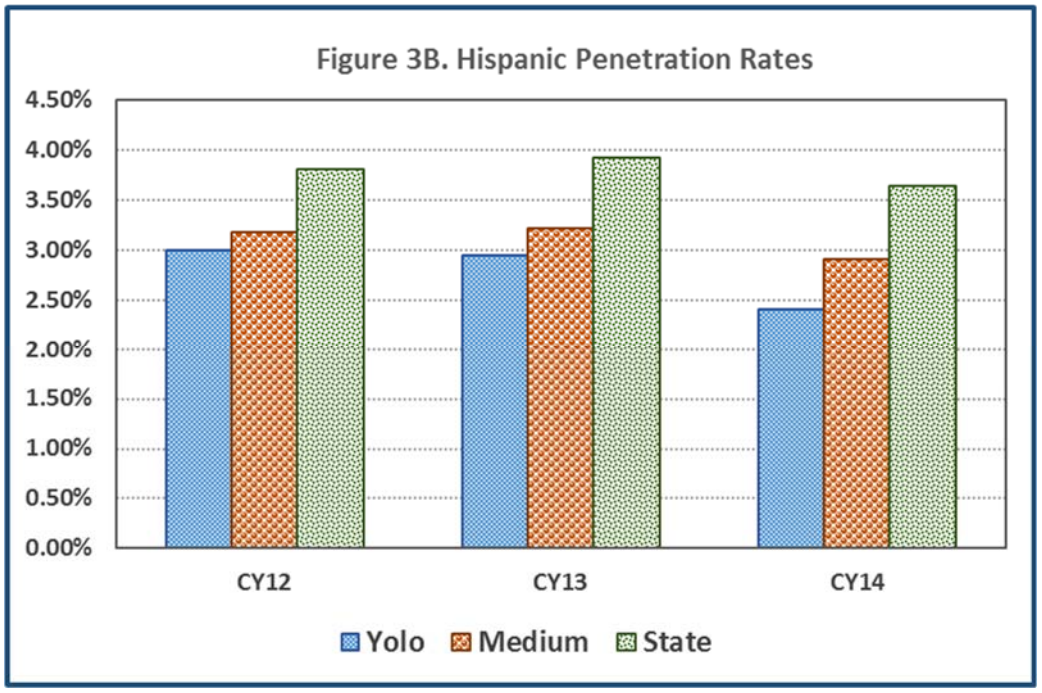
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Medium MHPs.





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 Medium MHPs.





HIGH-COST BENEFICIARIES

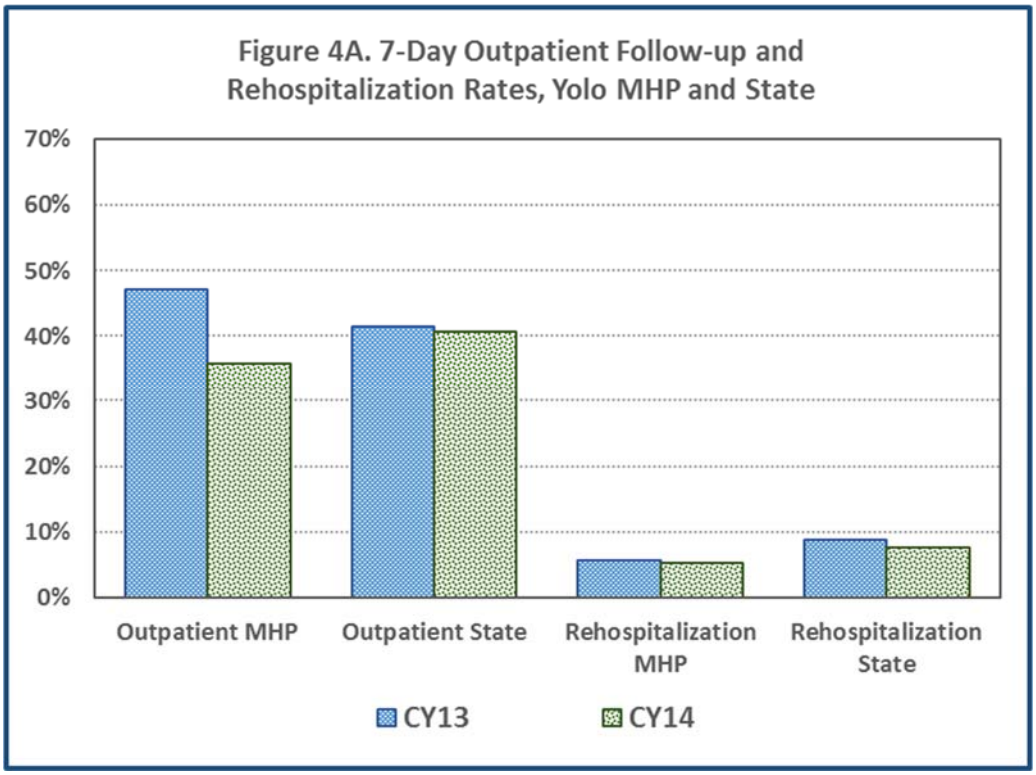
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

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%
Yolo	CY14	5	1,764	0.28%	$35,118	$175,592	3.22%
	CY13	24	1,822	1.32%	$49,584	$1,190,015	17.65%
	CY12	38	1,745	2.18%	$46,776	$1,777,496	23.26%

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 rehospitalization rates for CY13 and CY14.



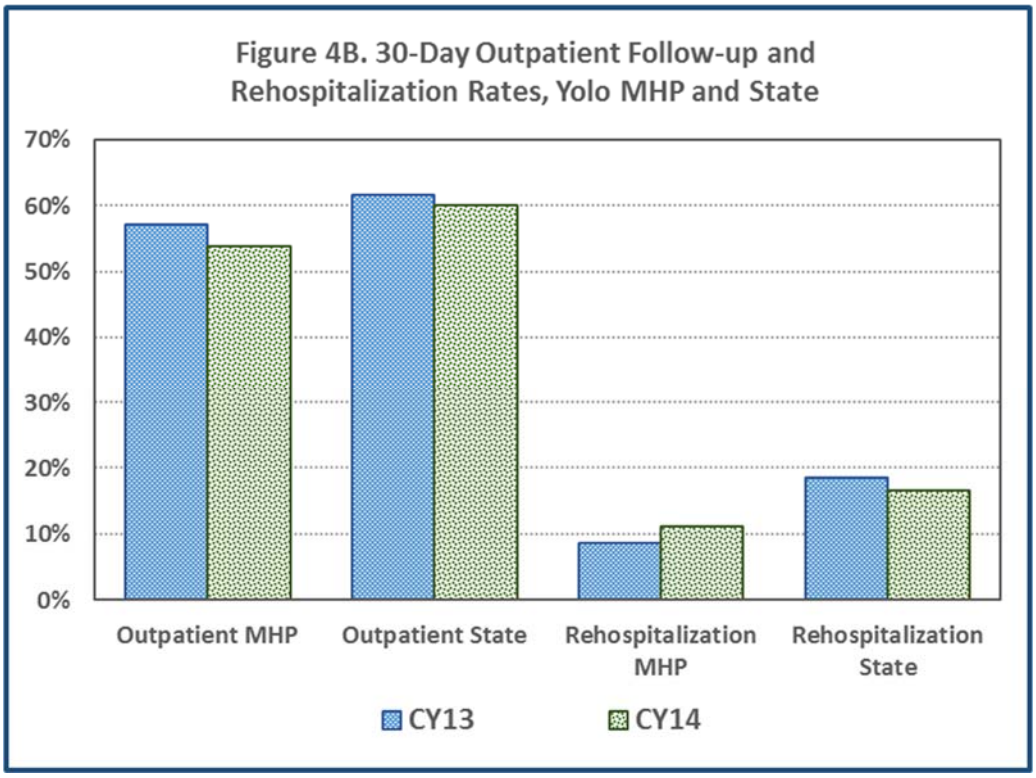
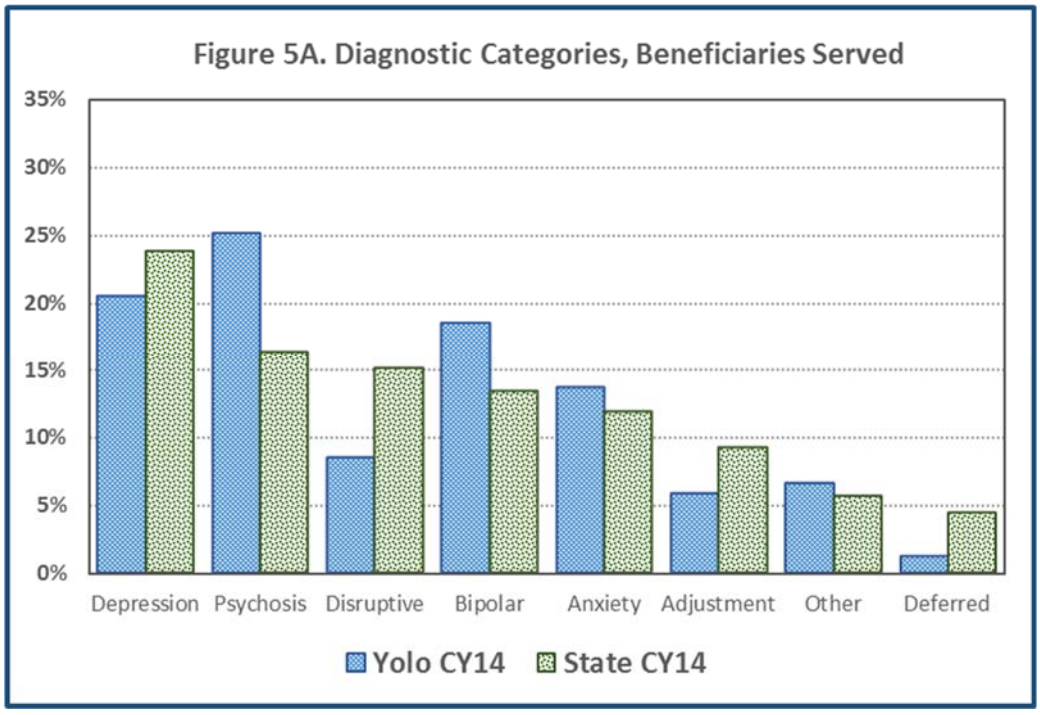
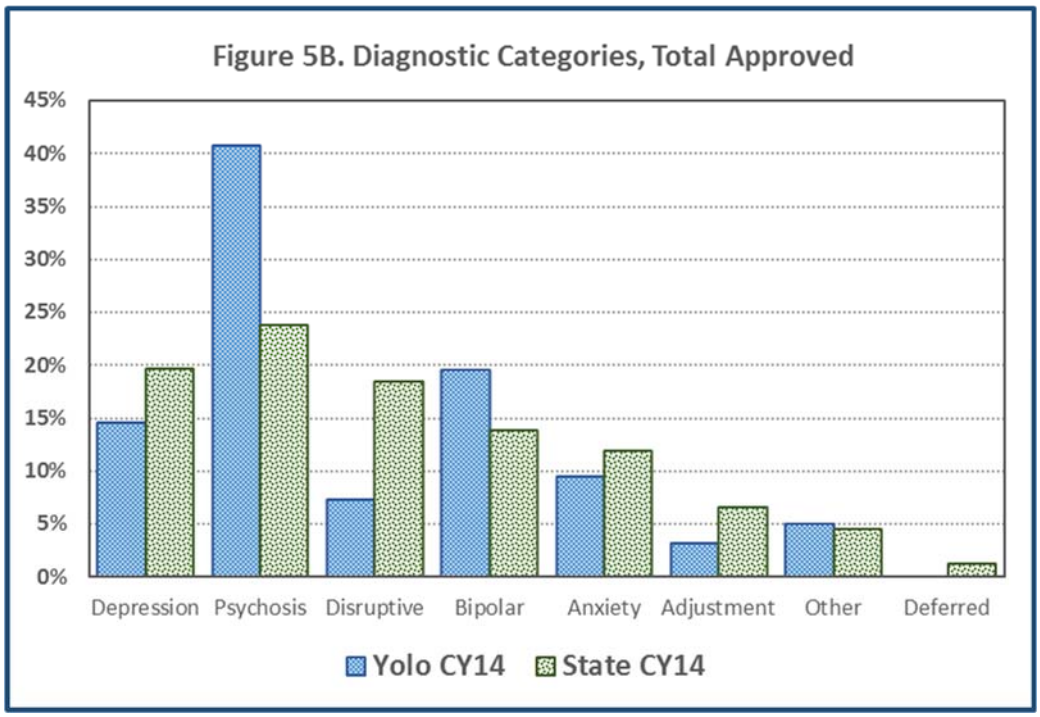


Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, Yolo MHP and State
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY13
CY14

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
    - The MHP's overall penetration rate had a slight—less than one percentage point—decline over the last year (i.e., from CY13 to CY14). Overall, the MHP's penetration rate is comparable to that of other medium counties, but is and has been consistently less than the state penetration rate.
    - The MHP's penetration rate for Foster Care has decreased each year since CY12. The MHP's Foster Care penetration rate is and has been considerably less than both medium and state averages. Given the integration of social services with mental health and improved coordination of services, starting July 2015, the MHP anticipates that the foster care penetration rate will increase.
    - The MHP's Hispanic penetration rate has declined each year since CY12. The Hispanic penetration rate steadily becomes less and less than both statewide and medium county averages.
    - Access to care for Hispanic population in Yolo is inadequate. Hispanics comprise the highest proportion of Medi-Cal enrollees in Yolo (at 46%), but only 2.4% of Hispanic beneficiaries are served. As a comparison, Whites make up 27% and African-Americans make up 4.2% Medi-Cal enrollees, but respectively 7.8% and 7.2% of the beneficiaries from these races are served.
- Timeliness of Services
    - The MHP's 7-day outpatient follow-up, following a hospital discharge, decreased from CY13 to CY14. The current rate is comparable, if only slightly less than, the statewide 7-day follow-up rate. The MHP's 30-day outpatient follow-up also decreased from CY13 to CY14. The 30-day rate in both years is less than the statewide follow-up rate.
    - The MHP does not provide timely follow-up post discharge to a considerable portion of their discharged beneficiaries. In the first 7 days post-discharge, the MHP can provide follow-up appointments to approximately 45% of the beneficiaries. In 23 days (i.e., from 8-30 days post discharge), the MHP is only able to provide follow-up appointments to an additional 10%, leaving approximately 45% who are not seen in 30 days, if at all.
    - The MHP's 7-day rehospitalization rate in CY13 and CY14 were comparable and both less than the statewide rehospitalization rate. The MHP's 30-day rehospitalization rate increased slightly from CY13 to CY14, but both are lower than statewide rehospitalization rate.

- Quality of Care
    - The number (and percentage) of HCB in the MHP decreased drastically from CY13 to CY14—from 24 to 5 HCB. The HCB total claims and HCB percentage by approved claims were also significantly less than the previous years. The MHP speculates that a contributing factor for this decline may be an increase in claim lag for this period. In the previous years, the HCB percentages, of counts and approved claims, have been less than the statewide averages but not drastically so.
    - The MHP's overall average approved claims per beneficiary increased from CY13, but remains significantly less than statewide and medium county averages in CY14.
    - The MHP's approved claims per Foster Care beneficiaries increased slightly from CY13 to CY14. The claims remain considerably less than both statewide and medium county claims. Ironically, while the average cost of claims has increased, the MHP is serving fewer foster care beneficiaries.
    - The MHP's average Hispanic approved claims per beneficiary was stable from CY13 to CY14 and remains significantly less than both statewide and medium county averages.
    - The largest proportion of beneficiaries served and claims approved were those diagnosed with Psychotic disorders, followed by Bipolar disorders. Both disorders are diagnosed more frequently in this MHP than statewide average diagnostic rate. Conversely, the MHP has fewer beneficiaries and claims for Disruptive Behaviors Disorders, Adjustment Disorders, and Deferred diagnoses.
    - That the MHP has fewer Deferred Diagnosis is not necessarily bad, and could point to improvements in diagnostic accuracy.
- Consumer Outcomes
    - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined 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.

YOLO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two PIPs during the 12 months preceding the review; Yolo MHP submitted one PIP for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	No Clinical PIP submitted.
Non-Clinical PIP	No Non-Clinical PIP submitted.

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

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

[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 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		7.4	Initial and repeat measurements, statistical significance, threats to validity	-	-
		7.5	Interpretation of results and follow-up	-	-
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	-	-
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	-	-
		8.3	Threats to comparability, internal and external validity	-	-
		8.4	Interpretation of results indicating the success of the PIP and follow-up	-	-
9	Validity of Improvement	9.1	Consistent methodology throughout the study	-	-
		9.2	Documented, quantitative improvement in processes or outcomes of care	-	-
		9.3	Improvement in performance linked to the PIP	-	-
		9.4	Statistical evidence of true improvement	-	-
		9.5	Sustained improvement demonstrated through repeated measures.	-	-

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

Table 3B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	-	-
Number Partially Met	-	-
Number Not Met	-	-
Number Applicable (AP) (Maximum = 30)	-	-
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	%	%

CLINICAL PIP—NONE SUBMITTED

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

- 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

NON-CLINICAL PIP—NONE SUBMITTED

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

- 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 MHP did not submit a formal non-clinical PIP; however, they presented a working document of their plan to study (and decrease) inpatient hospitalizations for beneficiaries who qualify as full service partnership consumers. The MHP has outlined three phases of their plan: Needs Assessment, Strategy Development, and PIP Formulation. The MHP is between the Strategy Development and PIP Formulation stage, where they are analyzing data, developing a hypothesis, and defining the study parameters (i.e., sample/participant population, data sources, and relevant indicators).

The EQRO provided to the MHP technical assistance to facilitate rolling out this plan as a PIP. The EQRO advised the MHP to:

- Re-analyze their retrospective data
- Provide a connection between the proposed interventions and FSP consumer hospitalizations
- Select indicators that are aligned with the interventions
- Simplify data collection

The MHP was encouraged to seek consultation with the EQRO to assure that appropriate PIP methods are being followed.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP is encouraged to articulate how the proposed study will improve access to care for FSP consumers. At the very minimum, the MHP should indicate how the plan to reduce inpatient hospitalizations will not negatively impact access to care.
- Timeliness of Services
    - The MHP did not present timeliness of services as a problem for FSP consumers.
    - The MHP should identify and target relevant timeliness indicators. For example, the MHP may want to examine the effect of the treatment teams, and presumably their coordination of care, on re-hospitalizations for FSP consumers.
- Quality of Care
    - The MHP should state explicitly how this study will affect quality of care for FSP consumers.
- Consumer Outcomes
    - The MHP intends to use two measures of consumer outcomes, the FSP Assessment and The Consumer Perception Survey Satisfaction with Service Availability. The MHP should evaluate how these particular assessments relate to inpatient hospitalizations and then determine if these or other measures can capture FSP consumer outcomes.

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 4, 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 4—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	NC	The MHP incorporates cultural competence principles through Cultural Competency trainings, several of which have been held during the past year. Beyond these trainings, cultural competence principles and practices were not effectively integrated into/with practices. Once the MHP can hire and retain a Cultural Competence Coordinator, the MHP will be better positioned to effectively assess, identify, or implement strategies to address the needs of diverse racial, ethnic, and cultural populations.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	NC	The MHP has made changes to meet beneficiary needs, including the additional day of triage in West Sacramento, implementation of telepsychiatry to older adults, and inclusion of a language button in Avatar. However, the MHP does not appear to make these changes through the utilization of data, assessment of demand-caseloads, or other evaluative approaches. These changes are based on anecdotal information and also reflect pre-existing plans for change/expansion of MHP practice.
1C	Integration and/or collaboration with community based services to improve access	FC	MHP collaborates with a number of community based organizations to facilitate housing, meals, physical health services, and other services. Consumers reiterated that the MHP staff assist them with supportive services through referrals and partnerships with community organizations. The MHP has integrated with the social service agency, forming the Health and Human Services Agency. Both departments have seen increased communication and collaboration, which will better serve consumers.

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

Timeliness of Services

As shown in Table 5, 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 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	NC	MHP tracks timeliness of first appointment; however, given data/EHR challenges, MHP does not conduct routine analyses to evaluate performance.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NC	As above, MHP tracks timeliness of first psychiatric appointment; however, given data/EHR challenges, MHP does not conduct routine analyses to evaluate performance.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	MHP does not track urgent appointments. MHC believes, based on anecdotal information, that urgent issues are addressed within 48 hours.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	MHP tracks and does some trending of follow-up appointments after hospitalization. MHP will benefit from including CBOs who provide follow-up appointments to this particular consumer population.
2E	Tracks and trends data on rehospitalizations	PC	MHP tracks rehospitalizations and evaluates utilization and performance during weekly meetings. The MHP's lack of certainty in the data precludes trending and utilization of data to affect consumer outcomes.
2F	Tracks and trends No Shows	NC	MHP does not consistently or systemically track No Shows. Although No Show tracking data was provided, the MHP was not certain of its validity or reliability.

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

Quality of Care

As shown in Table 6, 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 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	MHP has expanded its quality management team. The department is now better positioned to oversee, revise, and implement activities and tasks that improve services and affect consumer outcomes.
3B	Data are used to inform management and guide decisions	NC	While the MHP has a number of new projects/activities underway, the MHP did not provide evidence that these initiatives were influenced by actual, empirical data.
3C	Evidence of effective communication from MHP administration	FC	MHP has a number of means for communicating with staff, at all levels, and contractors. Consumers, family members, and community groups would benefit from more communication efforts.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	MHP has a broad network of stakeholders who provide input at meetings, on projects, and for service delivery.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	MHP has a broad network of stakeholders who provide input at meetings, on projects, and for service delivery.
3F	Measures clinical and/or functional outcomes of beneficiaries served	NC	MHP has only recently incorporated measures to assess clinical and functional outcomes of beneficiaries. More time is needed to determine actual utilization and impact. MHP is further limited because they do not access the outcome measures that their contract providers use.
3G	Utilizes information from Consumer Satisfaction Surveys	PC	MHP administered the state consumer satisfaction survey has done well to significantly increase the number of respondents. The MHP does not have the survey results or a proxy that they can use to improve services.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	MHP has positions for consumer/ family members within their system, but few are supervisory. The positions have neither upward mobility nor a defined career ladder.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	PC	MHP has consumer run programs at the Wellness Center. The program is limited to those who are referred to the program and cannot be accessed by all consumers.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Yolo County's MHP excels in providing integrated and collaborated services to improve access to care. The MHP has a broad network of contract providers and community based organizations with whom they partner to deliver services to a diverse consumer population.
    - The MHP relies heavily on contract providers to address cultural competency and expand its services to under-served communities. Cultural competency may be prioritized lower than other areas of the MHP's services. The MHP will benefit from hiring and maintaining a dedicated cultural competency coordinator.
    - The MHP does not appear to have a uniform mechanism or process for reviewing their capacity against the needs of beneficiaries. Of a number of new initiatives, the MHP referenced either anecdotal and historical basis or data from external sources as the foundation for the new program.
    - Given the expansion of the Quality Management team, the MHP is in a better position to conduct more (formal) capacity analyses, examine the needs of the consumers, and implement strategies to meet those needs.
- Timeliness of Services
    - The MHP is challenged in tracking timeliness of services throughout their system of care. Whether the measure was for first appointment, first

psychiatric appointment, hospitalizations, or any other service, the MHP was not able to provide valid, reliable, or accurate data.

- The MHP pointed to EHR user-error and variability as the reasons for challenges with tracking timeliness of services and overall data integrity.
- The MHP does not formally track urgent appointments. Staff indicated that a consumer with an urgent need would be seen immediately. Consumers did not present any concerns with urgent appointments, but they indicated that being seen more quickly was based on the *rapport* that they had established with the scheduler/reception, who would fit them in the schedule. Based on this scenario, it is possible that consumer's urgent needs are not being met.
- The MHP indicates that the EHR/Avatar is being modified to differentiate service provision and timeliness for adults versus youth/child consumers. A modification will also be made to reflect service and timeliness based on preferred language. The MHP anticipates that these modifications will be rolled out in July 2016.

- Quality of Care
  - The MHP has made a number of changes that reflect a focus on and concerted effort to affect quality of care.
  - The expansion of the Quality Management Team will have far-reaching effects, including enabling the MHP to run reports from the EHR, track and trend timeliness data, conduct capacity analyses, and, basically, use data to inform management and guide decisions.
  - The MHP excels in its ability to involve stakeholders. Staff, contract partners, and consumers all referenced MHP meetings that they attend, including quality improvement committee meetings. The contract providers indicated that the relationship and collaboration with the MHP has been improving.
  - Stakeholders indicated that while they have a forum to present their concerns, the MHP seemed limited in its ability to address these concerns (e.g., uncertainty about the agency integration; redundancy in paperwork for claims; and tedious and repetitive paperwork when accessing contractor services).
  - The MHP has adopted a team-based approach in some of their systems of care (e.g., Full Service Partnerships and Moderate Intensity). The teams include clinical and support staff that will shepherd the consumer's services and facilitate transition to other systems of care as needed.
  - The MHP has not used systemically any measures for clinical or functional outcomes. Reflecting the MHP's difficulty with data and tracking, the MHP is also unable to harness and utilize the consumer outcomes data that contract providers regularly obtain and provide to the MHP.

  - The MHP involves consumers in various parts of their services and especially at the Wellness Center. Consumers hold support positions primarily and only a few staff positions. The MHP will benefit from establishing a career track, with goals and benchmarks, to enable peer staff to advance within the MHP or, if no appropriate positions are available, externally.

- Consumer Outcomes
  - The MHP has adopted a results-based accountability framework that looks at consumer outcomes in addition to service provision. Each system of care has adopted and is implementing an outcome tool, including the Child and Adolescent Needs and Strengths (CANS), the Adult Needs and Strengths Assessment (ANSA), the Level of Care Utilization System (LOCUS, or other outcome measures.

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 two focus groups, which included the following participant demographics or criteria:

- A culturally diverse group of adult beneficiaries, including both high and low utilizers of MHP services, preferable those that have started receiving services within the past year.
- A culturally diverse group of Spanish speaking adult beneficiaries and parent/caregivers of child/youth beneficiaries, including both high and low utilizers of MHP services. Please also arrange for translation services.

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

The focus group participants included eight adult consumers, none of whom had entered services within the past year. All the participants saw a psychiatrist, some had case managers, and even fewer had therapists. Four participants also accessed housing services. The majority of the participants have been accessing Yolo County MHP services for approximately three years and two participants have been consumers for over ten years.

The focus group participants were generally pleased with the services, providing positive comments about case management and peer-to-peer support, in particular. The group described services as positive and well-coordinated.

Recommendations arising from this group include:

- Improve information regarding services within the MHP. It appeared that the consumer's point of entry determined or influenced the consumer's awareness of services. Those who entered through housing programs were less aware of available therapy services.
- Equip or inform consumers about how they can access their providers directly. Consumers were not aware of how to schedule an appointment with a psychiatrist without going through their case manager and consumers did not know (or struggled through) the process of changing psychiatrist when it was necessary.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1

Category		Number
Total Number of Participants*		8
Number/Type of Participants	Consumer Only	8
	Consumer and Family Member	0
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	8
	Older Adult (60+)	0
Preferred Languages	English	8
	Spanish	0
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	6
	Hispanic/Latino	0
	African American/Black	2
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	0

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Gender	Male	4
	Female	4
	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.*

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The focus group participants included six Latino consumers, one of whom entered services within the past year. All the participants saw a psychiatrist and had a case manager. One participant entered services within the past year. The participant was brought by law enforcement to the MHP, then was referred to Safe Harbor. The participant has seen a prescriber, is on medication, and is currently on a waiting list to see a therapist. The participant did not have any difficulties accessing services.

The participants were satisfied with the frequency of seeing mental health professionals, but indicated that they could contact their case managers to obtain more frequent or sooner appointments.

As with the other focus group, these participants found their case managers to be very helpful in connecting them to services.

Recommendations arising from this group include:

- Streamline and assist consumers who may have more complicated service needs, particularly for dependents.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		6
Number/Type of Participants	Consumer Only	3
	Consumer and Family Member	3
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	4
	Older Adult (60+)	2
Preferred Languages	English	1
	Spanish	5
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	0
	Hispanic/Latino	6
	African American/Black	0
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	0
Gender	Male	1
	Female	5
	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.*

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

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Consumers did not have difficulty accessing services. But consumers were not uniformly informed of available MHP services from which they could benefit.
    - Some consumers indicated excessive and repetitive paperwork especially when accessing services through contract providers.

  - Case Managers seem to be a primary source of information, access, and engagement with services.

- Timeliness of Services
  - Consumers did not have any concerns with timeliness or frequency of services. Overall, the frequency was perceived as adequate and sufficient. Moreover, consumers felt that they could adjust frequency as needed.
  - Consumers referenced contacting external agencies (e.g., Safe Harbor) more so than the MHP when they have urgent needs.
- Quality of Care
  - Group services are infrequently, it at all, offered to Latino consumers. Latino consumers may welcome more efforts to involve and engage family members in services and treatment.
  - Consumers need to be given the necessary information to make changes in providers. Similarly, consumers need to be given adequate notice when there is a change in their mental health staff.
  - Consumers were generally unaware of opportunities to provide feedback.
- Consumer Outcomes:
  - None Reported

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 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	54%
Contract providers	44%
Network providers	2%
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:

Not tracked

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

12%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☐ Yes ☒ No

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

- Penetration rates are not calculated by the MHP; however, EQRO data is reviewed at least annually.
- The MHP reported a 12% missed appointment rate; however, they question the accuracy of this data element. The MHP reported inconsistencies in staff data entry into Avatar of missed appointments

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar information system from Netsmart Technologies to support EHR, billing and state reporting functionality. The MHP reports having 126 Avatar users currently.
- The MHP reports that 54% of services are provided by county operated/staffed clinics, 44% by contract providers and 2% by network providers. The MHP reports 81% of services are claimed to Short Doyle/Medi-Cal (SD/MC).
- The MHP reports the top two reasons for claim denials for May 2015 period were: Medicare must be billed prior to the submission of this claim and Service exceeds total maximum allowed per day. The new Dimension Report application reported 3113 services submitted, 214 denied and 881 that remain pending adjudication.
- IT support, two staff members, remained unchanged from the previous EQRO review. There are no unfilled technology support positions.
- A few contract providers have Avatar access. Turning Point has full EHR access and Yolo Community Care Continuum has read only access.

MAJOR CHANGES SINCE LAST YEAR

- The ANSA is in Avatar and use began with the FSP population in June 2015.
- The CANS is also in Avatar and use began with a limited TAY population in August 2015.
- Dimensions Reports that will provide the ability to reconcile 837/835 Medi-Cal claims transactions and for the MHP to mine claims data was implemented in August 2015.
- The MHP began Medicare Part B billing in October 2015.
- A Clinical Information Systems Work Group was created and meets by biweekly. The work group is composed of quality management staff, program managers, and an IT representative.

- The transition to ICD-10 and the transmission of claims/state reporting using ICD-10 codes was completed.
- The MHP is in the exploratory phase of HIE. They have participated in two Redwood MedNet conference calls.

PRIORITIES FOR THE COMING YEAR

- A document imaging pilot project is anticipated to begin in March 2016.
- Implement eLab functionality with Quest Diagnostics.
- Implement the Avatar Managed Services Organization Module.
- Implement mobile telepsychiatry for the older adult population. The mobile van has been purchased and the target date for the older adult telepsychiatry initiative to go live is by December 31, 2016.
- An HHSA IT Manager position was created. A candidate has been selected is scheduled to begin in March 2016.
- Netsmart Technologies Enlighten Analytics training is scheduled for March 10-11. This product will provide packaged views of Avatar data and provide the capability to produce dashboard type reporting. The MHP has obtained five user licenses for this product.
- Create quality management reports to monitor timeliness to service and access to service by threshold languages.
- HHSA fiscal priorities include the rebuilding of the MHP Fiscal department infrastructure/staffing and reviewing claiming processes and claim accuracy. HHSA is currently recruiting an MHP Fiscal Manager. An Accountant position has also been approved, but is not yet in recruitment.
- Continue HIE initiatives as staffing permits.
- There is a County initiative to update the disaster recovery plan and security which will include new servers, a new virtual environment, two firewalls and updated encryption for all County connections.

OTHER SIGNIFICANT ISSUES

- The MHP still lacks sufficient management analytical and technology staff resources to successfully achieve and support a fully functional EHR system. Too few staff must maintain the present system, while also supporting the roll-out of additional EHR components and other interoperable functionality. See Prioritizes for Coming Year.

- The MHP needs to reassess their business process for field-level data edits and validations to ensure contemporaneous data entry, not data entry after the fact, which is/has been the current business process.
- Contract providers who do not have Avatar EHR access submit paper documentation to the MHP by fax or in person for data entry into Avatar.
- Many contract providers are utilizing outcome tools, but due to a lack of Avatar access and disparate contract provider databases, the MHP does not have access to this larger pool of data.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce SD/MC and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
myAvatar Cal PM	Practice Management	Netsmart Technologies	13	MHP
Avatar Clinical Workstation (CWS)	Electronic Health Record	Netsmart Technologies	10	MHP
Order Connect	e-Prescribing	Netsmart Technologies	2	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace the Avatar system as it meets their EHR, billing, and state mandated reporting requirements.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for EHR functionality.

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	Avatar	x			
Clinical decision support				x	
Document imaging	Avatar		x		
Electronic signature—client	Avatar		x		
Electronic signature—provider	Avatar	x			
Laboratory results (eLab)	Avatar - Order Connect		x		
Outcomes	Avatar	x			
Prescriptions (eRx)	Avatar - Order Connect	x			
Progress notes	Avatar	x			
Treatment plans	Avatar	x			
Summary Totals for EHR Functionality		6	3	1	0

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

- The electronic signature is fully implemented with MHP staff with the exception of field staff who do not regularly utilize signature pads. Three additional laptops with air cards are anticipated to be available in May 2016, which could support client signatures by while staff are in the field.
- A document imaging pilot project is anticipated for March 2016. Support staff will scan releases of information and hospital records during this initial phase.
- Also in March 2016, the MHP will implement eLab functionality with Quest Diagnostics.
- The following consumer outcomes are in Avatar: ANSA for FSP consumers and CANS for subset of TAY.
- The MHP continues to rely on a hybrid (paper and electronic forms) medical record model to support clinical operations.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
    - Mobile psychiatry is planned for the older adult population.

  - The MHP does not calculate penetration rates or access by language to assure effective outreach and timeliness of service to targeted populations.

- Timeliness of Services
  - The MHP is still unable to reliably track and aggregate No Show data.
  - The MHP does not track timeless of services to mono-lingual clients.
- Quality of Care
  - The MHP lacks sufficient management analytical and technology staff resources to simultaneously support current IS operations, while "standing-up" the list of pending projects. Which results in clinic operations workarounds and impacts staff productivity.
  - Contract providers access to Avatar remains limited and there are no plans to expand or add additional contract provider access to the EHR. Most providers periodically submit paper documents, which are then entered into Avatar by MHP staff.
  - The two additional QM Analyst positions should expand the MHP's capacity to meet the needs of an increasingly data-driven organization.
  - A Clinical Information Systems Work Group was created and meets biweekly. The work group is composed of QM staff, program managers, and an IT representative.
  - Urgent services are not tracked in the EHR.
- Consumer Outcomes
  - The CANS and the ANSA are in the EHR and being rolled out for use with FSP and TAY clients. The LOCUS is in use with adult clients.
  - While many contract providers are utilizing outcome tools, due to a lack of Avatar access and disparate contract provider databases, the MHP does not have electronic access to this larger pool of data.

SITE REVIEW PROCESS BARRIERS

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

- Due to an unexpected medical leave of the QM Manager (the primary MHP contact) before the review, and her return just days prior to the review, three key documents were submitted late. The EQRO reviewed those documents submitted in advance but did not have sufficient time to review all the documents in their entirety prior to the 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:
    - Formation of the Health and Human Services Agency and integration of the county departments should improve access to services. Staff reported increased communication and streamlined services. Staff perceive that this integration has already positively affected access to services with Katie A. sub-class.
    - The opening of the Wellness Center in West Sacramento has been well-received by consumers. They reported feeling more engaged and connected to the mental health services and their own recovery, wellness, and mental health.
- Opportunities:
    - The MHP has an opportunity to improve access to services for under-served, particularly Latino population, in the county. The MHP will benefit from conducting their own outreach activities and directly engaging the populations in need.
    - The MHP should also examine its services and then outreach to other under-served populations in the county, including Russians and Native Americans.

Timeliness of Services

- Strengths:
    - The expansion of the number of Quality Management team positions has the potential to improve the MHP's ability to track timeliness, analyze the data, and then use this data to inform services and practices.
- Opportunities:

- The MHP has an opportunity to assess timeliness of services by preferred language and consumer population (adults vs. youth), given impending EHR modifications.

Quality of Care

- Strengths:
  - The addition of two Quality Management analysts as well as the overall expansion of the Quality Management team has the potential to improve the MHP's capacity to analyze and evaluate capacity relative to consumer needs. The MHP will be better positioned to use data to modify or expand services as necessary.
  - The MHP has done well to involve and solicit participation from consumers. Consumer input is particularly evident at the Wellness Center.
- Opportunities:
  - The MHP has an opportunity to develop performance measures and criteria for 'graduating' peer staff and peer support workers. The performance measures should be based on achievement of goals or benchmarks, rather than time in the program. Consumers, in particular, will benefit from having formal transition to external workforce opportunities.
  - The MHP has an opportunity to articulate and clearly define processes and chains of command that were affected by the integration of the social services, mental health, and public health departments. The MHP should consult both staff and contract providers who can provide examples of areas in which more clarity or direction is needed.

Consumer Outcomes

- Strengths:
  - The MHP appears to be focused on consumer outcomes and results of services as evidenced by their recent adoption of the CANS, ANSA and LOCUS tools.
- Opportunities:
  - The MHP should standardize and ensure proper training of staff in the use of the outcome measures (e.g., LOCUS, CANS, ANSA) at the *outset*, so that user-error and reliability, do not pose challenges, as they currently do with the EHR.
  - The MHP has an opportunity to integrate or at the very least, use, the outcome measures provided to them by their contract providers.

- MHP will benefit from analyzing this outcome data and using it to inform services for consumers and collaboration with contract providers.

RECOMMENDATIONS

- Develop protocols and procedures for consistent provision of valid and reliable data for *all* measures of timeliness of and access to services. In so doing, the MHP should conduct a feasibility assessment of Netsmart Technologies ScriptLink that would eliminate manual processes that rely on exception reports.
- Develop and initiate two PIPs, both a clinical and a non-clinical PIP.
- Track and trend timeliness of urgent appointments. The MHP needs to set a standard and monitor timeliness of *urgent* appointments for services within its system of care.
- Produce a work plan and roadmap that outlines how and when contract providers will obtain direct access to Avatar EHR. The MHP will benefit from forming a stakeholder workgroup that includes MHP and contract providers' subject matter experts.
- Prioritize implementation of Avatar Managed Services Organization, document imaging, and e-lab modules to reduce reliance on hybrid medical record and to improve support for clinic operations and productivity.
- Continue to prioritize staff resources to expand the use of Dimension Reports and Enlighten Analytics tools to further improve the use of data for claims analysis and reconciliation.

ATTACHMENTS

Attachment A: Review Agenda

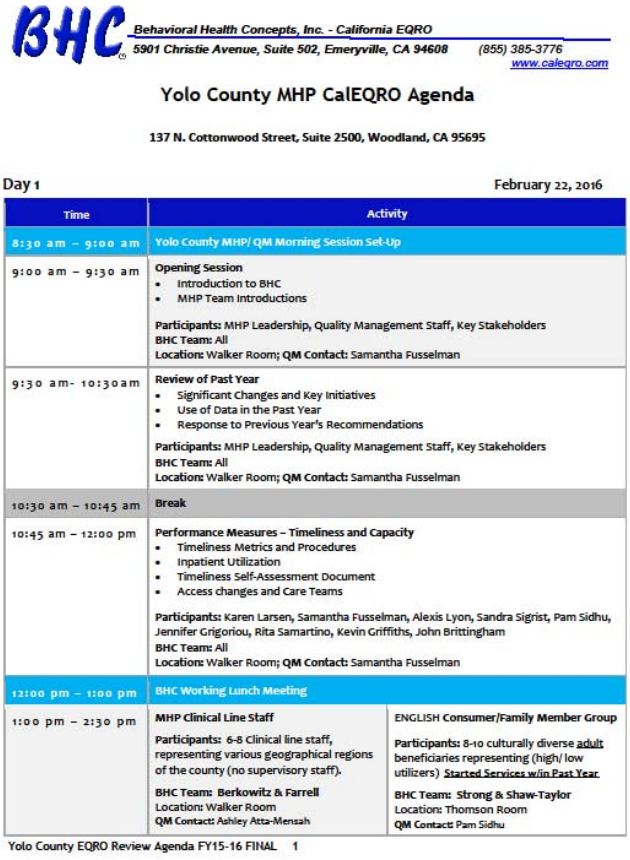
Attachment B: Review Participants

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 MHP On-Site Review Agenda:



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Yolo County MHP CalEQRO Agenda

137 N. Cottonwood Street, Suite 2500, Woodland, CA 95695

Day 1 February 22, 2016

Time	Activity	
8:30 am – 9:00 am	**Yolo County MHP/ QM Morning Session Set-Up**	
9:00 am – 9:30 am	**Opening Session** • Introduction to BHC • MHP Team Introductions **Participants:** MHP Leadership, Quality Management Staff, Key Stakeholders **BHC Team:** All **Location:** Walker Room; **QM Contact:** Samantha Fusselman	
9:30 am- 10:30am	**Review of Past Year** • Significant Changes and Key Initiatives • Use of Data in the Past Year • Response to Previous Year's Recommendations **Participants:** MHP Leadership, Quality Management Staff, Key Stakeholders **BHC Team:** All **Location:** Walker Room; **QM Contact:** Samantha Fusselman	
10:30 am – 10:45 am	**Break**	
10:45 am – 12:00 pm	**Performance Measures – Timeliness and Capacity** • Timeliness Metrics and Procedures • Inpatient Utilization • Timeliness Self-Assessment Document • Access changes and Care Teams **Participants:** Karen Larsen, Samantha Fusselman, Alexis Lyon, Sandra Sigrist, Pam Sidhu, Jennifer Grigoriou, Rita Samartino, Kevin Griffiths, John Brittingham **BHC Team:** All **Location:** Walker Room; **QM Contact:** Samantha Fusselman	
12:00 pm – 1:00 pm	**BHC Working Lunch Meeting**	
1:00 pm – 2:30 pm	**MHP Clinical Line Staff** **Participants:** 6-8 Clinical line staff, representing various geographical regions of the county (no supervisory staff). **BHC Team: Berkowitz & Farrell** Location: Walker Room **QM Contact:** Ashley Atta-Mensah	**ENGLISH Consumer/Family Member Group** **Participants:** 8-10 culturally diverse adult beneficiaries representing (high/ low utilizers) Started Services w/in Past Year **BHC Team: Strong & Shaw-Taylor** Location: Thomson Room **QM Contact:** Pam Sidhu

Yolo County EQRO Review Agenda FY15-16 FINAL 1

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Gale Berkowitz, Lead Quality Reviewer
Ewurama Shaw-Taylor, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Deb Strong, 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 SITE

Yolo County Department of Health and Human Services
137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695

CONTRACT PROVIDER SITES

No Contract Provider Sites were visited

Participants Representing the MHP

Name		Position	Agency
Anderson	Brad	Cool Beans	Turning Point
Andrade-Lewis	Christin	Supervisor	CommuniCare
Argueta	Eliana	Lead CREO/CORE Program	CommuniCare
Atta-Mensah	Ashley	QM Senior Staff Nurse	Yolo County HHSA
Azevedo	Marcie	Accountant	Yolo County HHSA
Barrett	Katherine	QM Supervising Clinician, A&A Branch	
Beesley	Joan	MHSA Manager, Adult & Aging	Yolo County HHSA
Benites	Pete	Office Manager	RISE, Inc
Blanc	Jim	Senior Svcs. Analyst, Child Welfare	Yolo County HHSA
Book	Alison	CWS Manager, Child Welfare	Yolo County HHSA
Brittingham	John	QM Analyst	Yolo County HHSA
Christensen	Laura	Supervising Clinician	Yolo County HHSA
Cune	Kristen	Supervising Clinician	Yolo County HHSA
Dickinson	Tracey	Homeless Program Coordinator	Yolo County HHSA
Dominguez	Kacey	Analyst	Yolo County HHSA

Dornbush	Edie	Clinical Director	Yolo County HHSA
Eckert	Katy	Deputy Director	Yolo County HHSA
Fitzgibrun	James	Cool Beans	Turning Point
Fogle	Linda	Supervising Clinician	Yolo County HHSA
Freitas	Julie	Supervising Clinician	Yolo County HHSA
Fusselman	Samantha	QM Manager, A&A Branch	Yolo County HHSA
Gallegati	Mario	Supervising Clinician	Yolo County HHSA
Garton	Alexandra	Youth Services Supervisor	CommuniCare
Gavin	Sara	Director, Behavioral Health	CommuniCare
Gerner	Christine	PSW	Yolo County HHSA
Giffiths	Kevin	Avatar Systems Admin	ITDD
Grigoriou	Jennifer	QM Clinician	Yolo County HHSA
Gump	Marcia	Director, Program Services	Turning Point
Her	Duazong	Accountant	Yolo County HHSA
Hernandez	Carolina	Mental Health Specialist II	Yolo County HHSA
Hitchcock	Jamie	PSW	Yolo County HHSA
Joy	Brian	QM Clinician	Yolo County HHSA
Kellogg	Michele	Executive Director	YCCC
Larsen	Karen	Mental Health Director	Yolo County HHSA
Lockohin	Gabriel	PSS	Turning Point
Ly	Lynn	Clinician II	Yolo County HHSA
Lyon	Alexis	Manager	Yolo County HHSA
Marquez	Victor	Cool Beans	Turning Point
McSorley	Jean	Clinician II	Yolo County HHSA
Moe	David	Cool Beans	Turning Point
Neblett	Lester	Executive Director	YFSA
Nelson	Alex	CWS Supervisor, Child Welfare	Yolo County HHSA
Planell	Joan	Director	Yolo County HHSA
Porter	Kimberly	WRAP Supervisor	CommuniCare
Prenter	Geoffrey	Clinician II	Yolo County HHSA
Redmond	Kathy	Admin. Svcs. Analyst, Child Welfare	Yolo County HHSA
Robinson	Winona	PSW	Yolo County HHSA
Samartino	Rita	Info Systems Coordinator	Yolo County HHSA
Shen	Sadie	Director, Adult Mental health	Turning Point
Sidhu	Pam	Analyst	Yolo County HHSA
Sigrist	Sandra	Clinical Manager	Yolo County HHSA
Smith	Theresa	Manager, Children & TAY	Yolo County HHSA
Smith	Tessa	Family Partner	Yolo County HHSA
Stewart	Carmel	Mental Health Specialist II	Yolo County HHSA
Sykes	Alissa	Branch Director, CYF	Yolo County HHSA
Tryon	Randy	Director	Fourth & Hope
Uribe	Jessica	Case Manager	RISE, Inc
Volzer	Matthew	Clinical Director	Turning Point

Wilson	Christina	PSW	Yolo County HHSA

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:

No Clinical PIP was submitted.

Non-Clinical PIP:

No Non-Clinical PIP was submitted.