

**FY16-17**

**Medi-Cal Specialty Mental Health**

**External Quality Review**

**MHP Final Report**

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**Yolo**

*Conducted on*

*February 1-2, 2017*

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## TABLE OF CONTENTS

<b>YOLO MENTAL HEALTH PLAN SUMMARY FINDINGS.....</b>	<b>4</b>
<b>INTRODUCTION .....</b>	<b>6</b>
<b>PRIOR YEAR REVIEW FINDINGS, FY15-16.....</b>	<b>8</b>
STATUS OF FY15-16 REVIEW RECOMMENDATIONS .....	8
<i>Assignment of Ratings</i> .....	8
<i>Key Recommendations from FY15-16</i> .....	8
CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS.....	10
<b>PERFORMANCE MEASUREMENT.....</b>	<b>12</b>
TOTAL BENEFICIARIES SERVED.....	12
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY .....	13
HIGH-COST BENEFICIARIES .....	17
TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE .....	18
DIAGNOSTIC CATEGORIES .....	19
PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS.....	20
<b>PERFORMANCE IMPROVEMENT PROJECT VALIDATION .....</b>	<b>22</b>
YOLO MHP PIPS IDENTIFIED FOR VALIDATION.....	22
CLINICAL PIP—INPATIENT UTILIZATION .....	24
NON-CLINICAL PIP—CARE COORDINATION COLLABORATIVE.....	26
PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS.....	27
<b>PERFORMANCE &amp; QUALITY MANAGEMENT KEY COMPONENTS .....</b>	<b>28</b>
<i>Access to Care</i> .....	28
<i>Timeliness of Services</i> .....	29
<i>Quality of Care</i> .....	30
KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS .....	32
<b>CONSUMER AND FAMILY MEMBER FOCUS GROUP(S) .....</b>	<b>34</b>
CONSUMER/FAMILY MEMBER FOCUS GROUP 1 .....	34
CONSUMER/FAMILY MEMBER FOCUS GROUP 2 .....	35
CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS.....	35
<b>INFORMATION SYSTEMS REVIEW .....</b>	<b>37</b>
KEY ISCA INFORMATION PROVIDED BY THE MHP .....	37
CURRENT OPERATIONS.....	38
PLANS FOR INFORMATION SYSTEMS CHANGE .....	39
ELECTRONIC HEALTH RECORD STATUS.....	39
MAJOR CHANGES SINCE LAST YEAR .....	40
PRIORITIES FOR THE COMING YEAR .....	41
OTHER SIGNIFICANT ISSUES .....	41
MEDI-CAL CLAIMS PROCESSING .....	42
INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS.....	43
<b>SITE REVIEW PROCESS BARRIERS .....</b>	<b>44</b>
<b>CONCLUSIONS .....</b>	<b>45</b>

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STRENGTHS AND OPPORTUNITIES .....	45
<i>Access to Care</i> .....	45
<i>Timeliness of Services</i> .....	45
<i>Quality of Care</i> .....	46
<i>Consumer Outcomes</i> .....	47
RECOMMENDATIONS .....	47
<b>ATTACHMENTS .....</b>	<b>49</b>
ATTACHMENT A—REVIEW AGENDA.....	50
ATTACHMENT B—REVIEW PARTICIPANTS.....	51
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA .....	54
ATTACHMENT D—PIP VALIDATION TOOL .....	56

## YOLO MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—1,511
- MHP Threshold Language(s)—Spanish, Russian
- MHP Size—Medium
- MHP Region—Central
- MHP Location—Woodland
- MHP County Seat—Woodland

### Introduction

Yolo's MHP is categorized as a Medium size and Central County MHP. Mental health services are subsumed under two branches of the county's Health and Human Services Agency (HHS): Adult and Aging and Child, Youth and Family. This year marks the second year of the integration of the HHS. The MHP has three service locations: Woodland (also the site of the MHP's administrative offices), West Sacramento, and Davis. The MHP provides outpatient, residential, mobile, and crisis intervention services.

During the FY16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality, and Outcomes of MHP and its contract provider services. Further details and findings from EQRO mandated activities are provided in the rest of the report.

### Access

As the HHS continued to integrate services over the past year, there have been changes with the mental health system. A primary change has been the departure of several staff in leadership positions and subsequent promotion and reassignment of other staff. In the latter half of the year, the MHP also discovered a significant budget shortfall due to denied and un-submitted claims. Clinical staff in some programs were reassigned to quality management and other departments where they could assist with timely billing and claims. Stakeholders linked the reassignment of/reduction in clinical staff, particularly from the transitional-age youth (TAY) programs, to a decrease in services and subsequent increase in hospitalizations for TAY. The MHP is revamping and rebuilding their TAY program. The MHP has a number of initiatives to improve and coordinate access for certain high-needs, at risk populations, including consumers experiencing homelessness, consumers discharged from a hospital, and older adult consumers with comorbid mental and physical health conditions. After a brief period of increased and stable psychiatric coverage last year, the MHP experienced a nearly 50% reduction in psychiatry coverage, which is consistent with stakeholders reports of frequent turnover of psychiatric providers. While the MHP has a large and predominately Latino population, the penetration rate for this population is among the lowest in

the State and has decreased from 2.41% in CY14 to 1.70% in CY15. In the MHP's ongoing efforts to increase access for Latinos, the MHP should include (or increase) the provision of groups in Spanish.

### **Timeliness**

The MHP has a new Access log that has enabled the MHP to revise their methodology for tracking timeliness to service. The revision affects timeliness for adult services, but not children's services. Contract providers, who provide much of the services in the children's system of care, reported that they do not routinely submit timeliness data to the MHP. The MHP does not meet their standard for a number of timeliness metrics, including first appointment, first psychiatry, and no shows, all of which have increased over the past year. Just as last year, the MHP did not track time-to-urgent conditions. The MHP presented anecdotal information that urgent conditions are responded to within 48 hours. With the increase in Quality Management (QM) department, the MHP should consider allocation of staff and resources to enable routine monitoring of time-to-urgent services.

### **Quality**

The MHP has increased their staffing in the quality management department by six full time equivalents (FTEs), including three FTEs to address discharge planning and authorization. . With this increase, the MHP is positioned to direct more resources to monitoring, data collection, and implementation of initiatives that improve quality, access, and timeliness. Already, with the help of QM, the MHP has been able to submit \$961,000 in additional gross billing for reimbursement. Stakeholders were all aware of the budget challenges of the MHP and perceived billing as the primary focus. The message that internal stakeholders have inferred is to maintain high productivity thus ensuring more billable services; staff reported trade-offs in quality to maintain productivity. There are communication challenges with both internal and external stakeholders. Internal stakeholders, in particular, reported a need for more transparent communication and equitable practices related to hiring and staff responsibilities.

### **Outcomes**

During the previous (FY15-16) review, the MHP featured results-based accountability as their framework for performance measures. During this review, few examples of results-based accountability were evident and the concept did not resonate with many stakeholders. CANS and ANSA are used by contract providers, but the results are not routinely reviewed or used to inform decision-making on a systemic level. Stakeholders reported that family members had difficulty participating in treatment, despite specific requests of the consumer. The MHP's 7-day and 30-day re-hospitalization rates remained stable from CY14 to CY15 and remain below corresponding statewide averages and may continue to decrease given the MHP's Clinical PIP to address readmission rates.

## 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 rules (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations [MCOs]) 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 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the FY16-17 findings of an EQR of the Yolo MHP by the California EQRO (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<sup>1</sup>

This report contains the results of the EQRO's validation of **eight Mandatory Performance Measures (PMs)** as defined by DHCS. The eight 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
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (\$30,000 or higher)

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<sup>1</sup> 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.

## **(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS<sup>2</sup>**

Each MHP is required to conduct two Performance Improvement Projects (PIPs) during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

## **(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES<sup>3</sup>**

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.

## **(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 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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

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

- Changes, progress, or milestones in the MHP's approach to performance management emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- 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 serves 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](http://www.caleqro.com).

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<sup>2</sup> 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.

<sup>3</sup> 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.

## PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section the status of last year's (FY15-16) recommendations are presented, as well as changes within the MHP's environment since its last review.

### STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 recommendations, which are summarized below.

#### Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when 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 is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

#### Key Recommendations from FY15-16

- Recommendation #1: 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.
 

Fully addressed                     
  Partially addressed                     
  Not addressed

  - Note: In the FY15-16 CalEQRO report, two recommendations that were both related to data quality were erroneously combined. The Netsmart Technologies ScriptLink is not a tool that can address reporting of timeliness.
  - The MHP developed an access log in Avatar to record new service requests and capture data elements necessary to measure timeliness from initial contact to first appointment, first mental health service, and first medication support service. Avatar data are also used to report and trend no-show services.
  - An external Treatment Authorization Request log combined with Avatar data are utilized to report follow-up contact after hospitalizations.



- Recommendation #2: Develop and initiate two PIPs, both a clinical and a non-clinical PIP.

Fully addressed                       Partially addressed                       Not addressed

- The MHP presented two PIPs, both of which were initiated and developed in 2016.
- The MHP was successful in translating a concept that they had last year to a viable clinical PIP.
- The MHP's Non-Clinical PIP about care coordination for older adults with comorbid somatic chronic diseases, may ultimately improve services but does specifically address a known problem or an area of weakness for the MHP. The MHP only speculates on potential risks and consequences of poor coordination. Ultimately, the project lacks some components that would make it a viable PIP.

- Recommendation #3: 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.

Fully addressed                       Partially addressed                       Not addressed

- While the MHP referenced a 48-hour standard for time to urgent conditions this standard was not written or stated in their *Self-Assessment of Timely Access*. The MHP also did not provide data on timeliness of appointments for urgent conditions.
- The MHP reported that anecdotally clients presenting with urgent conditions are seen within 48 hours.

- Recommendation #4: 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.

Fully addressed                       Partially addressed                       Not addressed

- The intent of this recommendation was for the MHP to grant access to Avatar by their contract providers. The MHP responded that they are developing an Information Systems work plan, but did not explore Avatar access by contract providers.
- Only one of the MHP's contract providers and their largest (Turning Point Community Programs) has Avatar access for service entry and treatment planning. The MHP has no plans to expand Avatar access for Turning Point.
- The MHP indicated that Avatar access by other contract providers is not among their top priorities, thus despite their requests and queries about the MHP's Avatar, access is unlikely.

- Recommendation #5: Prioritize implementation of Avatar Managed Services Organization, document imaging, and eLab modules to reduce reliance on hybrid medical record and to improve support for clinic operations and productivity.

Fully addressed       Partially addressed       Not addressed

- eLab and document imagining went live in July 2016. However, due to staffing constraints, scanning did not progress as planned and the MHP is currently reviewing the priority of documents to be scanned.
- The MHP continues to utilize a hybrid medical record. No progress was made in the past year on implementation of the Avatar Managed Service Organization module due to the departure of the Avatar Systems Administrator and his expertise in Avatar. The vacated position was filled in November 2016.
- Recommendation #6: 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.

Fully addressed       Partially addressed       Not addressed

- Dimension reports was utilized by the MHP after realizing their high rate of claim denial. The Behavioral Health unit of HHSA Administration borrowed staff from other programs to focus on delayed billing and claim denials. The effort resulted in \$961,000 in additional gross billing being submitted for reimbursement.
- Netsmart Technology provided Enlighten Analytics training in March 2016. However, due to the resignation of Avatar Systems Administrator and a subsequent loss of subject matter expertise in June 2016, the MHP did not further explore the use of Enlighten Analytics. The MHP has no immediate plans to use this product.

## 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
  - In an effort to recoup payments following the discovery of a significant budget shortfall, the MHP has reassigned a few program staff to the QM and other departments where they can assist with more timely billing and addressing denied claims. A number of stakeholders linked the reassignment of staff, from the Adult & Aging TAY Mental Health program, to decrease in services for TAY and an increase in hospitalizations for this population.
  - Although no specific change was referenced, stakeholders reported instability in psychiatric provider coverage. There appears to be frequent turnover of providers which contributes to interruption of client care and inconsistent medication prescribing practices, which affects access as well as consumer outcomes.

- The MHP received a Cooperative Agreements to Benefit Homeless Individuals grant which is funded by the Substance Abuse and Mental Health Services Administration. The grant is approximately \$2.4M over a three-year period (approximately \$800,000 annually) and will provide intensive wrap-around care to people experiencing homelessness with co-occurring mental health and substance use disorders including treatment, peer recovery supports, and housing as well as employment assistance.
- The MHP received a Social Determinants of Health Innovation grant funded by Partnership Health Plan of California. The grant will provide approximately \$500,000 over a two-year period to provide intensive wrap-around care including a 24-hour response to local emergency departments and housing navigation assistance to people experiencing homelessness who are medically vulnerable.
  - Timeliness of Services
- Timeliness to services and availability of clinicians to serve TAY beneficiaries has been affected by the reassignment of staff from the TAY Mental Health program.
  - Quality of Care
- The MHP reported a 70% turnover in a number of leadership and management positions since the last EQRO (February 22-23, 2016). Turnover included, among others, the Assistant Director; the Adult and Aging Branch Director; the HHSA Agency Director; the Adult and Aging Clinical Manager; the Child and TAY Mental Health Manager; and the Child, Youth and Family Branch Director; and the Fiscal Branch Director. HHSA also added a behavioral health medical director. The MHP has increased their staffing in the QM department by six. With additional staff, the MHP should be able to review documentation, ensure claims processing, and improve data collection and analysis.
  - Consumer Outcomes
- The MHP has completed the integration of mental health staff within Child Welfare Services. The MHP anticipates an increase in access to service for youth in foster care and improved outcomes due to increased oversight and collaboration.

## PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following performance measures 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 TBS Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (\$30,000 or higher)

### TOTAL BENEFICIARIES SERVED

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

<b>Table 1—Yolo MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity</b>				
<b>Yolo</b>				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	11,918	27.0%	742	49.1%
Hispanic	19,725	44.7%	336	22.2%
African-American	1,879	4.3%	120	7.9%
Asian/Pacific Islander	4,702	10.7%	72	4.8%
Native American	318	0.7%	25	1.7%
Other	5,540	12.6%	216	14.3%
Total	44,080	100%	1,511	100%

\*The total is not a direct sum of the averages above it. The averages are calculated separately.  
The actual counts are suppressed for cells containing n ≤11.

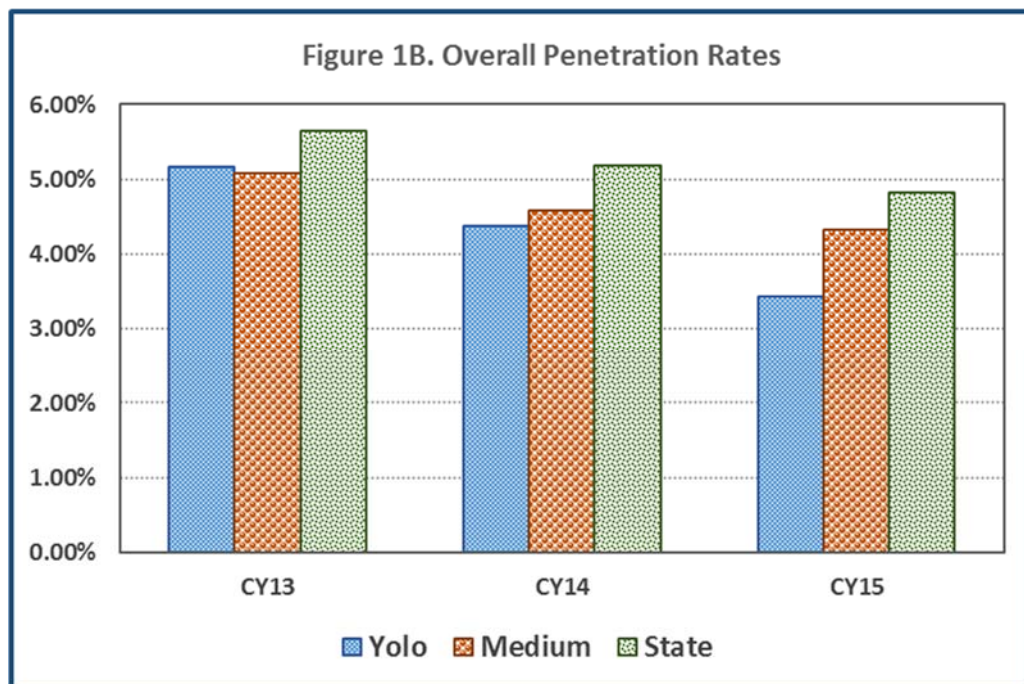
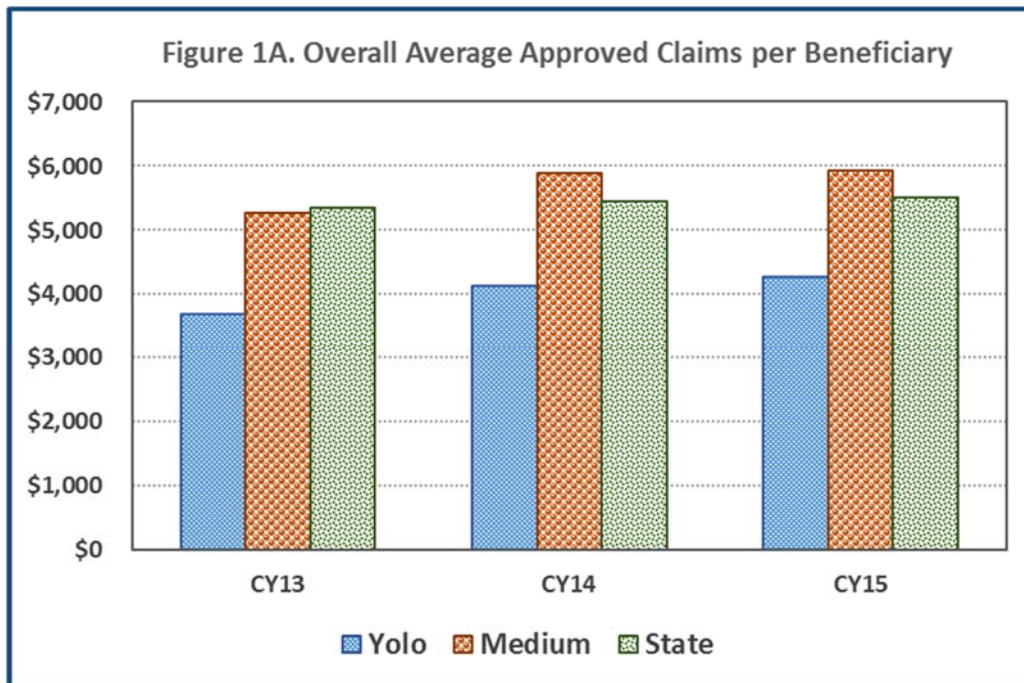
**PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY**

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.

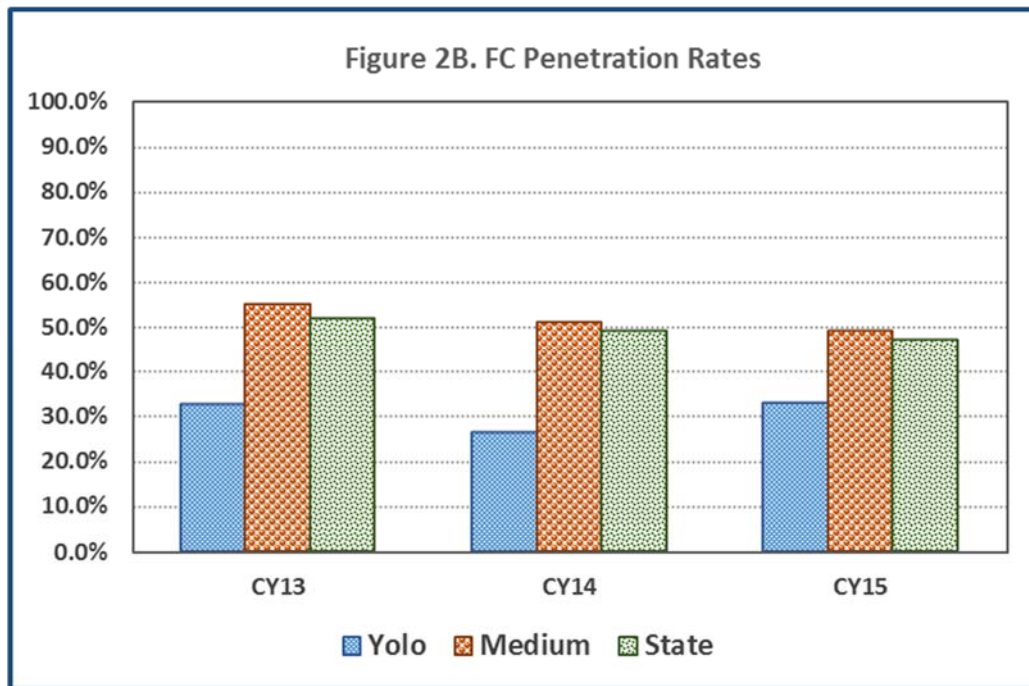
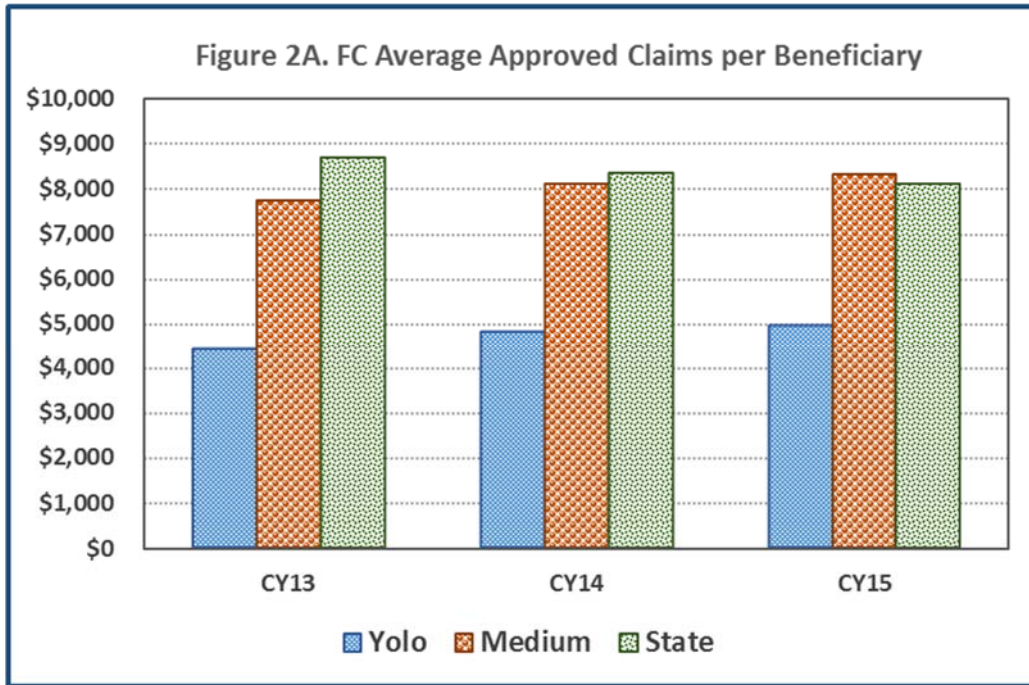
Regarding calculation of penetration rates, the Yolo MHP:

- Uses the same method as used by the EQRO.
- Uses a different method.
- Does not calculate its penetration rate. The MHP relies on data provided by CalEQRO.

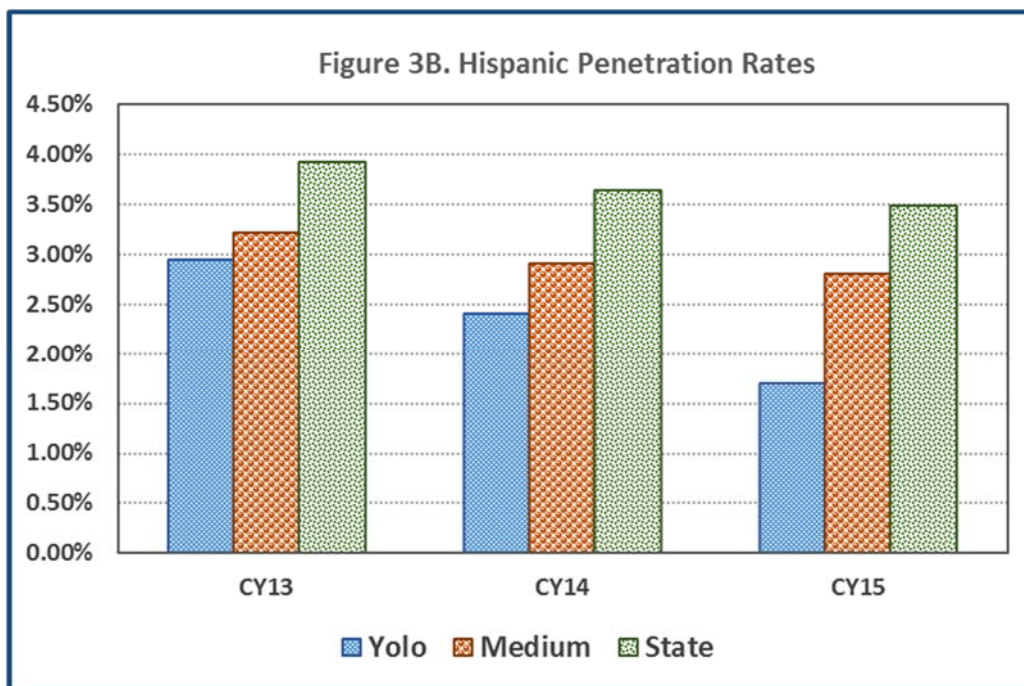
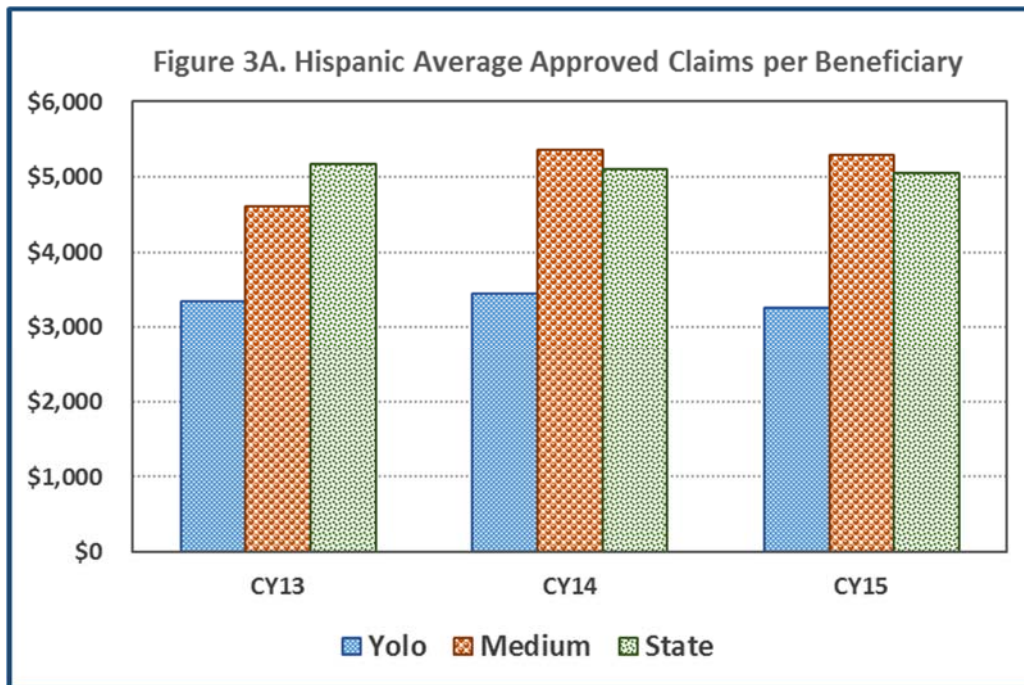
Figures 1A and 1B show 3-year trends of the MHP’s overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Medium MHPs.



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.



See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary.



**HIGH-COST BENEFICIARIES**

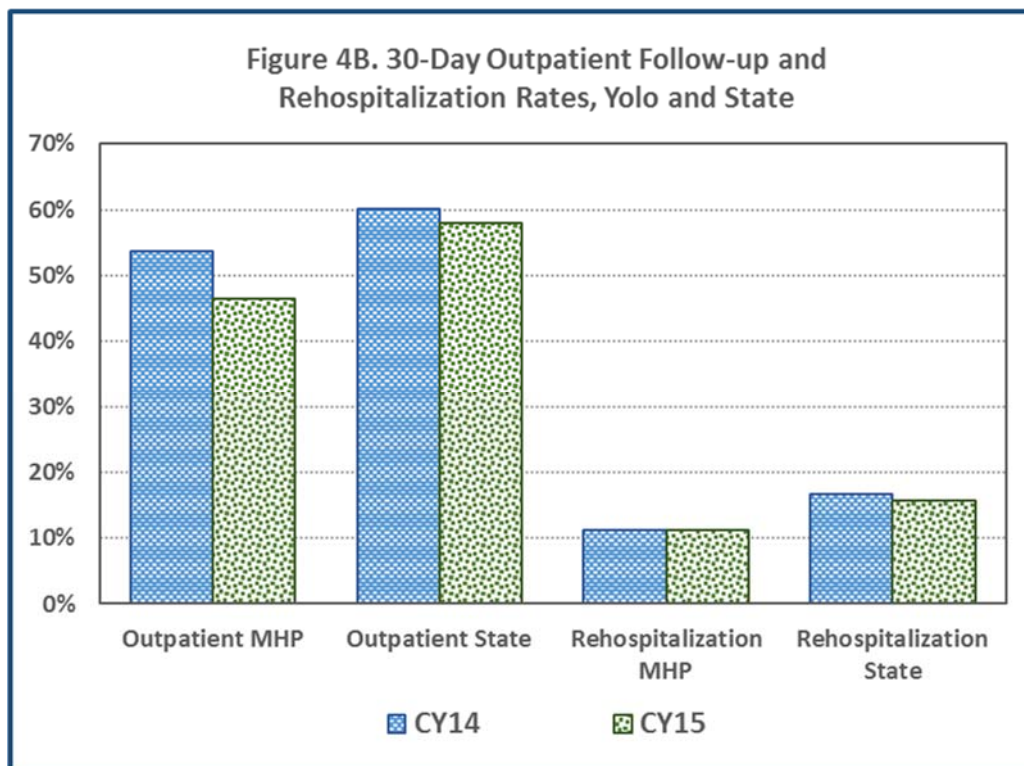
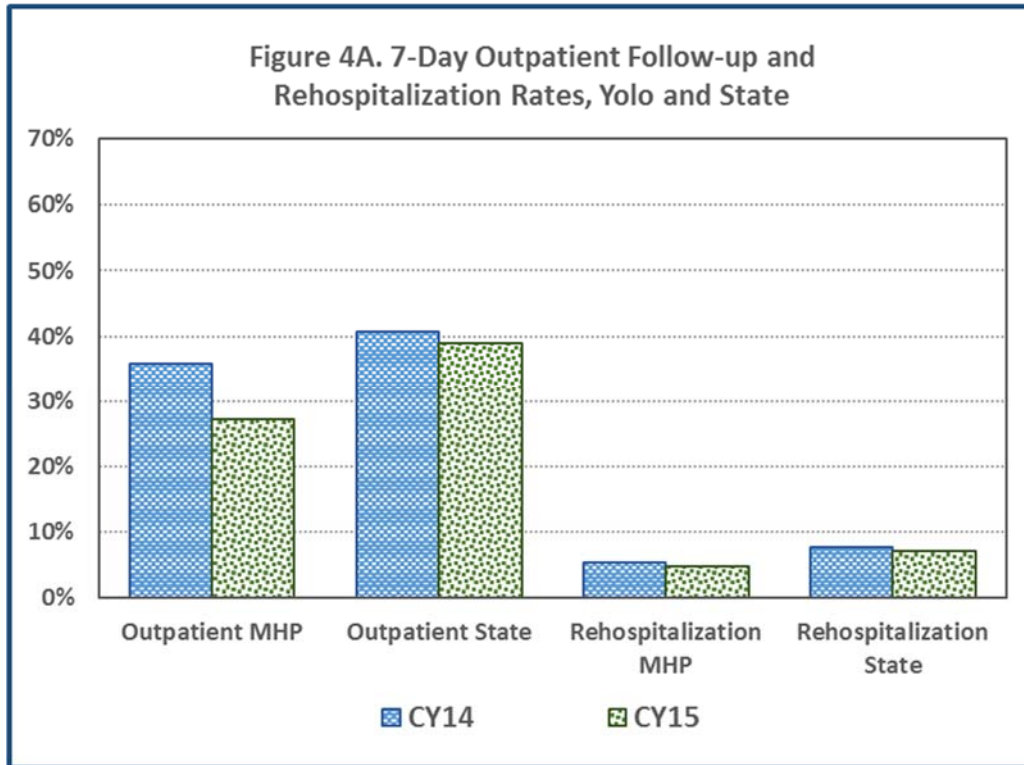
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP’s data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than \$30,000 in a year.

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	CY15	13,851	483,793	2.86%	\$51,635	\$715,196,184	26.96%
Yolo	CY15	40	1,511	2.65%	\$51,897	\$2,075,883	32.10%
	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%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under \$20,000; \$20,000 to \$30,000; and those above \$30,000.

**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 CY14 and CY15.

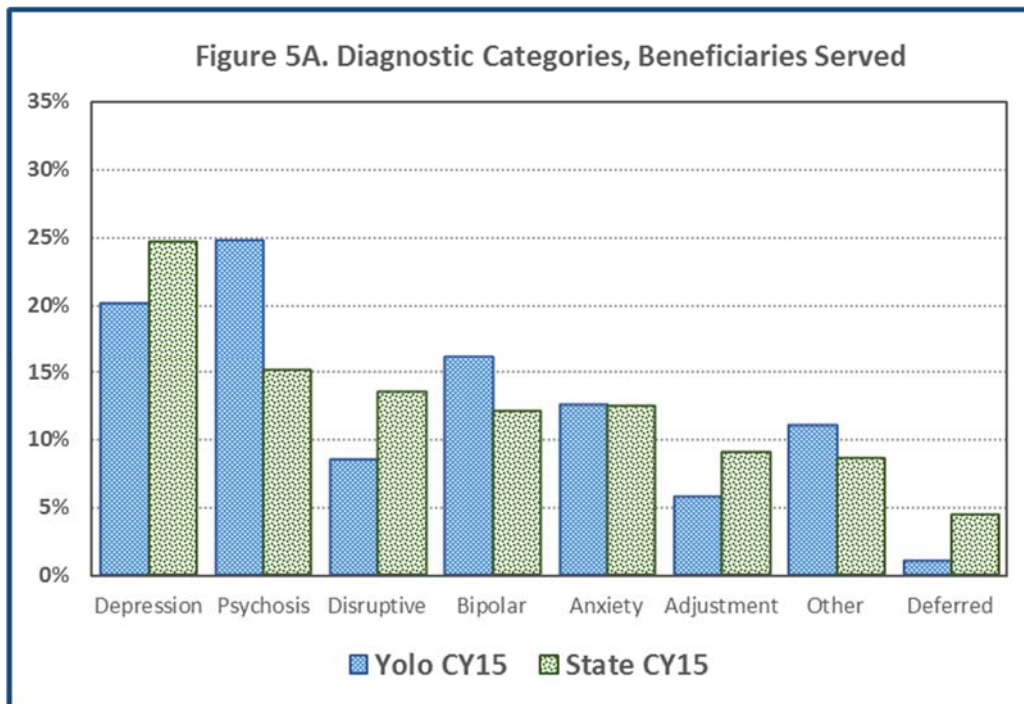


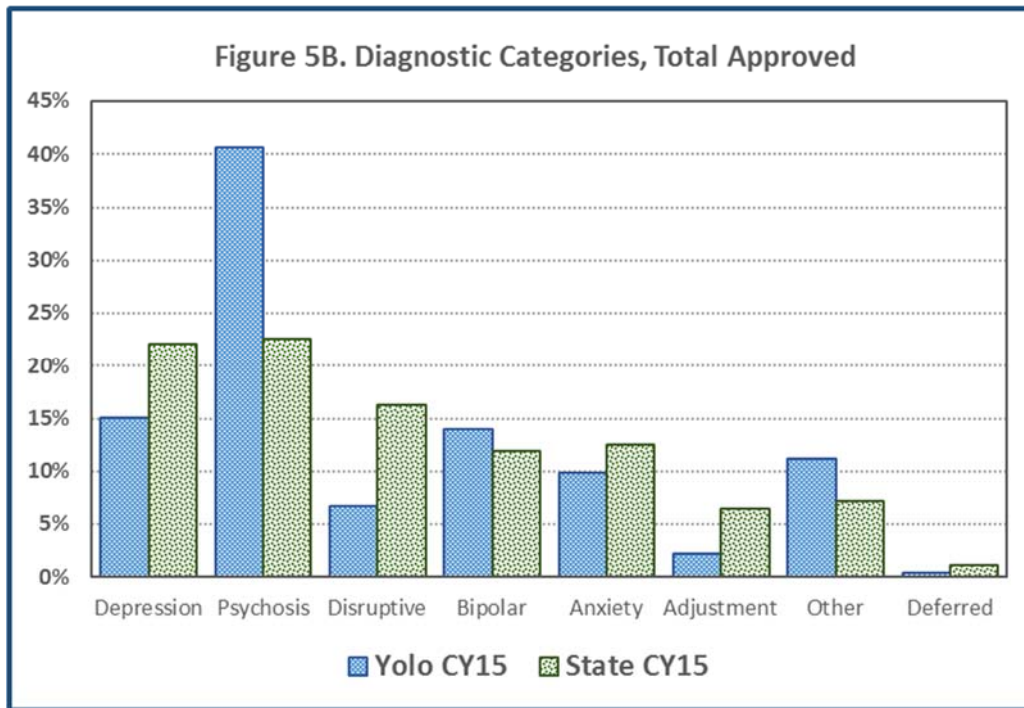
**DIAGNOSTIC CATEGORIES**

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 CY15.

- The MHP does not track the number of consumers with co-occurring (substance abuse and mental health) diagnoses.

N/A





**PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS**

- Access to Care
  - While the MHP’s number of eligibles rose from 41,280 in CY14 to 44,080 in CY15, beneficiaries served decreased from 1,802 to 1,511 during this period. This correlates to a drop in penetration rate from 4.37% in CY14 to 3.43% in CY15. The MHP experienced a penetration rate decline each year from CY13 to CY15 and CY15 Overall penetration rate (3.43%) remains less than both the medium county (4.31%) and statewide (4.82%) averages.
  - The MHP served 303 ACA beneficiaries of 13,913 eligibles, in CY15 for a penetration rate of 2.18% for this sub-group (see Table C1 in Appendix C).
  - When combining the Medi-Cal and ACA data, the MHP’s CY15 average monthly eligibles increased to 57,993 with 1,814 beneficiaries for a combined increase from CY14 Medi-Cal only data of 16,713 eligibles and 12 additional beneficiaries served.
  - The MHP’s Foster Care penetration rate increased from 26.30% in CY14 to 32.83% in CY15, but remains less than both the medium county (48.98%) and statewide (47.19%) averages.
  - The MHP’s Hispanic penetration rate declined from 2.41% in CY14 to 1.70% in CY15 and remains less than both the medium county (2.80%) and statewide (3.49%) averages.

- Timeliness of Services
  - In CY15, the MHP's 7- and 30-day follow-up rates after discharge from a hospitalization declined when compared to CY14 rates and remain less than the corresponding statewide averages.
- Quality of Care
  - The MHP's average Overall approved claims per beneficiary rose slightly from CY14 (\$4,136) to CY15 (\$4,282), but remains less than both the medium county (\$5,943) and statewide (\$5,522) averages.
  - The MHP's Foster Care approved claims per beneficiary increased slightly from CY14 (\$4,814) to CY15 (\$4,951), but remains significantly less than both the medium (\$8,324) and statewide (\$8,127) averages. The MHP had 109 Foster Care beneficiaries in CY15.
  - The MHP's CY15 average Hispanic approved claims per beneficiary declined slightly from CY14 (\$3,436) to CY15 (\$3,256), and remains less than both medium county (\$5,287) and statewide (\$5,045) averages.
  - While the MHP's percentage of HCBs has been trending upward and increased notably from CY13 (1.32%) to CY 15 (2.65%), it remains less than the CY15 statewide average (2.86%).
  - The percentage of total HCB claim dollars is greater than the statewide average in CY15 (32.10% vs. 26.96%). The MHP's CY15 high cost average approved claims per beneficiary has been trending upward from CY13 (\$49,584) to CY15 (\$51,897) and is now comparable to statewide average (\$51,635).
  - Varying from the statewide diagnostic pattern, a primary diagnosis of psychosis accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a higher rate of bipolar diagnoses and a lower rate of disruptive, adjustment, depressive and deferred diagnoses when compared to statewide averages.
  - Corresponding with the MHP's diagnostic pattern, the percentage of total approved claims for individuals with psychotic disorders were significantly higher than that of other diagnostic categories. Other diagnostic approved claims dollars were also aligned with the MHP's diagnostic patterns.
- Consumer Outcomes
  - The MHP's 7- and 30-day re-hospitalization rates remained stable from CY14 to CY15 and remain below corresponding statewide averages.

## PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by 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 2015.

### YOLO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated two MHP submitted PIPs as shown below.

Table 3—PIPs Submitted		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Inpatient Utilization
Non-Clinical PIP	1	Care Coordination Collaborative

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.<sup>4</sup>

Table 4—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	PM	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	M	NR
		1.4	All enrolled populations	M	NR
2	Study Question	2.1	Clearly stated	M	NR

<sup>4</sup> 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 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	M	NR
		3.2	Inclusion of the entire study population	M	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	NR
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	PM	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NR
		5.2	Valid sampling techniques that protected against bias were employed	NA	NR
		5.3	Sample contained sufficient number of enrollees	NA	NR
6	Data Collection Procedures	6.1	Clear specification of data	PM	NR
		6.2	Clear specification of sources of data	PM	NR
		6.3	Systematic collection of reliable and valid data for the study population	PM	NR
		6.4	Plan for consistent and accurate data collection	M	NR
		6.5	Prospective data analysis plan including contingencies	NM	NR
		6.6	Qualified data collection personnel	M	NR
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	UTD	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NM	NR
		8.2	PIP results and findings presented clearly and accurately	PM	NR
		8.3	Threats to comparability, internal and external validity	NA	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NR

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	NA	NR
		9.4	Statistical evidence of true improvement	NA	NR
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NR

\*M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine; NR = Not Rated (Concept Only or None Submitted)

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	8	NR
Number Partially Met	7	NR
Number Not Met	2	NR
Number Applicable (AP) (Maximum = <b>28</b> <u>with</u> Sampling; <b>25</b> <u>without</u> Sampling)	18	NR
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	64%	NR

**CLINICAL PIP—INPATIENT UTILIZATION**

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

- “If the MHP improves discharge planning and care coordination processes for beneficiaries experiencing an acute psychiatric hospitalization, will there be a decrease in average length of stays and readmission rates as well as an increase in the rate of follow-up appointments within 7 days following discharge?”
- Date PIP began: August 2016
- Status of PIP:



- Active and ongoing
- Completed
- Inactive, developed in a prior year (*Not Rated*)
- Concept only, not yet active (*Not Rated*)
- Submission determined not to be a PIP (*Not Rated*)
- No PIP submitted (*Not Rated*)

Through a QM review of inpatient utilization, the MHP identified an increase in hospital admissions, average length of stay, and both 7-day and 30-day readmissions, over the past five (fiscal) years. The MHP has targeted readmissions and related duration of stay for improvement.

The goal of the PIP is to reduce the rate of readmission and reduce the amount of time that clients with severe mental illness (SMI) spend in acute psychiatric treatment. The PIP is also meant to increase timely access to post-discharge follow-up. The MHP's interventions focus on improving and enhancing discharge planning and care coordination; the MHP referenced literature that transitional interventions (i.e., those before and after a client's discharge from an inpatient setting) can reduce early readmissions. While care coordination may be an effective strategy, the MHP did not provide evidence that lack of coordination actually contributed to the increase in readmission or increase in stay that they have observed. As an example, the MHP could have shown that clients who do not have case managers experience longer delays to follow-up appointments or have higher readmission rates than those who have case managers. Nevertheless, the MHP has four interventions related to discharge planning and care coordination: (1) addition of a QM Nurse manager; (2) addition of a QM Administrative Support staff; (3) implementation of a case presentation for all MHP beneficiaries who have an inpatient admission; and (4) and provision of hard copy appointment letters to patients for follow-up appointments. The MHP believes that with a dedicated forum to discuss patients and their post-discharge needs and designated individuals, either the nurse or case manager, to facilitate services post-discharge, consumers will have uninterrupted care, which prevents readmissions. One month following the interventions, the MHP collected data that show decreased readmission and increased 7-day follow appointments; however, the length of stay increased. As the MHP continues this PIP, they should articulate their data collection and analysis plan.

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

The technical assistance provided to the MHP by CalEQRO consisted of a recommendation to include a case manager on the PIP team, as the PIP creates new or additional roles for case managers for which their input is valuable, and clearly specify how the interventions will affect length of stay.

## NON-CLINICAL PIP—CARE COORDINATION COLLABORATIVE

The MHP presented its study question for the Non-Clinical PIP as follows:

- “Will increased interdisciplinary collaboration between primary care and behavioral health providers lead to improved health outcomes and satisfaction among older adults with co-occurring SMI and chronic medical conditions?”
- Date PIP began: March 2016
- Status of PIP:
  - Active and ongoing
  - Completed
  - Inactive, developed in a prior year (*Not Rated*)
  - Concept only, not yet active (*Not Rated*)
  - Submission determined not to be a PIP (*Not Rated*)
  - No PIP submitted (*Not Rated*)

The goal of this PIP is to improve health outcomes and increase satisfaction of older adults with SMI and chronic medical conditions. The MHP cites literature that individuals with comorbid chronic health conditions and SMI have disproportionately higher incidence of poor health outcomes and that older adults have greater chronic health conditions. The MHP intends to improve health outcomes through interdisciplinary collaboration between primary care and behavioral health providers. The MHP provides general information about the link between comorbid somatic and mental health conditions, but the MHP does not provide any information specific to their population of older adults with chronic conditions and the present risks or needs of this population. The MHP indicates that older adults are the target, but no age range, criteria, or minimums are defined and, per the discussion during the review, the PIP may also include some high needs consumers who may be in their 40s. Not having clear target population after 10 months of implementation may make it difficult for the PIP to progress. The MHP has outlined four interventions, all of which are process interventions and do not directly affect older adults. The interventions improve only the mechanisms by which providers obtain health information about older adults. Similar to the MHP’s articulation of the problem, the MHP makes a general statements about the outcomes; that is, that the PIP will improve health outcomes, but does not specify how or which health outcomes.

While there may be a need for improved services and care for older adults with SMI, the PIP has not articulated the need sufficiently. The PIP team provided general information about what could happen, rather than what has or is happening with this population. It does not appear that the issues the MHP presented are actually concerns for their population. Not having this foundation has affected the identification of the target population, the interventions, and the outcomes of the PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommendations to more quickly identify their target population and revise their indicators, such that they can measure actual change (e.g., measuring the prevalence of contra-indicated medications rather than the presence of medication lists, which can only be a post-intervention measure).

## PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The Clinical PIP increases consumer access through: (1) linkage with either a case manager or QM nurse manager and (2) standardization of scheduling of 7-day post-hospitalization follow-ups.
  - The Non-Clinical PIP identifies an at-risk population for whom coordinated care would improve access (and quality) of care.
- Timeliness of Services
  - Through standardizing the process for post-hospitalization appointments, the MHP can improve timeliness of services. The Non-Clinical PIP also includes measures to remind consumers about their follow-up appointments, potentially decreasing no-show rates for hospital follow-ups.
- Quality of Care
  - Both PIPs involve increasing and routinizing communication among providers. Through coordination of care among providers, the MHP can improve the quality of care for shared consumers.
  - Case managers, some of whom have lived experienced, are a critical component of facilitating care coordination and post-hospitalization services for consumers. Case managers can provide a different perspective on quality of care and their input should have been solicited and incorporated in the development and ongoing implementation of the PIP.
- Consumer Outcomes
  - The MHP has noted some improvements in readmission rates but no changes, and in fact, an increase in length of stay following the start of the Clinical PIP. The MHP should re-examine their interventions to determine if there is a correlation between length of stay and coordinated care.
  - The Non-Clinical PIP does not have any measures that directly assess or relate to 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 include 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. These are discussed below.

### Access to Care

As shown in Table 6, 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 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP was without an Ethnic Services Manager/ Cultural Competence Coordinator. The position was filled in October 2016, after which Cultural Competence Committee (CCC) meetings and activities resumed. (A Workforce Education and Training coordinator position was also filled in October 2016). The CCC reported a need to revise data capture to enable differentiation of populations with diverse cultural, ethnic, and linguistic backgrounds. A number of different stakeholders were unaware of the CCC and their meetings. Through the Pathways program, the MHP is attempting to meet the needs of homeless consumers in Davis, West Sacramento and Woodland. The unit in Davis includes a case management services and assistance locating stable housing. The program focuses on short term housing and extensive case mgmt.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP states the majority of children’s services are contracted. Through improved agency integration, mental health children’s clinicians are embedded in child welfare. The MHP made some changes to staffing and program structure that have had a negative effect on access to services, but the MHP is attempting to restructure programs, particularly for TAY.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP is part of an integrated agency that includes public health, social services (e.g., child welfare), and substance use services. In the community, the MHP collaborates with schools, managed care organizations, hospitals/ERs, and churches and several other partners.

*\*FC =Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

## Timeliness of Services

As shown in Table 7, 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 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP utilizes a 14-day standard. The MHP does not report separate adult and child-youth service data. The MHP has revised their tracking of timeliness to first appointment over the past year. With their most revision, reflecting the period July 1 November 30, 2016, the MHP averaged 33 days (52% meeting standard; range: 0-114 days). The MHP reported the hiring of a consultant to review clinic flow.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP utilizes a 30-day standard. The MHP does not report separate adult and child-youth service data. The MHP has also revised their tracking of timeliness to first psychiatric appointment. With their most revision, reflecting For the time period July 1November 30, 2016, combined Adult/child-youth services are reported as averaging 45 days (31% meeting standard; range: 1-109 days).
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP does not track timeliness data for urgent conditions.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP utilizes a 7-day standard. The MHP does not report separate adult and child-youth service data. For the time period July 2016 – November 2016, combined adult/child-youth first non-psychiatric service is reported as averaging 4 days (61% meeting standard) while first psychiatric service is reported as averaging 18 days (27% meeting standard).
2E	Tracks and trends data on rehospitalizations	FC	For the time period July 2016 – November 2016, combined 7-day adult/child-youth acute inpatient readmission rate is reported as 4.8% and 30 day readmission rate is reported as 14.7%. Hospital Utilization is closely monitored by the MHP and was also the topic of one of their PIPs.
2F	Tracks and trends no-shows	PC	The MHP tracks and trends no-shows for psychiatrists and for non-medical clinicians. The acceptable no-show standard is 5% for non-medical clinicians and 15% for psychiatrists.

Table 7—Timeliness of Services		
Component	Compliant (FC/PC/NC)*	Comments
		The MHP has high no-show rates for psychiatry. For the time period July 2016 – November 2016, this no show rate was reported as 27.63%. The MHP cited scheduling issues (e.g., double-booking) as factors. Clinician no-show rate was 4.32%.

*\*FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

### Quality of Care

As shown in Table 8, 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, clinical care, 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 8—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3A Quality management and performance improvement are organizational priorities	FC	The MHP had two Quality Improvement Committee (QIC) meetings (April 2016 and January 2017) since the last EQRO review. The MHP plans to have monthly QIC meetings beginning in March 2017. The MHP is revamping their QM department, including increasing staff to focus on documentation and data collection and reporting.  In October 2016, QM took on the responsibility of inpatient discharge planning. All utilization review, grievances, sentinel events, provider relations (site certification) for MH/Alcohol and Other Drugs and Avatar and authorization of outpatient services are the responsibility of QM.
3B Data are used to inform management and guide decisions	PC	An access log was developed in Avatar to record new service requests and capture data to measure timeliness from initial contact to first appointment and initial contact to first mental health service. The MHP has revised their QI Plan making it more targeted and setting goals that are reasonable, given resources and priorities. The MHP conducted an evaluation of their MHPSA programs. Much of the review of services and programs were related to MHPSA programs and not all of the MHP’s programs.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	NC	The MHP has a number of means to communication with stakeholders, through newsletters, emails, and meetings. The MHP’s staff satisfaction survey also showed high ratings for some aspects of communication. However, overall, stakeholders remarked that communication was not bidirectional and that there were few opportunities for their input. Communication from management was described as inconsistent and lacking transparency.
3D	Evidence of stakeholder input and involvement in system planning and implementation	NC	While the MHP has formal meetings (e.g., QIC, CCC, contract provider meetings), few stakeholders reported that they had attended or that there were opportunities to provide their input. Some stakeholders were not aware of the meetings and that they could attend. The sense among the stakeholders, particularly among internal stakeholders, was that their input would not be recognized or validated. In contrast, the MHP had robust community participation in a number of community stakeholder meetings, focus groups, summits, and other forums geared toward preparing the new MHSA plan.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	PC	The MHP has partnerships with a number of community service providers to enhance quality of services. Staff partner with these agencies, however meetings were not routine and integration continues to be a work in progress.
3F	Evidence of a systematic clinical Continuum of Care	PC	The MHP has a continuum of care approach. Recent efforts appear to be focused on honing or adhering to criteria for services. Some consumers are able to move through the continuum of care easier than others. Through the expansion of the QM department, the MHP has more means to review and analyze the effectiveness of their continuum of care approach.
3G	Evidence of individualized, client-driven treatment and recovery	PC	Integration of peers within programs demonstrated the MHP’s focus on wellness and recovery. However, stakeholders reported inconsistent engagement of consumers in self-care, wellness, and recovery.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The MHP has a specific classification for peers and in the past year increased the wages of the Peer Employees. Peers are also present at the Wellness Center. The MHP does not have specific manager or supervisory positions for persons with lived experience.
3I	Consumer run and/or consumer driven	PC	Consumers have the opportunity to contribute to programming at the wellness centers during the monthly meetings. The programming at the wellness

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
	programs exist to enhance wellness and recovery		centers serves consumers who are open to mental health services, but is otherwise not limited to any sub population. The program is consumer-driven, but not consumer-run.
3J	Measures clinical and/or functional outcomes of consumers served	NC	Contract providers are required to submit a completed CANS to the MHP with every authorization request. When received, the MHP reviews each CANS to determine medical necessity and evaluate clinical quality of care. There is some discrepancy between what the contract providers reported as the frequency of their submission and what the MHP reported. In either case, CANS is not entered into Avatar. ANSA is limited to full service partnerships and clients receiving moderate intensity case management. The MHP does not collect or compile any of the consumer outcome data for routine or system-wide review.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP participated in the CPS survey and conducted a number of their own surveys. The MHP conducted their own analyses comparing prior year’s data with current year.

*\*FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

**KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS**

- Access to Care
  - The MHP has undergone some changes in staffing (e.g., reassignment of staff in Child, Youth and Family program) and program structure that have adversely affected access, but the MHP is on a course to address and improve these access challenges (e.g., through the TAY Continuum).
  - As the cultural competency committee is re-established, the MHP should promote the committee and increase participation by stakeholders whose input is important for raising awareness about needs of consumers with diverse ethnic, racial, and linguistic needs.
- Timeliness of Services
  - The MHP indicated that they combine adult and children’s data on timeliness. Contract providers, who provide much of the services for children’s system of care, reported that they do not routinely submit timeliness data to the MHP. Thus the MHP’s data does not appear to capture timeliness for children’s system of care.



- The MHP has revised their methodology to track timeliness to services. While the MHP does not routinely meet their standards in some areas (e.g., first appointment and first psychiatry appointment), the MHP is better able to monitor and report on this data for adult services.
- While the MHP provides urgent services and on-demand services, through walk-ins, the MHP has not committed to making necessary changes to adequately track and measure time to urgent appointments.
- Psychiatric providers are a limited resource in the MHP and a psychiatry no-show (at 27.63%) only exacerbates the problem of stable coverage.
  - Quality of Care
- As the MHP rebuilds and develops their QM department, they will be poised to direct more attention to initiatives and activities that improve quality, as well as access and timeliness. The clinical PIP is an example of how more resources have enabled an improved project.
- There were several examples of perceived bias and favoritism, particularly related to recent staffing changes—hires, promotions, and reassignments.
- Stakeholders, both internal and external, do not feel engaged with the MHP and that their input is sought or appreciated.
  - Consumer Outcomes
- The MHP does not use outcome tools/instruments routinely nor systemically.
- The MHP (and HHSA, more generally) reported results-based accountability as a systemic approach to outcomes; however, few stakeholders besides the management team were aware of this approach or how it was operationalized.

## 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 with 8 to 10 participants each, the details of which can be found in each section below.

The Consumer/Family Member Focus Group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

### CONSUMER/FAMILY MEMBER FOCUS GROUP 1

CalEQRO requested a culturally diverse group, including those Russian speaking, of adult beneficiaries, transitional age youth, and parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held at the MHP clinic in West Sacramento.

Number of participants – 7

None of the participants had *entered services within the past year*.

General comments regarding service delivery that were mentioned included the following:

- Consumer reliance on one case manager who was particularly helpful in advocating, coordinating services, and problem-solving with consumers in the Slavic community.
- Lack of responsiveness and some insensitivity by current psychiatric providers was mentioned.

Recommendations for improving care included the following:

- Provide more staff who are bi-cultural and bilingual in Russian and, more generally, Slavic culture
- Allow families to participate in their family member's treatment.

Interpreter used for focus group 1:  No  Yes      Language(s): Russian

## CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a group of Hispanic/Latino adult beneficiaries and parents/caregivers of child/youth beneficiaries whose preferred language is Spanish, including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held at the MHP site/clinic in Woodland.

Number of participants – 10

For the three participants *who entered services within the past year*, they described their experience as the following:

- Being easier and faster to access than the previous time they received services through the MHP.
- Services were helpful.

General comments regarding service delivery that were mentioned included the following:

- Frequent changes in mental health staff, especially of psychiatric providers was disruptive.
- The need for better availability of culturally responsive services and a respect for their linguistic needs.

Recommendations for improving care included the following:

- Provide Spanish-language groups
- Stabilize staffing of psychiatric providers

Interpreter used for focus group 1:  No  Yes      Language(s): Spanish

## CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Participants reported an ease of access to services, despite frequent turnover of mental health staff.
  - Groups are another means to provide services. However, there are a limited number of Spanish-language groups for monolingual (or bilingual) Spanish-speaking consumers.
- Timeliness of Services
  - Participants reported faster access to initial services than in their previous contact with the MHP.

- Quality of Care
  - Participants recognize the MHP's efforts to provide culturally-responsive and linguistically appropriate services, but also identified a need for more initiatives (e.g., a full-time Russian speaking receptionist), particularly in the Russian-speaking communities in West Sacramento.
  - Participants reported several issues with the quality of psychiatric services, including the lack of stable providers and insensitivity to consumers' needs. Participants provided an example of a certain psychiatric provider refusing to allow family members to participate in treatment, despite the desire of the consumer, which is counter to the principles of wellness and recovery.
- Consumer Outcomes
  - Being able to express one's needs reflects both engagement and progress in treatment. When psychiatric providers deny requests (e.g., for family member participation) or dismiss consumers' questions (e.g., about medication adjustments), opportunities are hindered for consumers to participate in their own treatment.

## 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	45%
Contract providers	53%
Network providers	2%
<b>Total</b>	<b>100%</b>

- Percentage of total annual MHP budget is dedicated to support information technology operations: (includes hardware, network, software license, IT staff)

2%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within Electronic Health Record (EHR) or a consumer portal or a third-party PHR:

Yes                     
  In Testing/Pilot Phase                     
  No

- MHP currently provides services to consumers using a telepsychiatry application:

Yes                     
  In Testing/Pilot Phase                     
  No

- o If yes, the number of remote sites currently operational:

N/A

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE): The MHP experienced a significant loss subject matter expertise during the past year.

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
2	1	2	1

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE): Data Analytic staff retention and turnover is a significant issue.

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
1	0	2	1

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

- The Avatar Systems Administrator resigned in June 2016; that position was filled in November 2016 by the Avatar Systems Coordinator, subsequently creating an Avatar Analyst vacancy which is currently in recruitment.
- In 2016, one additional Analyst position was allocated to support Avatar and one Analyst position was lost by QM, leaving the net allocated analytic capacity unchanged from the previous year. The MHP has two of three Analyst positions unfilled, one in IS and one in QM.
  - A new Avatar Analyst position was created in September 2016 and filled in December 2016 by a QM Analyst. One Avatar Analyst position remains in recruitment.
  - QM had two data analytical staff; one transferred to the Avatar Analyst position and the other retired in December 2016 leaving QM without an Analyst. The MHP is actively recruiting for this QM Analyst vacancy.

**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 121 Avatar users.

- The MHP reports that 45% of services are provided by county operated/staffed clinics, 53% by contract providers, and 2% network providers. Approximately 81% of services are claimed to Short Doyle/Medi-Cal (SD/MC).
- Penetration rates are not calculated by the MHP; however, CalEQRO data is reviewed at least annually.
- The MHP does not utilize tele-psychiatry.

Table 12 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 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 12— Primary EHR Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
AvatarCalPM	Practice Management	Netsmart Technologies	13	County IT
Avatar CWS	Clinical Workstation	Netsmart Technologies	10	County IT
OrderConnect	Electronic Prescribing/Lab Results	Netsmart Technologies	3	County IT
Dimension Reports	835/835 Reconciliation	Dimension Reports	1	County IT

**PLANS FOR INFORMATION SYSTEMS CHANGE**

- The MHP has no plans to replace their current Avatar system.

**ELECTRONIC HEALTH RECORD STATUS**

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar CalPM/Netsmart			X	
Assessments	CWS/Netsmart	X			

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Document imaging/storage	Netsmart		X		
Electronic signature—consumer	Netsmart	X			
Laboratory results (eLab)	OrderConnect		X		
Level of Care/Level of Service	CWS/Netsmart	X			
Outcomes	CWS/Netsmart		X		
Prescriptions (eRx)	OrderConnect	X			
Progress notes	CWS/Netsmart	X			
Treatment plans	Netsmart	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 ANSA outcome tool is available in Avatar for full service partnership clients.
- Contract providers utilize the CANS in paper format. When received by the MHP, the outcome measure is only reviewed for individual case authorization and not aggregated for systemic analysis. The MHP went live with document imaging in July 2016. Scanning began with release of information and hospital discharge information for clients as of July 1, 2016. Scanning has not progressed as quickly as the MHP had hoped due to staffing limitations. The MHP is also reviewing the document scanning schedule.
- Consumer’s Chart of Record for county-operated programs (self-reported by MHP):
  - Paper
  - Electronic
  - Combination

**MAJOR CHANGES SINCE LAST YEAR**

- Netsmart Technology provided Enlighten Analytics training in March 2016. However, due to the resignation of Avatar Systems Administrator and a subsequent loss of subject matter expertise in June 2016, the MHP did not continue to explore the use of Enlighten Analytics. The MHP has no immediate plans to use this product.



- Document imaging capability went live in July 2016. Scanning did not progress as anticipated due to staffing restraints. The MHP is currently reviewing the priority of documents to be scanned.
- eLab with Quest Diagnostics went live in July 2016.
- In August 2016, the Behavioral Health unit of HHS Administration borrowed four employees from other programs to focus on delayed billing and claim denials. The effort resulted in \$961,000 in additional gross billing being submitted for reimbursement.
- An access log was developed in Avatar to record new service requests and capture data elements necessary to measure timeliness from initial contact date to first appointment as well as initial contact to first mental health service.

#### PRIORITIES FOR THE COMING YEAR

- Continue to develop QM reports including reports on first request for service and first service available.
- Prioritize and continue document scanning.
- Create a report for LOCUS due date.
- Research Meaningful Use requirement as a knowledge gap occurred when the Systems Administrator resigned in June 2016.
- Implement the Avatar Managed Services Organization module.
- Collaborate with County IT on an updated County disaster recovery plan.
- The MHP plans to implement mobile tele-psychiatry and anticipates focusing this resource on older adults in rural areas. Implementation is expected by December 2017.
- Prioritize the implementation of a personal health record.

#### OTHER SIGNIFICANT ISSUES

- The MHP reported that race/ethnicity information is not trustworthy as they do not believe the data is being correctly entered into Avatar. While the MHP suspects data entry issues, a definitive cause has not been identified and a remediation plan has not been developed.
- While contract providers utilize the CANS in paper format, the documents are not received by the MHP and not entered into Avatar.
- Contract provider access to Avatar has been an ongoing issue. Turning Point Community Programs has Avatar access for service entry and treatment planning. There are no

plans to expand Avatar access for Turning Point Community Programs. While other contract providers continue to express a desire for Avatar access, the MHP has no plans to expand current EHR access.

- The MHP does not track consumers served with co-occurring (substance abuse and mental health) diagnoses.

**MEDI-CAL CLAIMS PROCESSING**

- Normal cycle for submitting current fiscal year Medi-Cal claim files:
  - Monthly     More than 1x month     Weekly     More than 1x weekly
- MHP performs end-to-end (837/835) claim transaction reconciliations:
  - Yes     No

If yes, product or application:

Dimension Reports

- Method used to submit Medicare Part B claims:
  - Clearinghouse     Electronic     Paper

Table 14—Summary of CY15 Processed SDMC Claims—Yolo							
Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
27,412	\$3,776,930	\$1,206,519	31.94%	6,613	\$2,570,411	\$2,253	\$2,568,158

- The MHP had one Accounting Technician to processing billing and resolve denied claims. In August 2016, after realizing their high rate of claim denial, the Behavioral Health unit of HHS Administration borrowed four employees from other programs to focus on delayed billing and claim denials. The effort resulted in \$961,000 in additional gross billing being submitted for reimbursement.
- Two additional Accounting Technician positions have been allocated to assure continued adequate claims processing staff. One position has been filled while the other is in the final stages of recruitment.

- The MHP reported the July – October 2016 denied claims rate as 4.32%. The top reasons for claim denial were reported to be: beneficiary not eligible and Medicare must be billed prior to the submission of this claim.
- In November 2016, the Fiscal Supervisor was promoted to another department; this position is currently vacant.

#### INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Penetration rates are not calculated by the MHP; however, CalEQRO data is reviewed at least annually. The MHP's Hispanic penetration rate, 1.70%, is among the lowest in the State.
  - The MHP reported that race/ethnicity information is not trustworthy as they do not believe the data is being correctly entered into Avatar.
- Timeliness of Services
  - An access log was developed in Avatar to record new service requests and capture data elements necessary to measure timeliness from initial contact date to first appointment as well as initial contact date to first mental health service.
  - The MHP does not track time to urgent conditions.
- Quality of Care
  - Lack of contract provider access to Avatar has been an ongoing issue. While contract providers continue to express a desire for Avatar access, the MHP has no plans to expand current electronic health record access.
  - The MHP does not track consumers served with co-occurring (substance abuse and mental health) diagnoses.
  - The Fiscal Supervisor position was vacated in November 2016 and remains unfilled.
  - Two additional Accounting Technician positions were allocated to assure timely billing and denied claim resolution. One position is filled and one remains in recruitment.
  - Competing priorities and limited Information Technology staffing is hindering the full implementation of the Avatar system.
- Consumer Outcomes
  - Contract providers utilize the CANS in paper format. When received by the MHP, the outcome measure is only reviewed for individual case authorization and not aggregated for systemic analysis.

## SITE REVIEW PROCESS BARRIERS

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

- No barriers were encountered during the preparation or implementation of this review.

## CONCLUSIONS

During the FY16-17 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 is part of an integrated health care agency, which positions the MHP to provide shared clients (i.e., public health, housing, social services) with coordinated services.
  - Through two grants, the MHP has increased financial resources and partnerships to facilitate services for consumers experiencing homelessness.
- Opportunities:
  - Although improved psychiatric coverage was reported by the MHP, several stakeholders indicated frequent turnover and multiple psychiatric providers.
  - Given uncertainty of the accuracy of the race/ethnicity data, the MHP has an opportunity to review how these data are captured.
  - The MHP should examine and perhaps increase outreach efforts to Hispanic consumers to address the 1.70% penetration rate which is among the lowest in the State.
  - The MHP should review staffing of the programs whose staff were reassigned to other departments and determine current capacity and how best to meet the needs of the consumers going forward.
  - The MHP should leverage their integration in the HHSA to ensure diverse stakeholder representation on their PIP committees, particularly at it relates to physical health care.

#### Timeliness of Services

- Strengths:
  - The MHP has revised their methodology of tracking timeliness to services. This enables more accurate reporting of their time to services and identification of where to direct efforts to improve timeliness.

- An access log was developed in Avatar to record new service requests and capture data elements necessary to measure timeliness from initial contact to first appointment as well as initial contact to first mental health service.
- Through standardization of the scheduling process for post-hospitalization appointments (as part of Non-Clinical PIP), the MHP can improve timeliness of services.
  - Opportunities:
    - The MHP should investigate and implement measures to reduce psychiatry no-show rate currently at 27.63%.
    - The MHP should regularly collect the relevant data from contract providers in order to monitor timeliness of children's services.
    - As the MHP has an expanded QM department, some resources may be turned to capturing and monitoring time to urgent appointments.

### Quality of Care

- Strengths:
  - The MHP uses the lessons learned from the integration of multiple agencies to guide ongoing change and improvements in services.
  - The expansion QM department increases the MHP's capacity for monitoring, analysis, and improvement initiatives in several areas of services.
  - Consumers recognize the MHP's efforts to provide culturally-responsive and linguistically appropriate services.
- Opportunities:
  - The MHP needs to turn attention to communication. Bi-directional and transparent communication with stakeholders and explicit valuing of staff (including their years of experience, commitment during continuous change, and their ongoing efforts to provide quality services) were reported to be lacking.
  - Competing priorities and limited Information Technology staffing is hindering the full implementation of the Avatar system.
  - The Fiscal Supervisor position was vacated in November 2016 and remains unfilled.
  - As the PIP continues, the MHP should look for ways to incorporate key stakeholders (e.g., case managers and physical health providers/practitioners) whose voice is currently lacking.
  - The MHP needs to have a mechanism, which is clearly communicated to all clinical providers, that allows family members to participate in treatment, particularly when it is the express wish of the consumer.
  - The MHP does not track consumers with co-occurring diagnoses.

- Lack of contract provider access to Avatar has been an ongoing issue.

### Consumer Outcomes

- Opportunities:
  - The MHP needs to have a mechanism, which is clearly communicated to all clinical providers, that allows family members to participate in treatment particularly when it is the express wish of the consumer.
  - The MHP should incorporate measures that directly assess or relate to consumer outcomes in their Non-Clinical PIP.
  - Contract providers utilize the CANS in paper format. When received by the MHP, the outcome measure is only reviewed for individual case authorization and not aggregated for systemic analysis.

### RECOMMENDATIONS

- Institute regular meetings (either monthly or twice monthly) with supervisory and line staff as a first step to improving bi-directional communication and as a forum to address staff job-related needs and growing concerns.
- Review psychiatric coverage across all systems of care, modify staffing to reduce frequent turnover, and provide coverage by providers who are culturally-responsive and demonstrate a commitment to wellness and recovery.
- Fill the Fiscal Supervisor position that has been vacant since November 2016 to assure continued timely claims submittal and resolution of denied claims.
- Investigate the following information technology solutions:
  - Work with County and Health Human Resources to develop plans and strategies to fill open technology and data analytical positions.
  - Develop and implement a training program for staff development so staff achieve a level of subject matter expertise as soon as practical to support a complex electronic health record (EHR) system.
  - Investigate the feasibility to contract with Netsmart Technologies for technical assistance or staff development training to further support technology and data analytical capacity.
  - Query other Medium size MHPs located in the northern region (e.g., Butte, Solano, and Sonoma) who use Avatar EHR and assess their level of technology and data analytical staffing standards.

- Identify the cause of the erroneous Avatar race/ethnicity data and develop a remediation plan as well as ensure the accuracy of future race/ethnicity data entered into Avatar.
- Develop an information technology (IT) project management plan including a timeline and estimated resources required for project completion. Assign a staff to actively monitor the project plan to assure availability of staffing resources and timely project completions.



## 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

The following sessions were held during the MHP on-site review either individually or in combination with other sessions:

<b>Table A1—EQRO Review Sessions - Yolo MHP</b>
Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Access Call Center Site Visit
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.

## ATTACHMENT B—REVIEW PARTICIPANTS

### CALEQRO REVIEWERS

Ewurama Shaw - Taylor, PhD, Quality Reviewer  
 Lisa Farrell, Information Systems Reviewer  
 Luann Baldwin, 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

137 N. Cottonwood Street, Suite 2500  
 Woodland, CA 95696

#### CONTRACT PROVIDER SITES

Contract Provider Name, 500 A – B Jefferson Blvd., West Sacramento, CA 95605

### PARTICIPANTS REPRESENTING THE MHP

<b>Name</b>	<b>Position</b>	<b>Agency</b>
Karen Larsen	Director	Health & Human Services Agency (HHSA)
Marcie Azevedo	Accountant II	HHSA
Rita Samartino	Systems Software Specialist, IT	HHSA
Samantha Fusselman	QM Manager	HHSA
Katherine Barrett	QM Supervisor	HHSA
Amy Leino	QM Clinician	HHSA
Theresa Smith	Cultural Competence Coordinator	HHSA
Alison Book	CWS Manager	HHSA
Ashley Atta-Mensah	QM Nurse	HHSA
Sean Geary	QM Clinician	HHSA
Sandra Sigrist	Branch Director, Adult & Aging	HHSA

<b>Name</b>	<b>Position</b>	<b>Agency</b>
Pam Sidhu	Information Systems Analyst	HHSA
Julie Freitas	Clinical Manager	HHSA
Mike Martinez	IT Manager	HHSA
Jean Beesley	MHSA Manager	HHSA
Mina Lee	Accounting Technician	HHSA
Brad Finlayson	Case Manager	HHSA
Jennie Pettet	Branch Director, Child, Youth & Family	HHSA
Alex Nelson	CWS Supervisor	HHSA
Kim Narvaez	Supervising Clinician	HHSA
Jana Cooper	Project Director	Turning Point Community Programs
Kimberly Porter	Wraparound Supervisor	CommuniCare Health Center
Allison Rodriguez	Youth Services Supervisor	CommuniCare Health Center
Tessa Smith	Family Partner	HHSA
Kellymarie Chen	MHSA Support Specialist	HHSA
Asia Lee Huff	Peer Support Worker	HHSA
Christina Wilson	Peer Support Worker	HHSA
Dennis A. Cortopassi	Peer Support Worker	HHSA
Christine Gerner	Peer Support Worker	HHSA
Sally Maltby Hays	Peer Support Worker	HHSA
Liana Coffland	Peer Support Worker	HHSA
Steve Schroeder	Administrative Supervisor, Fiscal	HHSA
Connie Cessna Smith	Fiscal Administrative Officer	HHSA
Carolina Hernandez	Mental Health Rehabilitation Specialist (MHRS), Adult & Aging	HHSA
Sammy Mayfield	Specialist, Adult & Aging	HHSA
Josefina Elliott	Clinician, Adult Protective Services	HHSA
Robert Villarreal	Clinician, Adult & Aging & Crisis	HHSA
Emily Vaden	Accreditation Coordinator, Community Health	HHSA
Ron Chapman, MD	Public Health Officer	HHSA
Laura Prosser-Horch, RN	Nurse Navigator	HHSA
Spring Ackerman	MHRS, Child Welfare Services	HHSA
Terri Lipelt	MHRS, Forensic	HHSA

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<b>Name</b>	<b>Position</b>	<b>Agency</b>
Linda H. Fogle	Supervisor	HHSA
Mario Gallegati	Supervising Clinician	HHSA
Jean McSorley	Supervising Clinician	HHSA
Melanie Henrich	Program Director, Safe Harbor Crisis House	Yolo Community Care Continuum
Gail Nelsen	Clinical Director	Yolo Community Care Continuum
Sara Gavin	Director of Behavioral Health	CommuniCare Health Center
Lester Neblett	Executive Director	Yolo Family Service Agency
Edie Dornbush	Clinical Director	Yolo Family Service Agency
Sadie Shen	Director, Adult Mental Health Programs	Turning Point Community Programs

**ATTACHMENT C—APPROVED CLAIMS SOURCE DATA**

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing  $n \leq 11$ .

Table C1 shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

<b>Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary Yolo</b>					
Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	\$533,318,886	\$4,060
Medium	272,209	17,965	6.60%	\$79,457,048	\$4,423
Yolo	8,326	303	3.64%	\$1,386,780	\$4,577

<b>Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary Yolo</b>					
Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	\$533,318,886	\$4,060
Medium	444,730	17,965	4.04%	\$79,457,048	\$4,423
Yolo	13,913	303	2.18%	\$1,386,780	\$4,577

Table C2 shows the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under \$20,000; \$20,000 to \$30,000, and those above \$30,000.

Table C2—CY15 Distribution of Beneficiaries by ACB Range Yolo								
Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
\$0K - \$20K	1,444	95.57%	94.46%	\$3,734,243	\$2,586	\$3,553	57.75%	61.20%
>\$20K - \$30K	27	1.79%	2.67%	\$656,471	\$24,314	\$24,306	10.15%	11.85%
>\$30K	40	2.65%	2.86%	\$2,075,883	\$51,897	\$51,635	32.10%	26.96%

## ATTACHMENT D—PIP VALIDATION TOOL

### PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

### CLINICAL PIP

#### GENERAL INFORMATION

**MHP:** Yolo

**PIP Title:** Inpatient Utilization

**Start Date (MM/DD/YY):** 06/01/16

**Completion Date (MM/DD/YY):** Ongoing

**Projected Study Period (#of Months):** 5

**Completed:** Yes  No

**Date(s) of On-Site Review (MM/DD/YY):** 02/01-02/17

**Name of Reviewer:** Ewurama Shaw-Taylor

**Status of PIP (Only Active and ongoing, and completed PIPs are rated):**

**Rated**

- Active and ongoing (baseline established and interventions started)
- Completed since the prior External Quality Review (EQR)

**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**

- Concept only, not yet active (interventions not started)
- Inactive, developed in a prior year
- Submission determined not to be a PIP
- No Clinical PIP was submitted

**Brief Description of PIP** (including goal and what PIP is attempting to accomplish): A five-year review of inpatient utilization revealed an increase in hospital admissions, average length of stay, and both 7-day and 30-day readmissions. Given the MHP’s limited ability to affect the initial admissions process, the MHP has focused on ways to reduce the length of stay and the rate of readmission. The goal of the PIP is to reduce the amount of time clients with severe mental illness spend in acute psychiatric treatment. The specific objectives of the PIP are to: decrease the average length of stay and number of readmissions. The PIP is also meant to increase timely access to post-discharge follow-up.



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?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The MHP formed a PIP team of stakeholders who are involved in or knowledgeable of the inpatient process. The PIP team also includes analysts who can facilitate data gathering. The team would benefit from the inclusion of a case manager, as case managers will be taking on new/additional roles.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team reviewed five (fiscal) years of data on various aspects of inpatient utilization including admission, inpatient days, length of stay, readmission rates, and post-discharge follow-up rates. The data show increasing utilization of inpatient care.
<b>Select the category for each PIP:</b> Clinical: <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		Non-Clinical: <input type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP addresses a number of aspects of inpatient utilization (see 1.2). The PIP (or its interventions) focus on improving the coordination of services while the patient is still in the hospital to affect outcomes post-discharge.
1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP includes all enrolled populations (and also uninsured) who have an inpatient hospitalization.
<b>Totals</b>		<b>3</b> Met <b>1</b> Partially Met <b>0</b> Not Met <b>0</b> UTD

STEP 2: Review the Study Question(s)						
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> If the MHP improves discharge planning and care coordination processes for beneficiaries experiencing an acute psychiatric hospitalization, will there be a decrease in average length of stay and readmission rates as well as an increase in the rate of follow-up appointments within 7 days following discharge?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The study question is clear and has a measurable impact.				
<b>Totals</b>		<b>1</b>	Met	<b>0</b>	Partially Met	<b>0</b> Not Met <b>0</b> UTD
STEP 3: Review the Identified Study Population						
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i>  <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other                 </p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP defines all the Medi-Cal enrollees to whom the study question is relevant—all those who are admitted to and have an inpatient hospitalization stay. According to the PIP document, the PIP team will be able provide a breakdown of inpatient utilization by demographics, however, they did not provide this breakdown for the baseline or preliminary data.				
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i>  <input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification  <input type="checkbox"/> Other: Text if checked                 </p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The data collection approach will be able to capture all enrollees to whom the study question is applicable.				
<b>Totals</b>		<b>2</b>	Met	<b>0</b>	Partially Met	<b>0</b> Not Met <b>0</b> UTD

STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ol style="list-style-type: none"> <li>1. Average length of stay</li> <li>2. 7-day re-admission rate</li> <li>3. 30-day re-admission rate</li> <li>4. Percentage of hospital discharges that resulted in a 7-day follow-up</li> </ol>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP team provides four indicators that are objective and measurable. The PIP is also meant to connect patients with a care coordinator/discharge planner—either their case manager or a QM Nurse Manager. The PIP team should have included an indicator for this planning, such as the percentage of clients that have MHP assistance with discharge planning.</p>

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input checked="" type="checkbox"/> Health Status                      <input checked="" type="checkbox"/> Functional Status  <input type="checkbox"/> Member Satisfaction              <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Unable to Determine</p>	<p>The indicators measure change in health or functional status (i.e., the readmission rates) and process change. It is unclear if and how average length of stay will be affected by the PIP team’s intervention. Long-term outcomes were non-specific, but included improving health outcomes for clients with severe mental illness.</p>
<b>Totals</b>		<p><b>0</b> Met    <b>2</b> Partially Met    <b>0</b> Not Met    <b>0</b> UTD</p>
<b>STEP 5: Review Sampling Methods</b>		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?  b) Confidence interval to be used?  c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i>  Text</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame  _____ N of sample  _____ N of participants (i.e. – return rate)</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<b>Totals</b>		<p><b>0</b> Met    <b>0</b> Partially Met    <b>0</b> Not Met    <b>0</b> UTD</p>

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team identifies the data to be collected related to the hospital stay and outpatient care. The PIP team does not specify the data collection related to the interventions (e.g., the number of clients that have a case manager/nurse manager, the number clients discussed in psychiatric care committee, etc.), which are important variables to determine how the interventions are working/being applied.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member      <input checked="" type="checkbox"/> Claims      <input type="checkbox"/> Provider</p> <p><input checked="" type="checkbox"/> Other: EHR</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team specifies the data sources for the inpatient utilization and outpatient hospital data, but not for other data (e.g., case presentations) that they presumably will collect or track.</p>
<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team indicates what data will be collected and by whom, but does not indicate at what frequency the data will be collected and who (of the QM nurse, analyst, and support staff) is responsible for what.</p>
<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey      <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool      <input type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other: EHR and claims (TAR/Short Doyle) data</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP has a TAR/Short-Doyle tracking process. There was nothing to suggest that this would not be able to collect consistent and accurate data.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team did not indicate a data analysis plan.</p>

<p>6.6 Were qualified staff and personnel used to collect the data?  <i>Project leader:</i>                  Name: Samantha Fusselman                  Title: HHS Quality Management Manager                  Role: Project Lead  <i>Other team members:</i>                  Names: The PIP team included two program managers, the medical director, the discharge planner, and a supervising clinician.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data will be entered and reviewed by staff who are familiar with the tracking systems. There was nothing to suggest that this would not be able to provide consistent and accurate data.
<b>Totals</b>		<b>2</b> Met <b>3</b> Partially Met <b>1</b> Not Met <b>0</b> UTD
<b>STEP 7: Assess Improvement Strategies</b>		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?   <i>Describe Interventions:</i>                  Create a QM Nurse Manager position                  Create a QM Administrative Support staff position                  Implement a case presentation format in Psychiatric Care Committee                  Provide clients with a hard copy letter listing their appointments</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	While the PIP team has four interventions and provided reasons for those interventions, they do not consistently or clearly state the barriers that they are trying to address. For example, regarding the QM Nurse, the PIP team articulates only the benefits (e.g., increasing efficiency, regular presence on-site, etc.). The provision of the hard copy letter to the client appears to be related to consumers forgetting their follow-up appointments, but the PIP team did not indicate if this is the only or primary reason that clients do not attend their 7-day follow-up appointments. Additionally, the PIP team did not provide reasons for the increased length of stay in the hospital, so it is unclear if the psychiatric care coordination (which all clients may not actually get) is an effective intervention.
<b>Totals</b>		<b>0</b> Met <b>0</b> Partially Met <b>0</b> Not Met <b>0</b> NA <b>1</b> UTD
<b>STEP 8: Review Data Analysis and Interpretation of Study Results</b>		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?   <i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 6.5.

<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP team has provided interim results for their interventions, showing some improvements, with the exception of length of stay. The PIP team provides a table with the indicator as the reference point, but does not indicate which interventions were applied. The 7-day follow-up does not have an Intervention Applied Date.</p>
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<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP team provided only preliminary data following two (or three) months of the intervention. Data collection and analysis will continue.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> Text</p> <p><i>Conclusions regarding the success of the interpretation:</i> Text</p> <p><i>Recommendations for follow-up:</i> Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<b>Totals</b>		<p><b>0</b> Met <b>1</b> Partially Met <b>1</b> Not Met <b>2</b> NA <b>0</b> UTD</p>
<b>STEP 9: Assess Whether Improvement is “Real” Improvement</b>		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	



<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<b>Totals</b>		<b>0</b> Met <b>0</b> Partially Met <b>0</b> Not Met <b>5</b> NA <b>0</b> UTD

<b>ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)</b>		
<b>Component/Standard</b>	<b>Score</b>	<b>Comments</b>
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS</b>	
<i>Conclusions:</i> Text	
<i>Recommendations:</i> Text	
Check one:	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible <input type="checkbox"/> Confidence in PIP results cannot be determined at this time

**PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17** **NON- CLINICAL PIP**

GENERAL INFORMATION	
<b>MHP:</b> Yolo	
<b>PIP Title:</b> Care Coordination Collaborative	
<b>Start Date (MM/DD/YY):</b> 03/01/16  <b>Completion Date (MM/DD/YY):</b> Ongoing  <b>Projected Study Period (# of Months):</b> 10  <b>Completed:</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  <b>Date(s) of On-Site Review (MM/DD/YY):</b> 02/01-02/17  <b>Name of Reviewer:</b> Ewurama Shaw-Taylor	<b>Status of PIP (Only Active and ongoing, and completed PIPs are rated):</b>  <b>Rated</b> <input type="checkbox"/> Active and ongoing (baseline established and interventions started)  <input type="checkbox"/> Completed since the prior External Quality Review (EQR)  <b>Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.</b> <input checked="" type="checkbox"/> Concept only, not yet active (interventions not started)  <input type="checkbox"/> Inactive, developed in a prior year  <input type="checkbox"/> Submission determined not to be a PIP  <input type="checkbox"/> No Non-Clinical PIP was submitted
<b>Brief Description of PIP</b> (including goal and what PIP is attempting to accomplish): The MHP cites literature that individuals with comorbid chronic health conditions and serious mental illness (SMI) have disproportionately higher incidence of poor health outcomes. The MHP is also taking part in the county/HHSA’s Community Health Improvement Plan (CHIP) project, which targets older adults with chronic health conditions as a priority population. The MHP’s PIP combines these populations, older adults with chronic physical health conditions and comorbid mental health illness. The goal of this PIP is to improve health outcomes for an Older Adults with SMI and chronic medical conditions and increase their satisfaction.	

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?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team includes a number of stakeholders from the mental health side, but would benefit from stakeholders from physical health or pharmacy. During the review, the MHP discussed their attempts to collaborate with physical health providers.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team provides general information about the link between comorbid physical and mental health conditions, but does not provide any information about their specific population—the present risk or the need.
<b>Select the category for each PIP:</b> Clinical: <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input checked="" type="checkbox"/> High risk conditions		Non-Clinical: <input type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP has the ability to affect various aspects of enrollee care and services (e.g., self-management of chronic health conditions), but the PIP is not yet structured to capture this.
1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team has yet to fully identify or clearly articulated who their target population is. While they indicate older adults, they do not provide an age range or minimum and per the discussion during the review, the PIP may also include some high needs consumers who are not older per se.
<b>Totals</b>		<b>0</b> Met <b>2</b> Partially Met <b>1</b> Not Met <b>1</b> UTD

STEP 2: Review the Study Question(s)						
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> Will increased interdisciplinary collaboration between primary care and behavioral health providers lead to improved health outcomes and satisfaction among older adults with co-occurring SMI and chronic medical conditions?"</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>While the intervention—inter disciplinary collaboration—is clear, the measurable impact is not. The PIP team identifies “improving health outcomes”, which is very broad. The PIP team also intends to improve satisfaction, but there was nothing to suggest that the target population was dissatisfied or wanting something more from the current coordination.</p>				
<b>Totals</b>		<b>0</b> Met	<b>1</b> Partially Met	<b>0</b> Not Met	<b>0</b> UTD	
STEP 3: Review the Identified Study Population						
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP document indicates that the study population are older adults with chronic physical health conditions. However, from the data provided (and different population numbers used) and from the discussion during the review, the population may extend beyond older adults with chronic health conditions. Given the finite number of consumers who this PIP targets, it is unclear why that the PIP team has yet to identify the total population.</p>				
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team’s approach is to screen potential participants for a chronic health condition. The PIP team did not articulate how/when the screenings are conducted. To date (after 7 months), the PIP team has only identified 55% of their target population. The PIP team’s process for screening and identifying participants is not efficient.</p>				
<b>Totals</b>		<b>0</b> Met	<b>0</b> Partially Met	<b>2</b> Not Met	<b>0</b> UTD	

STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ol style="list-style-type: none"> <li>1. Clients screened for chronic health condition</li> <li>2. Current Release of Information (in the EHR)</li> <li>3. Current Care Coordination Plan</li> <li>4. Medication Reconciliation</li> <li>5. Client Satisfaction</li> </ol>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Of the five indicators that the PIP team provides, only indicator 2 is objective and measurable. Indicator 1 is not an indicator. Identifying the target population is a basic necessity of any project. Indicators 3 and 4 do not have baselines, so there would be nothing to compare it to because they are measures of the intervention. For indicator 4, for example, the PIP team should measure the prevalence of contra-indicated medications in participant’s medication list, which is something that can be measured both before and after the intervention. Indicator 5 also lacks baseline for four months.</p>

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input type="checkbox"/> Health Status                      <input type="checkbox"/> Functional Status  <input type="checkbox"/> Member Satisfaction              <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> Unable to Determine</p>	<p>As above, only Indicator 2 will be able to measure change—a process change. Indicator 5 can measure change in satisfaction, however, the survey, apparently, was only implemented four/five months after the start of the intervention, so presumably not all participants would have pre-intervention data.</p> <p>The long-term outcome is improved health. The PIP team also indicates that participants will benefit from increased life expectancy.</p>
<b>Totals</b>		<p><b>0</b> Met    <b>0</b> Partially Met    <b>2</b> Not Met    <b>0</b> UTD</p>
<b>STEP 5: Review Sampling Methods</b>		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?  b) Confidence interval to be used?  c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i>  Text</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame  _____ N of sample  _____ N of participants (i.e. – return rate)</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	
<b>Totals</b>		<p><b>0</b> Met    <b>0</b> Partially Met    <b>0</b> Not Met    <b>0</b> UTD</p>

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study design specifies the data to be collected (e.g., release of information in the EHR, medication reconciliation, etc.). The PIP team did not include a plan for collecting satisfaction data.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member      <input type="checkbox"/> Claims      <input type="checkbox"/> Provider</p> <p><input type="checkbox"/> Other: EHR</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The EHR is the source of the data that the MHP intends to collect. The PIP team did not include</p>
<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study design does not articulate or specify the method of collecting various data elements for the target population. For example, the coordination plan is used to facilitate communication between the physical health provider and the MHP. The form is to be completed by the case manager (assuming all clients have case managers), but the PIP team did not articulate how the physical health provider would get this information. The PIP team indicates that medication information will be obtained by self-report from participants, which may introduces some amount of variability and inconsistency with accurate reporting.</p>
<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey      <input checked="" type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool      <input type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>There is nothing to suggest that the EHR would not provide consistent and accurate information. As above, relying on participants to provide accurate medication information about their medications poses some risk, especially when it is already suspected that participants may not even accurately reported their physical health conditions.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team did not provide a data analysis plan.</p>



<p>6.6 Were qualified staff and personnel used to collect the data?  <i>Project leader:</i>                  Name: Alexis Lyon                  Title: Clinic Manager                  Role: Project Lead  <i>Other team members:</i>                  Names: Karen Larsen, Julie Freitas, Pam Sidhu, Carolina Hernandez, Jean McSorely, and Sandra Sigrist</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP document identifies a number of different individuals, by position, as entering the data (e.g., the case manager, nurses, NPs,). For some data, it was not indicated who would collect or review it (e.g., the ROIs).
<b>Totals</b>		<b>0</b> Met <b>3</b> Partially Met <b>2</b> Not Met <b>1</b> UTD
<b>STEP 7: Assess Improvement Strategies</b>		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?   <i>Describe Interventions:</i>                  1. Develop and implement a process for obtaining and tracking chronic health conditions                  2. Develop processes to obtain current release of information to allow for bidirectional sharing and support care coordination                  3. Develop and implement a process to provide care coordination plans that can be shared with clients PCP to aid in whole health goals                  4. Implement medication reconciliation through the use of the EHR</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team does not indicate what the barriers and risks are relative to their own population of older adults with chronic conditions. Rather, the team provides general information about what 'could' happen. It does not appear that the issues that they are presenting are actually concerns for their population. As such, it is difficult to determine if the interventions would actually address or solve a problem.
<b>Totals</b>		<b>0</b> Met <b>0</b> Partially Met <b>0</b> Not Met <b>0</b> NA <b>1</b> UTD
<b>STEP 8: Review Data Analysis and Interpretation of Study Results</b>		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?   <i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	See 6.5.

<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>As the study is ongoing, the PIP team has provided only preliminary data. However, the data/results are unclear. Different numbers are provided for the population (e.g., 86, 67, and 46). As Indicators 3 and 4 were not actual indicators, the PIP team was not able to provide did interim results.</p>
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<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p>Text</p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p>Text</p> <p><i>Recommendations for follow-up:</i></p> <p>Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<b>Totals</b>		<p><b>0</b> Met <b>0</b> Partially Met <b>2</b> Not Met <b>2</b> NA <b>UTD</b></p>
<b>STEP 9: Assess Whether Improvement is "Real" Improvement</b>		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<b>Totals</b>		<b>0</b> Met <b>0</b> Partially Met <b>0</b> Not Met <b>5</b> NA <b>0</b> UTD

<b>ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)</b>		
<b>Component/Standard</b>	<b>Score</b>	<b>Comments</b>
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS</b>	
<i>Conclusions:</i> Text	
<i>Recommendations:</i> Text	
Check one:	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible <input type="checkbox"/> Confidence in PIP results cannot be determined at this time