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FY 2018–19 MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

YOLO MHP FINAL REPORT

Prepared for:

**California Department of
Health Care Services (DHCS)**

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) 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 State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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 fiscal year (FY) 2018-19 findings of an EQR of the Yolo MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Medium

MHP Region — Central

MHP Location — Woodland

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 1,985

MHP Threshold Language(s) — Spanish and Russian

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures¹

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects²

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities³

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies for calculating PMs.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary 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.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

- Changes, progress, or milestones in the MHP’s approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP’s performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY 2017-18

Recommendation 1: Create a system to ensure that information and beneficiaries' questions about their medications are addressed during psychiatric appointments. Survey beneficiaries to ensure this is happening.

Status: Met

- The MHP added to the robust confirmation call, made by support staff, a question about whether the beneficiary had any questions concerning their medications to be addressed in the upcoming appointment.
- A Registered Nurse (RN), Licensed Psychiatric Technician (LPT), or Medical Assistant (MA), checks vitals also asks if the beneficiary has any questions or issues concerning their medications and documents this in the beneficiary's chart.
- At each appointment with the beneficiary, prescriber staff ask if there are any questions about medication, and documents this in the clinical note.
- Stakeholders interviewed during the onsite review concurred that they were queried at various times about issues and compliance with medication.

- The MHP is currently developing a questionnaire for beneficiaries to complete upon leaving a physician appointment. This questionnaire includes questions asking about medication information and issues.

Recommendation 2: Increase Information Technology (IT) resources as follows:

- Request IT resources necessary through budgeting for FY 2018-19. Include requests to change Netsmart to a hosted environment and expand Care Connect to add Care Quality.
- Work with Yolo County and Health and Human Resources to develop plans and strategies to fill open technology and data analytical positions.
- Research options for utilization of interns with IT skills from local colleges and universities to supplement IT staffing.
- Investigate the feasibility to contract with Netsmart Technologies for technical assistance (TA) or staff development training to further support technology and data analytical capacity.

Status: Met

- The MHP expanded its Netsmart contract for FY 2018-21, which includes a change to a hosted environment and the expansion of CareConnect to add CareConnect Inbox. A copy of the contract Schedule for Committed Funds is contained within the EQRO document submissions.
- The MHP added new technology positions to the FY 2018-19 Health and Human Services Agency (HHS) budget, including 1.0 full time equivalent (FTE) HHS IT Manager and 1.0 FTE Programmer Analyst for the Adult and Aging Branch. The HHS IT manager started in December 2018. Upon further analysis, the MHP decided to replace the Programmer Analyst position with an Information Systems Coordinator; this position will be responsible for Avatar as well as other applications within the Adult and Aging Branch and the Administrative Branch.
- The MHP created a discretionary fund component to the new FY 2018-21 Netsmart contract, which includes a “bucket of professional services” funds for any ad hoc system changes during the full term of the contract. A copy of the contract schedule for discretionary funds is contained within the EQRO document submissions.
- While the MHP did not pursue the recommendation to research options for hiring interns from local colleges and universities due to lack of resources available to them, the MHP met the recommendation in other ways.

Recommendation 3: Resolve the issue of the MHP’s inability to collect and report the consumer’s first contact with the MHP and connect that event to subsequent services delivered.

Status: Met

- The MHP implemented a new Access Log that captures all the required reporting elements for Managed Care Final Rule (i.e., parity, network adequacy, and the Drug Medi-Cal Organized Delivery System). Following months of development, the new Access Log went live July 1, 2018.
- Copies of flow charts of the Access Log, the instructional manual and Avatar user's guide were provided within the documents submitted to the EQRO. This system creates a beneficiary file that connects with services delivered following first contact/request for services.

Recommendation 4: Design and implement an outreach protocol to increase awareness and facilitate access for underserved Latino/Hispanic beneficiaries.

Status: Met

- The MHP developed an outreach and engagement plan to increase awareness and facilitate access for underserved Latino/Hispanic beneficiaries. The plan is contained within the EQRO document submissions. Progress to date includes:
 - The MHP established ongoing Latino and Hispanic workgroup meetings in 2019. HHSA Latino outreach programs were invited as regular members. (The meetings were held in February, April, June, August, and October of 2018.)
 - The MHP added additional Latino and Hispanic outreach programs/entities, Empower Yolo and Health Education Council (located in the Mexican Consulate), to the committee's membership.
 - The MHP engaged other community partners to share resources and services with Latino outreach programs, to include senior peer counseling.
 - The MHP reviewed information and worked on draft of a brochure for undocumented immigrants regarding available HHSA services.
 - The MHP presented at the August 2018 workgroup meeting information to raise awareness regarding the Health Education Council's Mente Sana, Vida Sana (Healthy Minds, Healthy Life) mental health program, which is an implementation pilot project of the California Reducing Disparities project.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring \$30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 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 (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:⁴

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

⁴ Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:

<http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx>

3. Psychotropic Medication and HEDIS Measures:

http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

<http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx>

4. Assembly Bill (AB) 1299 (Chapter 603; Statutes of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:

The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at <https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
 - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
 - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
 - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Yolo MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	16,713	27.9%	800	40.3%
Latino/Hispanic	25,961	43.4%	423	21.3%
African-American	2,644	4.4%	140	7.1%
Asian/Pacific Islander	4,987	8.3%	57	2.9%
Native American	479	0.8%	19	1.0%
Other	9,042	15.1%	546	27.5%
Total	59,823	100%	1,985	100%
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

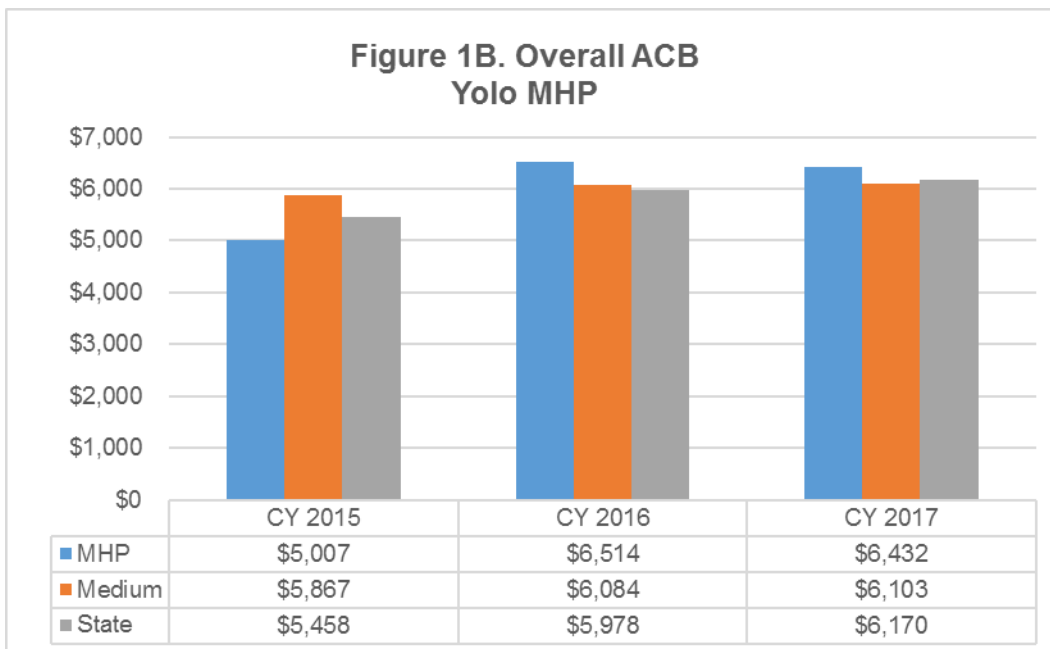
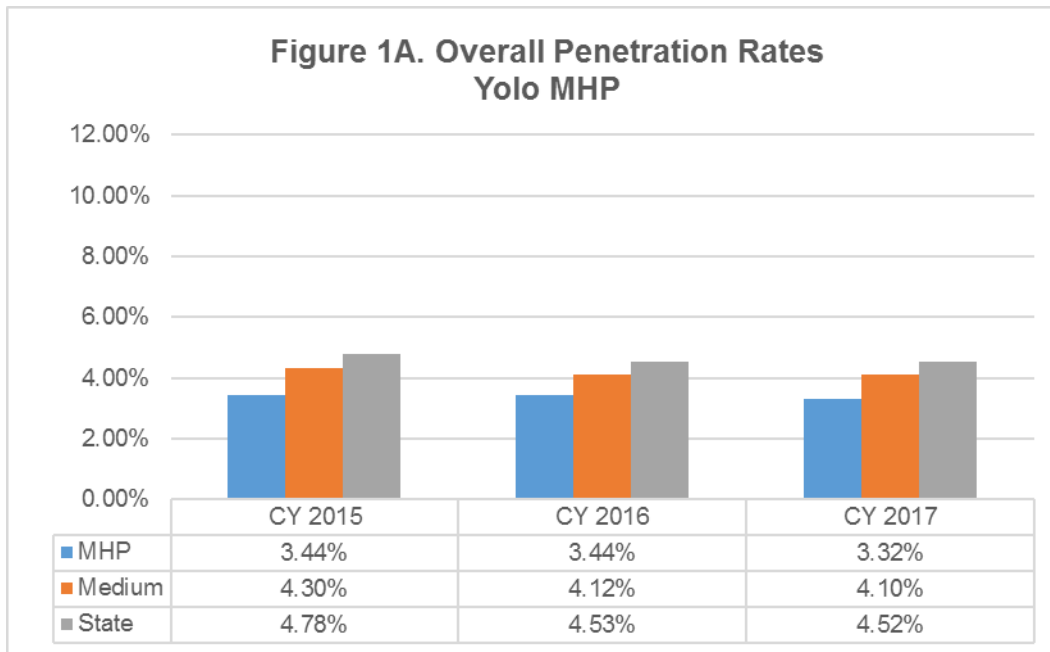
Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

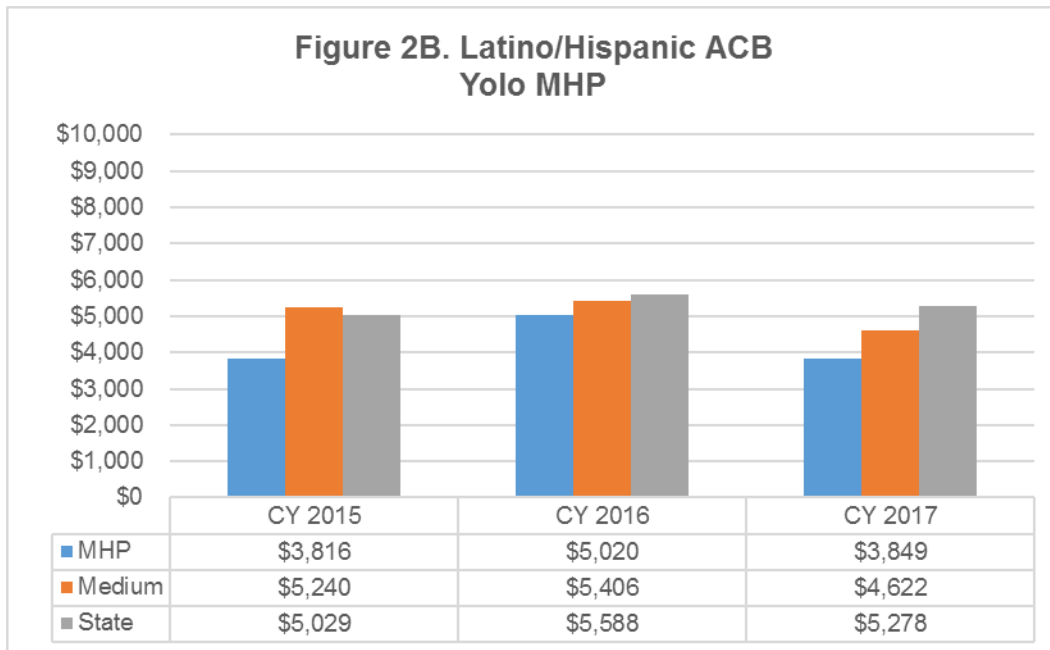
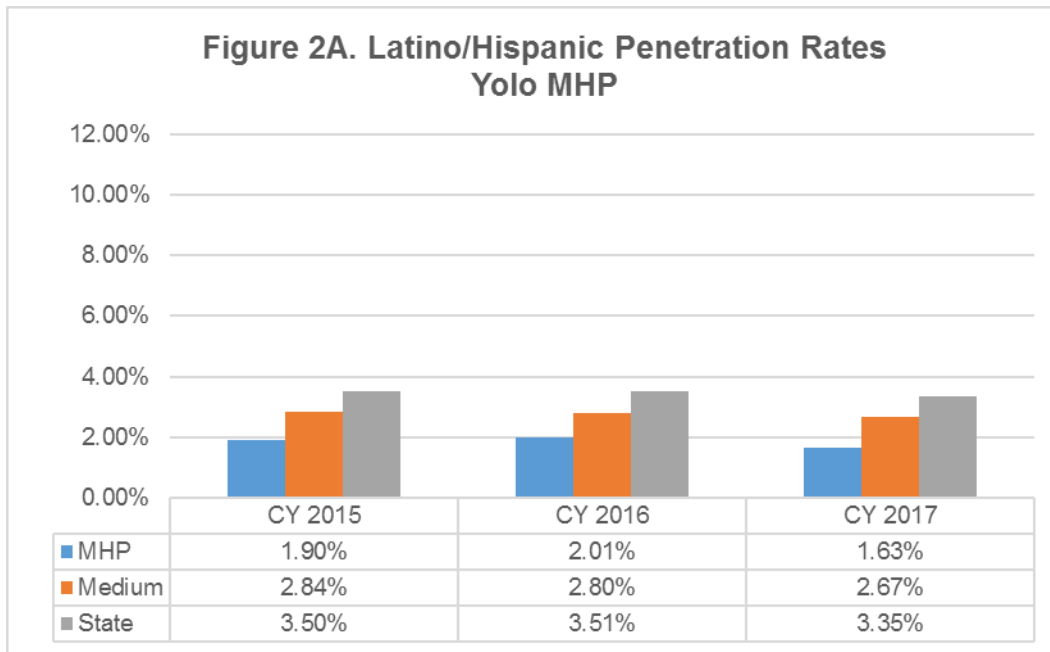
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Yolo MHP uses the same method used by CalEQRO.

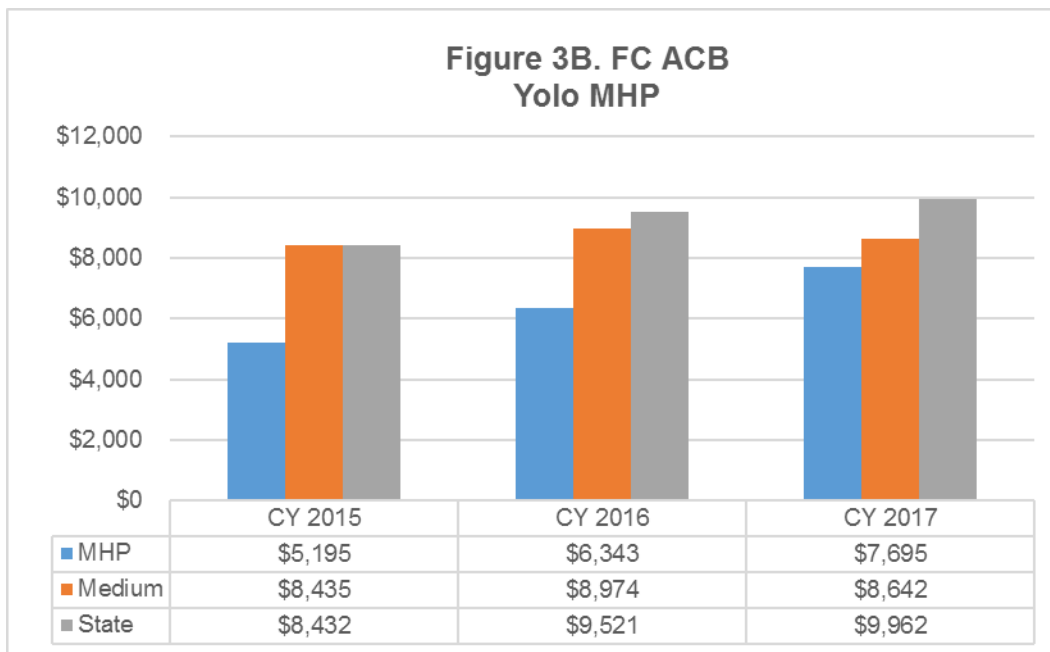
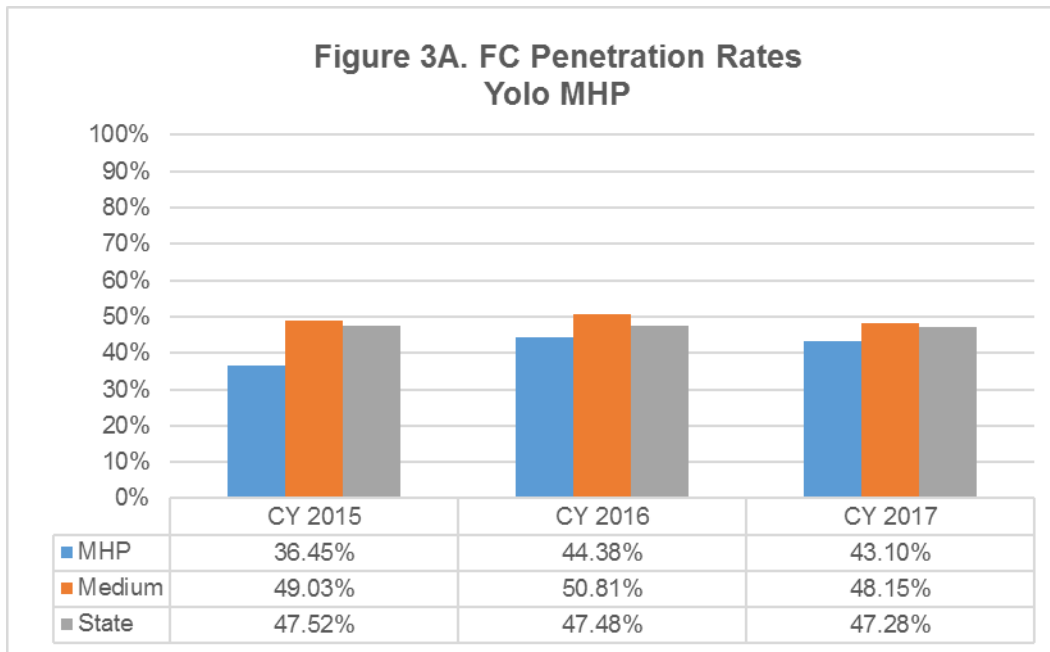
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP’s data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than \$30,000 in a year.

Table 2. High-Cost Beneficiaries Yolo MHP							
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	\$54,563	\$1,174,305,701	31.11%
MHP	CY 2017	86	1,985	4.33%	\$48,524	\$4,173,047	32.68%
	CY 2016	89	2,067	4.31%	\$55,222	\$4,914,784	36.50%
	CY 2015	60	1,988	3.02%	\$57,809	\$3,468,566	34.84%

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

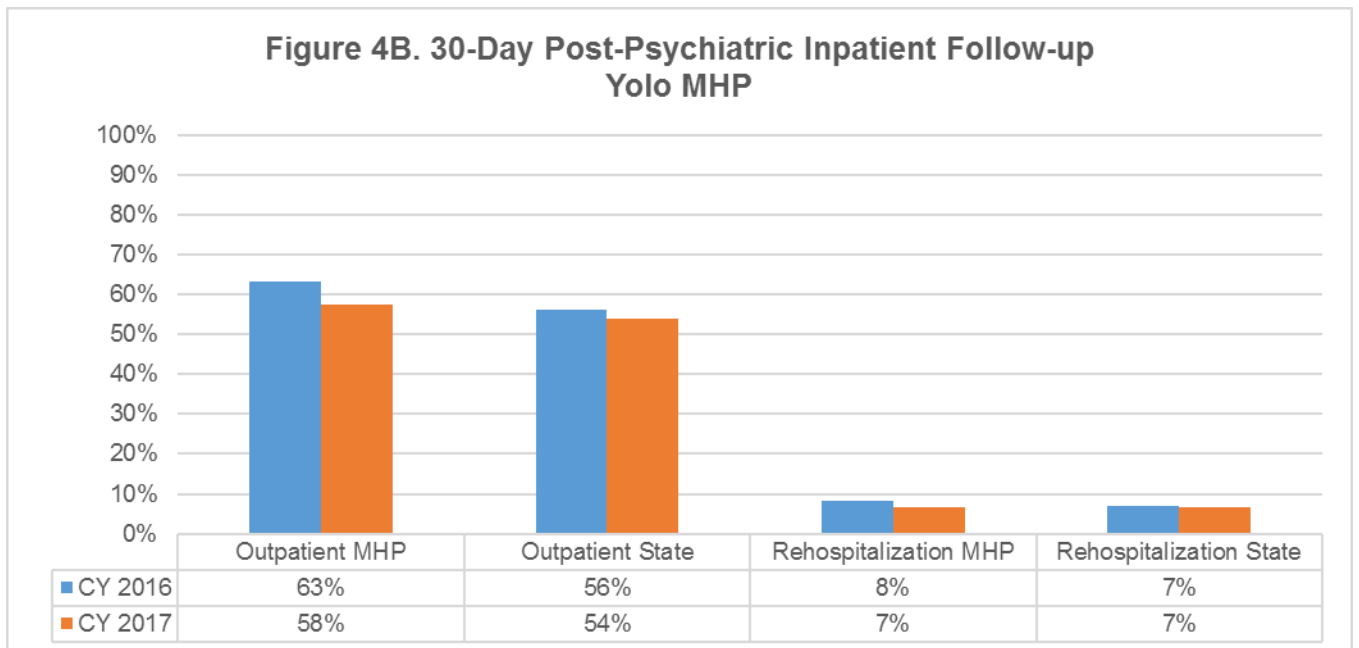
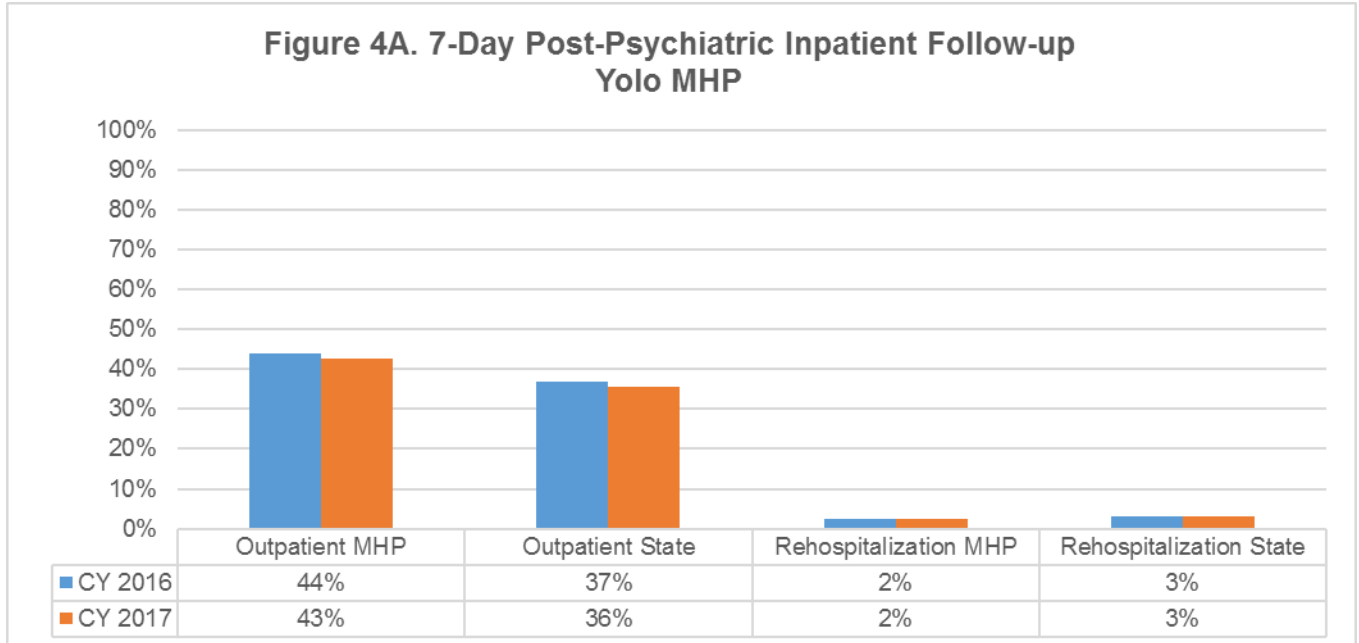
Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 3. Psychiatric Inpatient Utilization - Yolo MHP					
Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	324	621	9.46	\$12,153	\$3,937,462
CY 2016	297	525	9.02	\$15,105	\$4,486,112
CY 2015	233	520	8.88	\$8,472	\$1,974,061

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

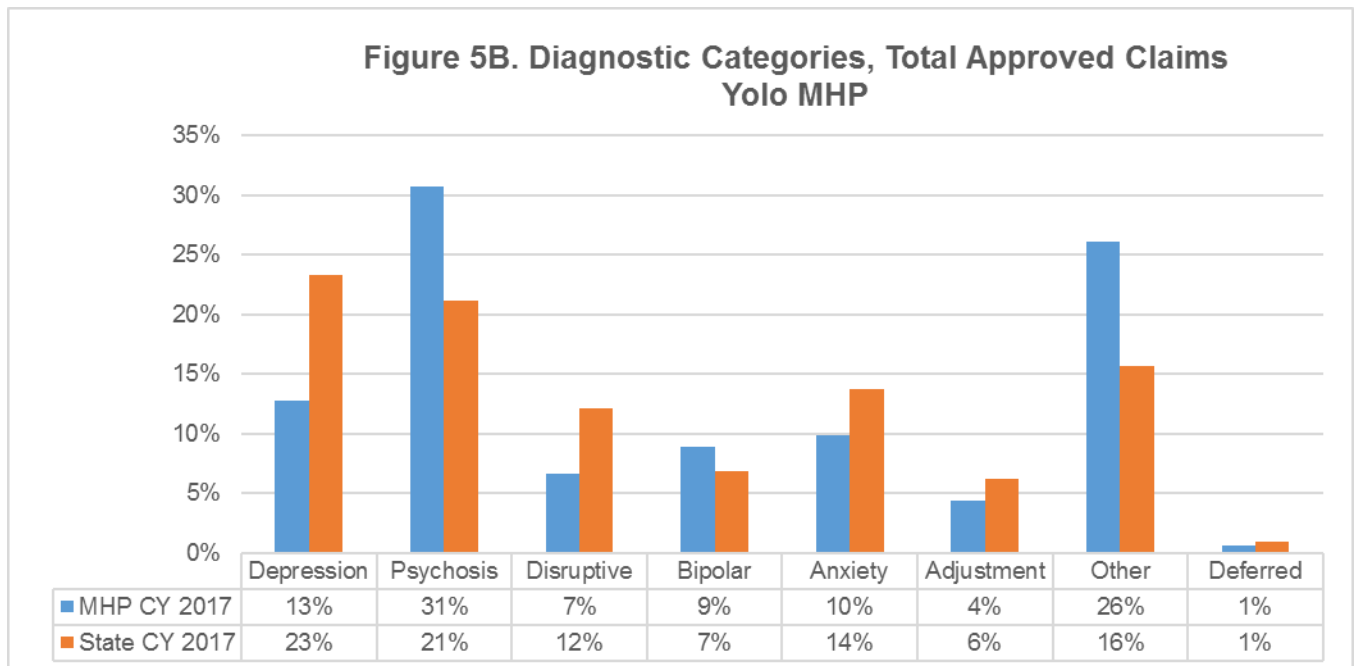
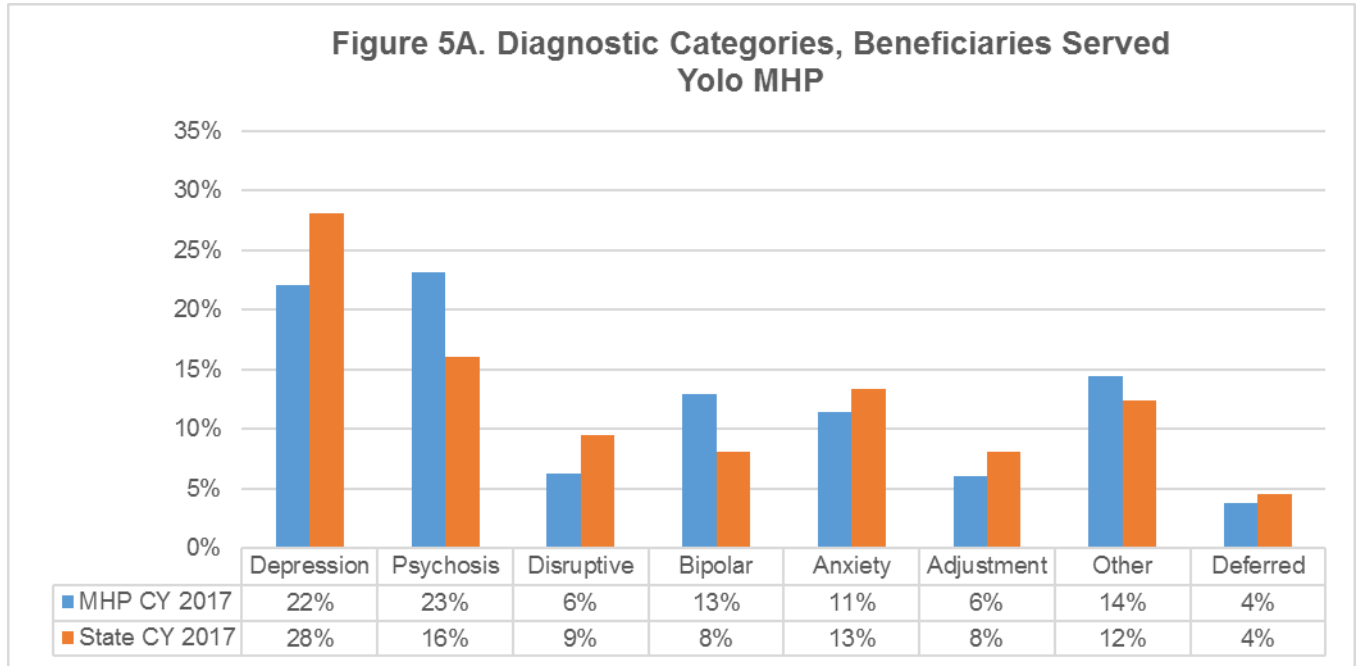
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.



Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: The MHP is unable to track.



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.” CMS’ EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Yolo MHP PIPs Identified for Validation

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

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.⁵

Table 4: PIPs Submitted by Yolo MHP		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving outcomes for SMI clients receiving intensive mental health services in treatment facilities.
Non-clinical PIP	1	Improving Tracking Access & Timeliness to Mental Health Services

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

⁵ 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 5: PIP Validation Review					
				Item Rating	
Step	PIP Section	Validation Item		Clinical	Non-Clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M

Table 5: PIP Validation Review						
					Item Rating	
Step	PIP Section	Validation Item		Clinical	Non-Clinical	
		6.4	Plan for consistent and accurate data collection	M	M	
		6.5	Prospective data analysis plan including contingencies	M	M	
		6.6	Qualified data collection personnel	M	PM	
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M	
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	M	
		8.2	PIP results and findings presented clearly and accurately	M	M	
		8.3	Threats to comparability, internal and external validity	M	M	
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	M	
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	M	
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	UTD	
		9.3	Improvement in performance linked to the PIP	M	UTD	
		9.4	Statistical evidence of true improvement	M	UTD	
		9.5	Sustained improvement demonstrated through repeated measures	M	UTD	

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-clinical PIP
Number Met	24	19
Number Partially Met	1	2
Number Not Met	0	0
Unable to Determine	0	4
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings $((\#M*2)+(\#PM))/(\text{AP}*2)$	98%	80%

Clinical PIP—Improving outcomes for SMI clients receiving intensive mental health services in treatment facilities

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

“Will improving clinical and care coordination processes for beneficiaries receiving intensive mental health services in treatment facilities result in a decrease in the average length of facility stays, number of step-ups to higher levels of care (LOC), transitions in care, and readmissions, as well as an increase in the number of step-downs to lower LOC (including community outpatient services) and average number of HHSA services provided to these beneficiaries [sic] during their facility stays?”

Date PIP began: 07/2017

End date: 02/2019

Status of PIP: Completed

The goal of this PIP is to improve outcomes for adult beneficiaries who have a severe mental illness (SMI), significant difficulty functioning at lower levels of care, and currently receive intensive mental health services in treatment facilities. This will be done by improving the clinical and care coordination processes between HHSA staff, facility staff, and the Public Guardian’s office (PGO).

Suggestions to improve the PIP: This is a completed PIP, which was presented in last year’s EQRO review. At that time EQRO suggested the following:

- Update and analyze findings at least quarterly.
- Specify who would do the data analysis and what their qualifications were.
- Incorporate at least one additional intervention to continue the PIP in the upcoming review year.
- Include beneficiaries or family members who have utilized high-cost services in the past to have a value-added component to the PIP team.

All recommendations were implemented and presented in the current PIP Implementation and Submission Tool.

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

The TA provided to the MHP by CalEQRO consisted of discussions of what is needed to make the PIP results the most useful. CalEQRO suggested the importance of a discussion of why the MHP feels that some interventions were successful and why others were not.

The MHP was encouraged to consult with CalEQRO early and often during new PIP formulations.

Non-clinical PIP—Improving Tracking Access & Timeliness to Mental Health Services”

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

“Will using new electronic mechanisms for tracking initial service requests and scheduling appointments, as well as increasing the MHP’s clinician capacity to conduct assessments, decrease the wait time to first offered, scheduled, and rendered mental health appointments?”

Date PIP began: 07/2018

Projected End date: 7/2019

Status of PIP: Active and ongoing

The goal of this PIP is to ensure that Yolo County beneficiaries receive outpatient MHP services in a timely manner following initial request for services. Timeliness of access to services that the PIP plans to achieve is in alignment with the DHCS MHSUDS Information Notice 18-011 on federal network adequacy standards: “Timely access standards refers to the number of business days in which a Plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service” (page 3).

Suggestions to improve the PIP: The PIP will continue for this FY. To adjust for any unexpected results, the MHP is encouraged to analyze data quarterly at a minimum. Contact CalEQRO early and often in development of PIP study process.

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

The TA provided to the MHP by CalEQRO consisted of discussion of the continuation of the PIP. EQRO reminded the MHP that a new intervention was needed to continue the PIP for the next year. The MHP agreed to reach out for TA from CalEQRO as needed as they continue this PIP.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP’s information system is essential to evaluating its 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 Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 2 percent.

<input checked="" type="checkbox"/> Under MHP control <input type="checkbox"/> Allocated to or managed by another County department <input type="checkbox"/> Combination of MHP control and another County department or Agency

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	40%
Contract providers	59%
Network providers	1%
Total	100%*

*Percentages may not add up to 100 percent due to rounding.

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP’s EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	Frequency
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

Yes No In pilot phase

Number of remote sites currently operational: One

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

<input checked="" type="checkbox"/> Hiring healthcare professional staff locally is difficult <input type="checkbox"/> For linguistic capacity or expansion <input type="checkbox"/> To serve outlying areas within the county <input type="checkbox"/> To serve beneficiaries temporarily residing outside the county <input type="checkbox"/> To serve special populations (i.e. children/youth or older adult) <input type="checkbox"/> To reduce travel time for healthcare professional staff <input type="checkbox"/> To reduce travel time for beneficiaries

- Telehealth services are available with English-speaking practitioners (not including the use of interpreters or language line).

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by FTE since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2.5	0	0	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
1.0	0	0	0

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

- The MHP added new technology positions to the FY 2018-19 HHS budget, including 1.0 FTE HHS IT Manager and 1.0 FTE Programmer Analyst for the Adult and Aging Branch. The HHS IT manager started December 2018. Upon further analysis, the MHP decided to replace the Programmer Analyst position with an Information Systems Coordinator.
- The Information Systems Coordinator (to be hired) will support the software specialist and all other aspects of the IT department within the Adult and Aging Branch, including Avatar.
- Two staff positions anticipated are business intelligence analysts, who will be hired once the County has determined which business intelligence tool they are going to purchase. One analyst will be dedicated to the adult system of care, the other to the children’s system of care.

Current Operations

- The MHP is moving Avatar to a hosted environment with Netsmart.
- The MHP transitioned Avatar from an episodic-based system to an “umbrella” or plan of care structure, which reduces the data entry duplication, errors related to duplication, and improves efficiency.
- The current budget for IT support is 2 percent, which is lower than most similar sized MHPs.
- While the MHP has had Dimension Reports for several years, they did not have staff dedicated to it until recently. With dedicated staff, the MHP has been able to reduce their denial rate (to 4.49 percent), which is still higher than the 2.7 percent statewide average, but an improvement for this MHP.

Table 11 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 (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar CalPM	Practice Management	Netsmart	15	County IT
Avatar CWS	Clinical Workstation	Netsmart	12	County IT
OrderConnect	Electronic Prescribing & Lab Results	Netsmart	5	County IT

The MHP’s Priorities for the Coming Year

- Complete migration to a Netsmart-hosted environment.
- Implement CareConnect Inbox – Netsmart application.
- Continue to reduce and eliminate paper processes, such as Notice of Adverse Benefit Determination (NOABD) forms, medication monitoring forms, assessments, treatment consent materials, and releases of information.

- Implement Child and Adolescent Needs and Strengths-50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) functional assessment data reporting requirements.

Major Changes since Prior Year

- Developed and implemented new and improved Access Log, access screening tools (Beacon adults and Beacon children), Crisis Assessment, Medication Consent form, Medication Services Client Plan.
- Development efforts included forms, widgets, and related reports.
- The Access Log will be helpful for network adequacy and tracking capacity within the MHP.

Other Areas for Improvement

- The MHP does not currently have a health informaticist position in their organization who can provide EHR clinical documentation support for clinicians, or work with the existing data to create customized reports and assist IT and Quality Management (QM) with responding to use of data reporting requests.
- A data warehouse should be explored as a related tool to support data extraction, analysis, and reporting.
- Claims data from contract providers are generally submitted to the MHP on paper and then the data are entered into Avatar by MHP fiscal employees. This is an inefficient and potentially error-prone process.

Plans for Information Systems Change

- The MHP has no plans to replace current system.

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	Avatar/Netsmart	X			
Assessments	Avatar/Netsmart	X			
Care Coordination				X	

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Document Imaging/Storage	Perceptive/Netsmart	X			
Electronic Signature—MHP Beneficiary	Netsmart	X			
Laboratory results (eLab)	OrderConnect	X			
Level of Care/Level of Service	Avatar/Netsmart	X			
Outcomes				X	
Prescriptions (eRx)	OrderConnect	X			
Progress Notes	Avatar/Netsmart	X			
Referral Management				X	
Treatment Plans	Avatar/Netsmart	X			
Summary Totals for EHR Functionality:					
FY 2018-19 Summary Totals for EHR Functionality:		9	0	3	0
FY 2017-18 Summary Totals for EHR Functionality*:		9	0	3	0
FY 2016-17 Summary Totals for EHR Functionality:		6	3	1	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

Progress and issues associated with implementing an EHR over the past year are summarized below:

- Contract providers do not have full access to many functions of the MHP’s EHR.
- Contract providers began to have access to Assessments through the Access Log starting in July 2018.
- Overall, the MHP has not added significant EHR functionality over the past two years.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

- Yes In Test Phase No

If no, provide the expected implementation timeline.

<input type="checkbox"/> Within 6 months	<input type="checkbox"/> Within the next year
<input type="checkbox"/> Within the next two years	<input checked="" type="checkbox"/> Longer than 2 years

Medi-Cal Claims Processing

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:

- Paper Electronic Clearinghouse

Table 13 summarizes the MHP’s SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims Yolo MHP							
Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
53,976	\$12,251,326	2,190	\$550,465	4.49%	\$11,700,861	\$1,883,292	\$9,817,569
Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2017 was 2.73 percent .							

Table 14 summarizes the top three reasons for claim denial.

**Table 14: Summary of CY 2017 Top Three Reasons for Claim Denial
Yolo MHP**

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Medicare or Other Health Coverage must be billed prior to submission of claim.	580	\$183,902	33%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	397	\$141,379	26%
Service line is a duplicate and repeat service modifier not present.	781	\$122,233	22%
TOTAL	2,190	\$550,465	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with “Medicare or Other Health Coverage must be billed prior to submission of claim” and “Void/replacement error” are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months, including those who identify as Hispanic and Latino. The group that participated was consistent with that request. The session was conducted at the Bauer Building, Livingston Room, 137 N. Cottonwood St., Woodland, CA 95695.

The session was attended by 11 adult beneficiaries, ages ranging from 18 – 59, the majority of whom were female. There were a majority of English-speaking and minority of Spanish-speaking attendees.

Number of participants: 11

The four participants who entered services within the past year described their experiences as the following:

- Access to services presented barriers to some while other participants stated that it was positive.
- The participants find the appointment process somewhat difficult and complex to understand and navigate.

Participants' general comments regarding service delivery included the following:

- The participants agree that the psychiatrist experience is positive, although several have telehealth and have never seen an in-person psychiatrist.
- Some participants felt that the staff did not take the time to understand people they were attempting to help.
- Housing is an issue for many of the participants, and some are currently homeless.

Participants' recommendations for improving care included the following:

- All participants agreed that they would like the staff to take the time to understand them before offering solutions to issues.
- Some participants recommended that the staff needs to have better communication skills, especially in listening and not interrupting the beneficiary.
- Along the same thoughts on communication was a recommendation to reach out to those beneficiaries who are quiet and reticent to speak up for themselves.
- Transitional-age youth (TAY) in the focus group noted that they would like help with both physical health and mental health issues.

Interpreter used for focus group one: Yes Language(s): Spanish

CFM Focus Group Two

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months, including parents/caregivers of child/youth beneficiaries whose preferred language is Spanish. However, no parents or caregivers attended this session. Consequently, no findings are presented.

Number of participants: None.

PERFORMANCE AND 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 described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 15: Access to Care Components		
Component		Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	PM
<p>The MHP reviews the Cultural Competency Plan annually and updates as needed. The MHP has created workgroups for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ), Russian-speaking, Hispanic culture, and other underserved beneficiaries. Beneficiaries and stakeholders reported that they receive culturally and linguistically competent services for the purpose of assessing cultural, ethnic, racial and linguistic needs and disparities, as well as identifying strategies to address these. The MHP continues to recruit bilingual candidates for employment. Rural Innovations in Social Economics (RISE), a contract provider, employs staff who are 90 percent bilingual/bicultural. Due to insufficient IT resources, the MHP is unable to fully evaluate the implementation and outcomes of its strategies to address these issues of disparity. This is reflected in the penetration rates noted in this report.</p>		
1B	Manages and adapts its capacity to meet beneficiary service needs	PM
<p>The MHP takes timely delivery of services and cultural competency seriously, and they have worked to adapt their capacity to meet beneficiary needs within the scope of their current resources. The MHP has been able to increase contract provider capacity incrementally. The Yolo HHS Mental Health Professional Shortage</p>		

Table 15: Access to Care Components		
Component		Quality Rating
Area (HPSA) re-evaluation by California's Office of Statewide Health Planning and Development was requested and is underway. The MHP has a current PIP that speaks to caseload numbers, level of care/level of services, and continuum of services.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has integration and collaboration with a variety of community-based services. The collaboration with Empower Yolo and Health Education Council (located in the Mexican Consulate) offer opportunities for outreach to the Spanish-speaking community. The MHP has engaged other community partners to share resources and services with Latino outreach programs, to include senior peer counseling. The MH collaborates with Health Education Council's Mente Sana, Vida Sana (Healthy Minds, Healthy Life) mental health program, which is an Implementation pilot project of the California Reducing Disparities project. The MHP has various outreach programs to increase access and engage Russian-speaking beneficiaries. The MHP partners with CommuniCare Health Centers, Dairy Council of California, Dignity Health, National Alliance on Mental Illness (NAMI) Yolo, Partnership Health Plans of California, Saint John's Retirement Village, Sutter Health, UC Cooperative Extension, Winters Senior Foundation, Yolo Adult Day Health Center, Area 4 Agency on Aging, Community Health Assessment, Community Health Improvement Plan, and County Nutrition Action Partnership among others.		

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		Quality Rating
2A	Tracks and trends access data from initial contact to first offered appointment	PM

Table 16: Timeliness of Services Components		
Component		Quality Rating
<p>The MHP instituted a new Access Log effective 07/01/2018 to meet final rule/parity requirements set forth by DHCS. The Access Log tracks “Initial request” data points, and effective October 1, 2018, the MHP began tracking first, second, and third offered appointments within the MHP’s Adult and Aging branch. Offered appointments are tracked through the scheduling calendar within the Avatar.</p> <p>FY 2018-19 October 1 – December 31, 2018: The MHP utilizes a standard of 14 calendar days (i.e. 10 business days), which they met 80 percent of the time for adult and older adults, with a mean of 6 days and a range of 0-23 days. There were no children’s services or FC data reported.</p>		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
<p>The MHP instituted a new Access Log effective 07/01/2018 to meet Final Rule/Parity requirements set forth by the state. The Access Log tracks “Initial request” data points, in addition to tracking first, second and third offered appointments; these data points, were implemented effective October 1st, 2018, within the MHP’s Adult and Aging branch. Offered appointments are tracked through the Scheduling Calendar within Avatar. The MHP is in the process of changing its operational workflow to offer a psychiatric appointment when offering an appointment for an assessment.</p> <p>FY 2018-19, October 1 – December 31, 2018: The MHP utilizes a standard of 21 days (i.e., 15 business days), which they met 29 percent of the time for adult and older adults, with a mean of 39 days and a range of 7-91 days. There were no children’s services or FC data available.</p> <p>FY 2017-18, July 1, 2017 – June 30, 2018: The MHP utilizes a standard of 21 days from initial request to first kept psychiatry appointment, which they met 20 percent of the time, 25 percent for adults and older adults, with a mean of 59 days and a range of 1-258 days, and 10 percent for children, with a mean of 107 days and a range of 1-312 days. FC data was not separated out.</p> <p>FY 2018-19, July 1, 2018 – December 31, 2018: The MHP utilizes a standard of 21 days from initial request to first kept psychiatry appointment, which they met 38 percent of the time, 43 percent for adults and older adults, with a mean of 40 days and a range of 2-98 days, and 0 percent for children, with a mean of 73 days and a range of 51-94 days. FC was not separated out. This represents six months of data since the Access Log went live.</p>		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
<p>The MHP instituted a new Access Log effective 07/01/2018 to meet Final Rule/Parity requirements. The Access Log tracks initial request data points, including urgent</p>		

Table 16: Timeliness of Services Components		
Component		Quality Rating
<p>requests. In addition, the MHP updated its scheduling calendar with Avatar, giving the MHP the ability to track urgent appointments. This was implemented effective October 1, 2018. FY 2017-18 data were unavailable for this measurement as there was no tracking methodology in place.</p> <p>FY 2018-19, July 1 – December 31, 2018: The MHP utilizes a standard of two business days, which they met 100 percent of the time. There were no children or FC data available. This represents six months of data since the Access Log went live.</p>		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
<p>The MHP uses an external tracking source (Excel) Treatment Authorization Request (TAR) Log and an EHR follow-up after hospitalization report. These two sources are combined to determine the data that need to be reviewed for timeliness of follow-up post psychiatric inpatient discharge. The MHP changed methodologies effective FY 2018-19. FY 2018-19 data includes follow-up encounters provided by the discharge planner post-hospital discharge. The MHP does not currently break out FC population data.</p> <p>Hospital Intercept Mapping – HHSA, in conjunction with the Chief Administrative Officer’s (CAO) office, is providing TA to local hospital partners, Woodland Memorial and Sutter Davis, to complete an intercept mapping project that identifies service gaps/needs as they relate to homeless beneficiaries being served by either hospital. Personnel from the CAO’s office, who previously conducted a similar process for the criminal justice continuum of care are facilitating this process in the hopes that there can be improved outcomes for homeless beneficiaries who contact the hospital system for physical, mental, or substance use service.</p> <p>FY 2017-18 July 1, 2017 – June 30, 2018: The MHP utilizes a standard of seven business days, which they met 49 percent of the time. There were 634 admissions and 650 hospital discharges during this time. Of those follow-ups meeting the HEDIS standard of seven days, 245 were adults and 76 were children, for a total of 321. Adults met the standard 50 percent of the time, while children met it 48 percent, with an overall a mean of 27 days, 30 days for adults and 17 days for children.</p> <p>FY 2018-19 July 1, 2018 – December 31, 2018: The MHP utilizes a standard of seven business days, which they met 78 percent of the time. Of those meeting the HEDIS standard of seven days, 192 were adults and 65 were children, for a total of 257. Adults met the standard 83 percent of the time, while children met it 60 percent, with an overall mean of seven days, six days for adults and ten days for children.</p>		
2E	Tracks and trends data on rehospitalizations	M

Table 16: Timeliness of Services Components

Component	Quality Rating
<p>The MHP uses an external Excel TAR Log for readmission rates. The MHP does not currently break out FC population data. The MHP uses the total number of discharges (not admissions) during the specified time period as the denominator.</p> <p>FY 2017-18, July 1, 2017 – June 30, 2018: There was a total of 650 discharged, with 46 (7 percent) readmitted within seven days (adults 36 or 7 percent, children 10 or 6 percent), and 110 (17percent) readmitted in 7-30 days (adults 85, or 7 percent, and children 25 or 6 percent).</p> <p>FY 2018-19, July 1 – December 31, 2018: There was a total of 262 discharged, with 16 (6 percent) readmitted within seven days (adults 15 or 8 percent and one child or 3 percent), and 41 (16 percent) readmitted in 7 - 30 days (adults 195 or 19 percent, and children 4 or 6 percent).</p> <p>HHSA, the CAO’s office, Sutter, and Dignity Health have embarked on an intercept mapping process to identify the process of homeless individuals moving in and out of the hospitals in Yolo County. The intercept mapping process allows for a robust analysis of a system as currently structured, while identifying gaps and needs of that system. HHSA, CAO, and Dignity staff have met twice this far to begin the process, and HHSA, CAO, and Sutter staff had their initial meeting in the beginning of November. All staff are now working together to develop next steps to provide a comprehensive and collaborative process.</p>	
<p>2F Tracks and trends no-shows</p>	<p>PM</p>
<p>No-shows are collected by the MHP within Avatar. The data are generated by physicians changing the service codes when writing a progress note to the appropriate code. The MHP currently uses no-show codes of Y9929, no-show, Y9930-no-show assessment. During data collection for FY 2017-18 no-show rates, it was discovered that services were being included and excluded incorrectly within the denominator (total number of mental health services). The report was amended to correct these issues, and data were recompiled and corrected for FY 2017-18 and FY 2018-19. Non-physician appointments are not scheduled within the EHR (Avatar) scheduling calendar and so remains the responsibility of the non-physician to enter the no-show when it occurs.</p> <p>The MHP standard for no-shows for psychiatrist is 15 percent and for clinicians other than psychiatrist, 5 percent. The MHP notes that this may be due to high turnover of psychiatrists that could possibly effect engagement of the beneficiary.</p> <p>FY 2017–18, July 1, 2017 – June 30, 2018: Average no-show rate for psychiatry was 16 percent, with 19 percent for adults and 3 percent for children. For clinicians other than psychiatrist, the average no-show rate was 5 percent, with 6 percent for adults and 2 percent for children.</p>	

Table 16: Timeliness of Services Components	
Component	Quality Rating
FY 2018-19: Average no-show rate for psychiatrist was 20 percent, with 22 percent for adults and 4 percent for children. For clinicians other than psychiatrist, the average no-show rate was 5 percent, with 5 percent for adults and 3 percent for children.	

Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective QI activities and data-driven decision making require strong collaboration among staff (including CFM 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 17: Quality of Care Components		
Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
<p>The MHP operates with a current quality improvement (QI) Performance Plan, supported by meeting minutes and the evaluation of the previous year's plan. The minutes are notable in that they communicate effectively, enabling readers to understand and track the improvement activities of the department's Strategic Plan goal of strengthening integration.</p> <p>The MHP Children's Mental Health, Children's Medical Services, and Child Welfare Services are departments in the Child, Youth and Family (CYF) branch led by one Branch Director. The departments' staff and Child and Family Teams (CFT) leadership are co-located and have a shared wellness center and lobby. The department managers meet on a quarterly basis to ensure ongoing collaboration, integration, and teaming on top of regular informal meetings to maintain connection and unified focus on HHSA's strategic plan goals. Trainings and leadership messaging for staff are provided across the branch regarding policy and program changes to strengthen practice of Continuum of Care Reform (CCR), to implement CFT with CANS, and to infuse the Integrated Core Practice Model's philosophies.</p>		
3B	Data used to inform management and guide decisions	PM
<p>The MHP strives to implement Results Based Accountability (RBA) and for programs to have outcomes data (both county and contracted programs). While this is a goal, it has not been implemented in a meaningful way to date. The MHP is not yet able to measure and monitor beneficiary outcomes using standardized tools that support treatment decisions; however, the CANS-50 and PSC-35 are being implemented this year into the EHR and a final decision on an adult outcomes tool is imminent.</p> <p>The MHP lacks IT resources to effectively engage in data extraction and analysis that pertains to access, timeliness, quality, and outcomes at a system level.</p>		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
<p>The MHP utilizes several means of communication with stakeholders, to include newsletters, emails, and meetings. Stakeholders at the wellness centers reported that they are encouraged to give input regarding services that they need, quality of what they are currently receiving, and suggestions for improvement. Staff interviewed reported that they receive regular communication about system planning and are able to provide input.</p>		

3D	Evidence of a systematic clinical continuum of care	PM
<p>The MHP showed evidence of a continuum of care. However, no data were available to show how the MHP uses level of care tools to measure outcomes and decisions of level of care needed. The new mental health urgent care clinic in West Sacramento, the TAY Wellness Center, opened in Davis, and the expanded Crisis Services to 24/7 response are all are examples of the MHP’s efforts to increase the continuum of care. The Children’s System of Care (CSOC) crisis clinician is embedded with the Child Welfare Services (CWS) crisis clinician. This team goes on emergency calls and does on-site assessment with children. When a previously unknown child presents to the hospital emergency department, the hospital notifies the Children’s Crisis team. The MHP presented evidence of a full continuum of care. Capacity issues with children’s psychiatry continues. The MHP continues to recruit for children’s psychiatry for both in person and telehealth.</p> <p>There was no data provided to show how the continuum of care tracks outcomes of changes in level of care/level of service.</p>		
3E	Evidence of peer employment in key roles throughout the system	PM
<p>There does not appear to be a defined career ladder for beneficiary/family member staff. Peer staff are offered and receive training when they start and continued training while n their positions. Trainings are through Relias or other various staff trainings (e.g., Mental Health First Aid, Wellness Recovery Action Plan (WRAP)).</p> <p>Through Mental Health Services Act (MHSA) funding, the MHP hired eight new Peer Support Workers (funded to work on program teams within the wellness centers).</p>		
3F	Peer-run and/or peer-driven programs exist to enhance wellness and recovery	M
<p>Yolo County HHS specialty mental health beneficiaries can participate in drop-in wellness centers located across the county. For adults, there are these locations: Woodland Wellness Center and West Sacramento Wellness Center. TAY Wellness Centers include: Support for Transition Age Youth (S.T.A.Y.) Well Center and TAY Davis Wellness Center.</p> <p>The TAY Davis Wellness Center site was visited during this review. The center has been open for a few weeks only and is run and managed by county staff with two peer support workers.</p> <p>Peer employees interviewed who work at the other wellness centers (S.T.A.Y. and adult wellness center), communicated that they work in peer-run and -managed centers.</p>		
3G	Measures clinical and/or functional outcomes of beneficiaries served	NM

The MHP is still undecided between using Level of Care Utilization System (LOCUS) or Milestones of Recovery Scale (MORS) for adult outcomes. The Adults Needs and Strengths Assessment (ANSA) is currently in use in the MHP as an outcome tool. One issue is that currently contract providers are using LOCUS. If the MHP decides on MORS, then it would be useful if the contract providers switched to MORS. Implementation of CANS-50 and PSC-35 functional assessment data reporting requirements is scheduled for this year. The MHP does not yet measure beneficiary outcomes at a system-wide level.

3H	Utilizes information from beneficiary satisfaction surveys	M
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The MHP administers the Consumer Perception Survey (CPS) twice yearly as mandated by DHCS. They also conduct several of their own surveys (i.e., foster families and wellness centers surveys). The MHP analyzes and compares the CPS data from previous years. This information is utilized in program planning decisions, as noted in QI minutes.

None of the beneficiaries in the CFM focus groups reported being asked or taking a survey within the past 12 months, therefore, they were not interviewed on their perceptions of the surveys.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Yolo MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Active and ongoing

Recommendations:

- The clinical PIP is complete. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. Contact CalEQRO for TA early and often as a new PIP is designed and implemented.
- The non-clinical PIP will continue for this FY. The MHP needs to add one new intervention (at a minimum) to continue the PIP.
- To adjust for any unexpected results in the non-clinical PIP, analyze data quarterly at minimum. Contact CalEQRO early and often in development of PIP study process.

Access to Care

Changes within the Past Year:

- The MHP expanded TAY services.
- The MHP opened a mental health urgent care clinic in West County.
- Following a competitive bid process, the MHP contracted with Heritage Oaks Hospital, in a new capacity as an outpatient provider, for the delivery of 24-7 Access Line coverage and after-hours community crisis response to local hospital emergency departments and law enforcement.
- The MHP expanded Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for youth and adolescent beneficiaries through the addition of two contract providers, Stanford Youth Solutions and Victor Community Support Services.
- The development and implementation of the hospital intercept mapping model.

Strengths:

- The HHSA, in conjunction with the Chief Administrative Officer's (CAO) office, is providing TA to local hospital partners, Woodland Memorial and Sutter Davis on an intercept mapping project which identifies service gaps/needs as they relate to homeless beneficiaries being served by either hospital. This allows access to homeless individuals who request services and for improved outcomes for homeless beneficiaries who contact the hospital system for physical, mental, or substance use service needs.
- The MHP expanded TAY services to include a new TAY Wellness Center in Davis.
- The MHP has created workgroups for LGBTQ, Russian-speaking, Hispanic culture, and other underserved beneficiaries. Beneficiaries and stakeholders reported that they receive culturally and linguistically competent services.

Opportunities for Improvement:

- None noted.

Recommendations:

- None noted.

Timeliness of Services

Changes within the Past Year:

- The MHP implemented a new Access Log that captures first contact to subsequent services delivered.
- The MHP updated its scheduling calendar with the Avatar.

Strengths:

- The MHP implemented a new Access Log that captures first contact to subsequent services delivered. This system creates a beneficiary file that connects with services delivered following first contact request for services timeliness to services.
- The MHP updated its scheduling calendar with the EHR, giving the MHP the ability to track urgent appointments. This was effective October 1, 2018.

Opportunities for Improvement:

- Currently, the MHP is not tracking FC youth as a subpopulation of children served, although they have the capability to track this.

- The MHP did not meet their standard for timeliness for children to psychiatry services (10 percent of the time from July 1 – December 31, 2018). In FY 2017-18 and FY 2016-17, the MHP did not separate children from adults.
- The MHP standard for no-shows for psychiatrist is 15 percent. The MHP notes that this may be due to high turnover of psychiatrists that could possibly effect engagement of the beneficiary.
- The MHP does not separate children's services in measuring timeliness of first offered appointment from request for services.
- The MHP is only tracking first offered appointment data from contract providers, not first appointment scheduled or kept. Contract providers should be providing data to the MHP on time from first contact to first appointment.

Recommendations:

- Begin tracking and generate reports that assess timeliness for foster youth.
- Implement a system that segregates timeliness data for children and children in FC care in all categories of service.
- Design and implement interventions to address timeliness to psychiatry services for children, to include FC.
- Implement avenues to allow contract providers to report timeliness data on first contact to first face-to-face service.

Quality of Care

Changes within the Past Year:

- The MHP added a Behavioral Health Compliance Officer to the Quality team.
- The MHP developed an Outreach and Engagement Plan to increase awareness and facilitate access for underserved Latino/Hispanic beneficiaries.
- The MHP provided 16-week Testing Empathy Agenda Setting Methods (TEAM) Cognitive Behavioral Therapy training to approximately 30 clinical staff.

Strengths:

- Outreach efforts for diversity were expanded.
- The MHP added a Behavioral Health Compliance Officer to the Quality team.

Opportunities for Improvement:

- The MHP does not yet measure beneficiary outcomes at a program or system-wide level.

Recommendations:

- Implement into the EHR an assessment to evaluate outcomes on a program and system-wide level.
-

Beneficiary Outcomes

Changes within the Past Year:

- The MHP has obtained two new contractors in past year to increase capacity, which allows beneficiaries better outcomes in treatment.
- The MHP added a restorative justice component to Mental Health Court.
- The MHP began a Mental Health Court Alumni Program.
- Through Mental Health Services Act (MHSA) funding, the MHP hired eight new Peer Support Workers (funded through to work on program teams within wellness enters).

Strengths:

- The MHP has obtained two new contractors in the past year to increase capacity, Victor Community Support Services and Stanford Youth Solutions. This eliminates the need for a wait list for children and youth needing these outpatient services.
- The MHP has increased activities in forensic services that improves services to and positive outcomes for treatment of beneficiaries in the judicial system.

Opportunities for Improvement:

- Beneficiaries interviewed reported that staff communication and cultural appropriateness needs to be improved. Examples given were staff not waiting for a beneficiary to finish speaking and interrupting them, and staff not getting acquainted with and understanding the issues of the beneficiary before offering solutions. These behaviors were perceived by the beneficiaries as lacking empathy.
- The MHP does not yet measure beneficiary outcomes at a system-wide level.

Recommendations:

- Implement CANS–50 and PSC–35 functional assessment data reporting requirements and use as outcomes tools.

- Create and implement training to increase staff understanding of communication with beneficiaries and to reduce behaviors that increase the beneficiaries' perception of stigma.

Foster Care

Changes within the Past Year:

- In April, Yolo Family Services Agency (a long-standing contractor provider) closed, and the beneficiaries and clinicians were largely absorbed by CommuniCare Health Centers.
- The MHP has obtained two new contractors in past year to increase capacity, Victor Community Support Services and Stanford Youth Solutions.
- The MHP is in discussion with Stanford Solutions and Lilliput providers to contract for therapeutic foster care (TFC).
- The Yolo County Interagency Placement Committee, formerly known as Multi-Disciplinary Assessment and Review Team (M-DART), is in the phase of revamp and rebranding. A new MOU is in its final draft of revisions and will be signed by leadership to support regulatory changes impacting the scope and work of this committee.

Strengths:

- An increase in capacity with the addition of two new contract providers has diminished the waiting list for services.
- Integrated core practice includes Interagency Placement Committee leadership, Children's Mental Health, Child Welfare Services, Juvenile Probation, and Yolo County Office of Education; with regular attendance by a Family Partner to ensure that the voices and choice of beneficiaries and family are always present. Meetings are held weekly and each week's agenda is focused on the children and youth who are identified to have intensive level of care mental health needs.
- Yolo County has an MOU with the local Multi-Disciplinary Interview Center, which is under the leadership of the District Attorney. The Multi-Disciplinary Interview Center is where child victims of sexual abuse come for forensic interviews, medical evidentiary examinations, advocacy, assessment, therapy, and support services. A children's mental health clinician is co-located at the center to provide on the spot crisis intervention, trauma counseling, and coordination of care.
- Documentation was presented on-site confirming that requirements of SB1291 insofar as medication monitoring were being fulfilled.

Opportunities for Improvement:

- The MHP did not segregate FC in the Timeliness Self-Assessment for any categories of service. Per Senate Bill (SB) 1291 (Chapter 844), numbers of Medic-Cal eligible minor and non-minor dependents in foster care served need to be reported separately from other timeliness data.
- There remains an issue of timeliness to services for children to include FC.

Recommendations:

- Segregate foster care data for timeliness in all categories of service and provide to EQRO in next review.
- Design and implement interventions to address the issue of timeliness to psychiatry services for children, to include FC.

Information Systems

Changes within the Past Year:

- The MHP expanded the Netsmart contract, including transitioning to a Netsmart-hosted environment; the addition of Care Quality and Care Connect Inbox Avatar applications; and allocation of discretionary funds to support ad hoc software development without needing to amend the Netsmart support contract.
- The MHP added new technology positions to the FY 2018-19 HHS budget, including 1.0 FTE HHS IT Manager and 1.0 FTE Programmer Analyst for the Adult and Aging Branch. The HHS IT manager started December 2018, and interviews are scheduled for the Programmer Analyst position.

Strengths:

- The MHP continues to automate paper processes, such as NOABD forms, medication monitoring forms, assessments, treatment consent materials, and releases of information. Electronic forms are available to authorized staff with access to Avatar.

Opportunities for Improvement:

- Claims data from contract providers are mostly submitted to the MHP on paper and data are entered into Avatar by MHP fiscal employees.
- Contract providers do not have full access to many functions of the MHP's EHR.
- Overall, the MHP has not added significant functionality to the EHR over the past two years and it continues to impact health care providers' capability to efficiently and effectively serve beneficiaries.

Recommendations:

- Many functions of the EHR require additional investment in IT staffing and resources. The MHP should strongly consider increasing the overall technology budget to a three or four percent range, on par with medium-sized counties' technology, project management, and support budgets. This will allow the MHP to increase EHR functionality.
- Implement a system for contract providers to submit claims data into the MHP's EHR system to eliminate data entry requirement of MHP fiscal employees.

Structure and Operations

Changes within the Past Year:

- The MHP developed and implemented new Access Log that captures all access reporting mandates for SMHS and DMC-ODS.
- The HHSA hired a new IT Manager, beginning December 2018.
- A new IT Programmer Analyst position was approved, and interviews are underway. The Programmer Analyst (to be hired) will directly support the software specialist and all other aspects of the IT department.
- The Netsmart contract was extended for three years with new solutions.

Strengths:

- Contract providers received access to assessments through the Access Log starting in July 2018.
- The Access Log supports network adequacy requirements and allows timeliness measure to captured and reported.
- The Netsmart contract was extended for three years, with new solutions, including a hosted environment, CareConnect Inbox, Care Quality, and discretionary funds for professional services.
- The IT budget is restrictive, however the MHP was able to gain approval for a new IT Programmer Analyst position.

Opportunities for Improvement:

- The MHP does not have a health informaticist position who can work with the existing data to create customized reports and assist IT and QM to develop and maintain an EHR system that fosters better collaboration among beneficiaries' various healthcare providers. Health Informatics play a critical role in the push towards healthcare reform.
- A data warehouse should be explored as a related tool to support data extraction, analysis, and reporting.

- The percentage of the budget dedicated to support IT has remained stagnant at 2 percent for the past few years and, in part, has contributed to the lack of sufficient technology and project management staff compared to other medium-sized MHPs EHR support.
- The MHP as not yet implemented CANS-50 and PSC-35 functional assessment data reporting requirements.

Recommendations:

- Implement CANS-50 and PSC-35 functional assessment data reporting requirements.
- Explore hiring a health informaticist who can support continued development of Avatar EHR to streamline clinical operations and create data dashboards and implement Health Information Exchange (HIE) between healthcare providers.
- Acquire a database application to support the business intelligence tool that the County is in the process of obtaining. A data warehouse will make it easier to pull data from multiple sources and support the County's current strategic initiative around agency integration and culture of quality and data-informed decision-making.
- Research opportunities to leverage increasing the overall technology budget to 3 or 4 percent range, on par with medium sized counties' technology, project management, and support budgets. This will allow the MHP to increase EHR functionality.

Summary of Recommendations

FY 2018-19 Recommendations:

- Implement Child and Adolescent Needs and Strengths-50 (CANS-50) and Pediatric Symptom Checklist-35 (PSC-35) functional assessment data reporting requirements to comply with MHSUDS Information Notices 17-052 and 18-048 to support timely data reporting requirements.
- The clinical PIP is complete. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. Contact CalEQRO for TA early and often as a new PIP is designed and implemented.
- The non-clinical PIP will continue for this FY. The MHP needs to add one new intervention (at a minimum) to continue the PIP.
- Adjust for any unexpected results in the non-clinical PIP by analyzing data quarterly at minimum. Contact CalEQRO early and often in development of PIP study process.
- Explore and implement avenues to allow contract providers to report timeliness data on first contact to first appointment.
- Implement into the electronic health record (EHR), a system to evaluate outcomes on a program and system-wide level.
- Reassess increasing the overall technology budget to 3 or 4 percent range, on par with medium-sized counties' technology, project management, and support budgets.
- Create and fill a position for a health informaticist position who can work with the existing data to create customized reports and assist IT and Quality Management (QM) with responding to data reporting requests from leadership.
- Implement system for contract providers to submit electronic claims data into the MHP's Avatar system to eliminate data entry requirement of MHP fiscal employees.
- Explore hiring a health informaticist who can support continued development of Avatar EHR to streamline clinical operations and create data dashboards.
- Acquire a database application to support the business intelligence tool that the County is in the process of obtaining.
- Create and implement training to increase staff understanding of communication with beneficiaries and to reduce behaviors that increase the beneficiaries' perception of stigma.

FY 2018-19 Foster Care Recommendations:

- Improve tracking and reports to be able to assess timeliness for foster youth.
- Separate out foster care data for timeliness in all categories of service and provide to EQRO in next review.
- Design and implement interventions to address the issue of timeliness to psychiatry services for children, to include foster care.

Carry-over and Follow-up Recommendations from FY 2017-18:

- None noted.

SITE REVIEW PROCESS BARRIERS

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

- The MHP was not able to recruit consumer/family members to participate in the consumer/family member focus group of parents/caretakers of children/youth as requested and agreed upon. Therefore, there was no opportunity for EQRO to receive input from this group of beneficiaries about their perceptions of the Medi-Cal services they receive from the MHP.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Yolo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Wellness Center Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Melissa Martin-Mollard, Information Systems Reviewer
Gloria Marrin, 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 in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

Yolo County Health and Human Services Agency
Bauer Building
137 N. Cottonwood Street
Woodland, CA 95695

Transitional Age Youth Davis Wellness Site
600 A Street
Davis, CA 95616

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Amadasun	Igbinosa	Program Director	Turning Point
Alvarenga	Silvana	HHSA Clinician	Yolo County HHSA
Azevedo	Marcie	HHSA Accountant	Yolo County HHSA
Barrett	Katherine	HHSA, BH Compliance Officer	Yolo County HHSA
Brown	Erica	Clinician (FSP)	Yolo County HHSA
Budhathoki	Sajana	HHSA Analyst	Yolo County HHSA
Carrara	Cody	Quality Improvement Director	YCCC
Cartwright	Genoveva	Wraparound Facilitator	CCHC
Ceja	Marina	Clinical Therapist II	Yolo County HHSA
Christensen	Laura	TAY Supervising Clinician	Yolo County HHSA
Cooper	Jana	Program Director	Turning Point
Cortepassi	Dennis	PSW	Yolo County HHSA
Cowan	Brandi	HHSA Clinician	Yolo County HHSA
Coye	Maliyah	HHSA Clinician	Yolo County HHSA
Duarte	Sylvia	HHSA Accountant	Yolo County HHSA
Elmore	Rich	Access Line CCRT	HOH
Evans	Ian	HHSA AOD Administrator	Yolo County HHSA
Freitas	Julie	HHSA Clinical Manager	Yolo County HHSA
Fusselman	Samantha	HHSA Deputy Mental Health Director	Yolo County HHSA
Gavin	Sara	Chief Behavioral Health Officer	CommuniCare Health Centers
Grandison	Christina	HHSA Administrative Assistant	Yolo County HHSA

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Green	Marisa	CWS Manager	Yolo County HHSA
Green	Mila	HHSA Program Manager	Yolo County HHSA
Grindle	Karen	HHSA Sr. Accounting Technician	Yolo County HHSA
Hajit	Gill	Director of A. R.	Heritage Oaks Hospital
Harrington	Leigh	HHSA Medical Director	Yolo County HHSA
Hendrickson	Cheri	HHSA Clinician	Yolo County HHSA
Henning	Cory	HHSA Clinician	Yolo County HHSA
Hernandez	James Glica	Local Mental Health Chair	LMHC
Hernandex	Xenia	Therapeutic Behavioral Specialist	Turning Point TBS
Herrera	Breanna	HHSA Registered Nurse	Yolo County HHSA
Idrogo	Rudy	Program Manager Steps to Success	CommuniCare
Kellog	Michele	Executive Director	YCCC
Larsen	Karen	HHSA Director	Yolo County HHSA
Le	Chau	HHSA Case Manager	Yolo County HHSA
Leino	Amy	HHSA Supervising Clinician	Yolo County HHSA
Lipelt	Terri	HHSA Case Manager	Yolo County HHSA
MacDula	Hannah	HHSA Clinician	Yolo County HHSA
Martinez	Angela	PSW	Yolo County HHSA
Mendenhall	Kristine	Clinician	CCHC
Mellot	Rebecca	HHSA Assistant Director	Yolo County HHSA
Michael	Jacquenette	Executive Director	Stanford Youth Solutions
Moe	David	PSW	Yolo County HHSA

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Mueller	Stacy	HHSA Clinician	Yolo County HHSA
Murphy	Megan	Executive Director	Victor Community Services
Neilsen	Laura	PM CWS Manager CYF	Yolo County HHSA
Ng	Helen	HHSA Analyst	Yolo County HHSA
Perez	Aida	Therapist	Turning Point
Pesce	Anthony	Therapist	Turning Point Bridges
Pettet	Jennie	HHSA CYF Branch Director	Yolo County HHSA
Richter	Megan	HHSA Clinician	Yolo County HHSA
Samartino	Rita	HHSA Systems Software Specialist	Yolo County HHSA
Shen	Sadie	Regional Director	Turning Point
Sidhu	Pam	HHSA, Senior Analyst	Yolo County HHSA
Sigrist	Sandra	HHSA Adult and Aging Branch Director	Yolo County HHSA
Smith	Tessa	Family Partner/Outreach Specialist	Yolo County HHSA
Smith	Theresa	HHSA Program Manager	Yolo County HHSA
Taula-Lieras	Anthony	HHSA Program Coordinator	Yolo County HHSA
Tessler	Jessie	PSW Forensic Team	Yolo County HHSA
Vaden	Emily	HHSA Program Coordinator	Yolo County HHSA
Valle	Fabian	HHSA Analyst	Yolo County HHSA
Vallejo	Anisa	HHSA Senior Analyst	Yolo County HHSA
Vaughn	Brian	HHSA CH Branch Director	Yolo County HHSA
Villarreal	Robert	Clinician II	Yolo County HHSA

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Wade	Shannon	Therapist	Turning Point
Warren	Rachel	BH Clinician South Services	CCHC
Yung	Mary	HHSA Interim Supervising Clinician	Yolo County HHSA
Zendejas	Tico	Executive Director	R.I.S.E. Inc.

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB Yolo MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	\$703,932,487	\$4,782
Medium	550,124	19,928	3.62%	\$98,243,489	\$4,930
MHP	17,385	370	2.13%	\$2,387,585	\$6,453

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band Yolo MHP								
ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< \$20K	1,826	91.99%	93.38%	\$6,856,943	\$3,755	\$3,746	53.70%	56.69%
>\$20K - \$30K	73	3.68%	3.10%	\$1,738,105	\$23,810	\$24,287	13.61%	12.19%
>\$30K	86	4.33%	3.52%	\$4,173,047	\$48,524	\$54,563	32.68%	31.11%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms

IHBS	Intensive Home Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconciliation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms

WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Yolo	
PIP Title: HHSA Quality Management (QM) Supervising Clinician	
Start Date: 07/17 Completion Date: 02/13/19 Projected Study Period: 20 Months Completed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date(s) of On-Site Review: 02/12-13/19 Name of Reviewer: Lynda Hutchens	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input type="checkbox"/> Active and ongoing (baseline established and interventions started)
	<input checked="" type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
	<input 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 Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP was to improve outcomes for adult beneficiaries who have a severe mental illness (SMI), significant difficulty functioning at lower levels of care, and currently receive intensive mental health services in treatment facilities. This would be done by improving the clinical and care coordination processes between HHSA staff, facility staff, and the Public Guardian’s office (PGO).	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
<p>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?</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 MHP assembled a broad multi-functional team based on involvement in and knowledge of the study topic area. Members include: QM Clinician (PIP lead, assists with data analysis of HHSA Behavioral Health QI efforts); QM Manager (provides consultation for Behavioral Health QI initiatives); QM Analyst (writes reports to pull utilization and outcome data from the electronic health record [EHR] Avatar); Intensive Services Manager and Compass Clinician (coordinate HHSA mental health services for beneficiaries receiving intensive mental health services); Yolo County Chief Deputy Public Guardian (facilitates care for conserved beneficiaries).</p> <p>This year, the PIP team was expanded to include the discharge planning clinician who assists with discharge and safety planning for the study population when they are hospitalized in acute psychiatric inpatient facilities.</p> <p>However, no beneficiaries or family members who have utilized high-cost services in the past were included.</p>

<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>CalEQRO provides annual data on Yolo County MHP's high utilizers of mental health services, defined as beneficiaries with approved claims of \$30,000 or more in a year. Based on this data, during the FY 2016-17 on-site review, CalEQRO recommended that the MHP explore their high utilizer population further to determine who they are and whether additional interventions are needed to ensure their needs are being adequately met. It was noted that high utilization of services may indicate that clients' mental health needs are not being adequately addressed; this may be particularly true for clients utilizing high-cost, intensive services, such as repeated and/or long-term use of locked inpatient or residential treatment facilities. The MHP decided to investigate claims generated/submitted to the MHP for \$30,000 or more (rather than approved) to get a more accurate picture of services being provided to beneficiaries.</p> <p>The MHP analyzed data on service utilization patterns and additional clinical indicators (e.g., average level of service in facility changes in level of care, acute psychiatric hospitalizations and readmissions).</p>
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<p>Select the category for each PIP:</p> <p><i>Clinical:</i></p> <p><input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services</p> <p><input checked="" type="checkbox"/> Care for an acute or chronic condition <input checked="" type="checkbox"/> High risk conditions</p>		<p><i>Non-clinical:</i></p> <p><input type="checkbox"/> Process of accessing or delivering care</p>
<p>1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services?</p> <p><i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The MHP noted that high utilization of services may indicate that beneficiaries’ mental health needs are not being adequately addressed; which may be a particular risk for those utilizing high-cost, intensive services, such as repeated and/or long-term use of locked inpatient or residential treatment facilities. The PIP was designed to research and address this issue.</p>
<p>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)?</p> <p><i>Demographics:</i></p> <p><input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language</p> <p><input checked="" type="checkbox"/> Other</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP includes high utilizer population (>\$30,000 per year), adult beneficiaries (age 18+) receiving intensive mental health services in contracted treatment facilities, including Institutions of Mental disease (IMD’s), augmented board and cares (AB&C’s), adult residential facilities (ARF’s), skilled nursing facilities (SNF’s), and Mental Health Rehabilitation centers (MHRC’s).</p> <p>The MHP decided to focus on this target population not only because of the needs identified through the baseline data exploration (presented in the PIP submission tool), but also because the MHP believed they could reasonably impact outcomes for this population.</p>

Totals		3 Met	1 Partially Met	0 Not Met	0 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: Will improving clinical and care coordination processes for clients (beneficiaries [sic]) receiving intensive mental health services in treatment facilities result in a decrease in the average length of facility stays, number of step-ups to higher levels of care (LOCs), transitions in care, and readmissions, as well as an increase in the number of step-downs to lower LOC's (including community outpatient services) and average number of HHSA services provided to these beneficiaries [sic] during their facility stays?</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP study question was updated to reflect CalEQRO's suggestions from last year's EQRO review.</p>			
Totals		1 Met	0 Partially Met	0 Not Met	0 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></p> <p><input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input checked="" type="checkbox"/> Other</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Adult beneficiaries (age 18+) experiencing SMI with significant difficulty functioning at lower levels of care who are receiving intensive mental health services in contracted treatment facilities where the facility is the holder of the treatment plan. The facilities where these beneficiaries were receiving treatment included: Institutions of Mental Disease (IMD's), augmented board and cares (AB&C's), adult residential facilities (ARF's), skilled nursing facilities (SNF's), and Mental Health Rehabilitation Centers (MHRC's).</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?</p> <p><i>Methods of identifying participants:</i></p> <p><input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: <Text if checked></p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The PIP intends to address the entire target population. To help ensure this, the PIP team will monitor indicators for all beneficiaries and track which are receiving the study's interventions. This will also help determine the impact /effectiveness of the interventions as they are being implemented.</p>
Totals		<p>2 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators? <i>List indicators:</i></p> <p>1 Average length of stay in days per target population facility stay.</p> <p>2a Percentage of beneficiaries experiencing an acute psychiatric hospitalization (overall).</p> <p>2b Percentage of beneficiaries experiencing an acute psychiatric hospitalization (during facility stay).</p> <p>3a Acute psychiatric hospitalization readmission rate.</p> <p>YEAR-2 ADDITION:</p> <p>3b Acute psychiatric hospitalization readmission rate (during facility stay).</p> <p>4 Average length of stay in days per acute psychiatric hospitalization.</p> <p>5 Number and percentage of admissions with a step-up in level of care.</p> <p>6a Number and percentage of admissions with a step-down in level of care.</p> <p>6b Number and percentage of admissions with step-down to community outpatient.</p> <p>YEAR-2 ADDITION</p> <p>6c Number and percentage of beneficiaries (unduplicated) with step-up or step-down in level of care.</p> <p>7 Average number of HHSA services provided per target population facility admission.</p> <p>8 Percentage of admissions with at least one HHSA service rendered.</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Upon review and analysis, the PIP team identified additional meaningful indicators; 3b and 6 c.</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 beneficiary-focused.</p> <p><input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	
Totals		2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 5: Review Sampling Methods		
<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>This PIP did not utilize sampling methods.</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></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>This PIP did not utilize sampling methods.</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>	<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>This PIP did not utilize sampling methods.</p>
Totals		0 Met 0 Partially Met 0 Not Met 3 NA 0 UTD

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>This section was updated based on CalEQRO's feedback on the previous PIP, with a focus on items that were partially met. Data to be collected.</p> <ul style="list-style-type: none"> • List of beneficiaries who are adult (age 18+) receiving intensive mental health services in contracted treatment facilities where the facility is the holder of the treatment plan. • Inpatient utilization reports (Discharge, Admissions, Length of Stay and Readmissions) specific to target population (See above 2.) and all reported utilizers of the MHP system. • Service Detail reports, showing all services for identified target population while receiving intensive mental health services in the contracted treatment facilities. <p>Episode Management reports, showing all admission and discharges for identified target population.</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 <input checked="" type="checkbox"/> Other: See narrative</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Data Sources:</p> <ul style="list-style-type: none"> • Avatar: IMD PIP Episode report, IMD PIP Services Detail Report, High Utilizers Report, and Inpatient Utilization Admission and Discharge Report • TAR/Short-Doyle Excel spreadsheet • Conserved Client List Excel spreadsheet

		<ul style="list-style-type: none"> • Fiscal Authorization Excel spreadsheet • Fiscal Contract Report spreadsheet
<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>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	<p>Method of Data Collection:</p> <ul style="list-style-type: none"> • Avatar data collection is completed on a daily basis and is updated by MHP support staff, Compass team, discharge planning team and fiscal staff. • TAR/Short-Doyle Excel spreadsheet data collection is completed by the Quality Management Senior Nurse. Data is entered from TAR/Short-Doyle documentation. • Conserved Client List Excel spreadsheet is maintained by the Compass team and is completed with the assistance of the Public Guardian's office. • Fiscal Authorization Excel Spreadsheet is maintained by fiscal staff, where data is obtained from program staff with authorization start date, end date and service codes. • Fiscal Contract Report Excel spreadsheet is maintained by the fiscal department. Data are collected from claims data, for payment of services rendered.

<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 checked="" type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool</p> <p><input checked="" type="checkbox"/> Outcomes tool <input checked="" type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	
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<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The prospective data analysis plan was:</p> <ul style="list-style-type: none">• Provide a report for the placement committee meeting, anticipated to go live in January, which can be reviewed for beneficiaries who are receiving intensive mental health services in the contracted treatment facilities.• Utilize the EHR-Avatar system as the primary source of data containment as multiple custom-built reports can be generated• Continue to pull and analyze PIP indicator data quarterly at minimum• Discharge Planner to participate in placement committee meetings <p>In the event that results are untoward, the following contingencies were put into place:</p> <ul style="list-style-type: none">• Identification of the barriers causing the adverse results will be analyzed.• Weekly placement committee meetings will be held to discuss results and develop interventions to address identified barriers.• Implement, record, and analyze data on a monthly basis.
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<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Julie Freitas, LMFT Title: Clinical Manager Role: Compass Team Lead Personnel Type: Full time MHP Staff</p> <p><i>Other team members:</i> Name: Pam Sidhu Title: QM Senior Administrative Analyst Role: Data Analyst Personnel Type: Full Time MHP Staff</p> <p>Name: Ashley Atta-Mensah, RN Title: Quality Management Senior Nurse Role: Inpatient Utilization Authorization Personnel Type: Full Time MHP Staff</p> <p>Name: Stacy Mueller, ASW Title: Clinician Role: Compass Team Clinician Personnel Type: Full Time MHP Staff</p> <p>Name: Jocelyn Bueno Title: Administrative Clerk II Role: Discharge Planning Support Staff Personnel Type: Full Time MHP Staff</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	
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<p>Name: Brandi Cowan, AMFT Title: Clinician Role: Discharge Planner Personnel Type: Full Time MHP Staff</p> <p>Name: Laurie Haas Title: Chief Deputy Public Guardian Role: Public Guardian Personnel Type: Full Time MHP Staff</p> <p>Name: Amy Leino, PhD Title: Quality Management Supervising Clinician Role: Project Lead Personnel Type: Full Time MHP Staff</p> <p>Name: Kati Moore Title: Support Team Supervisor Role: Episode Management Personnel Type: Full Time MHP Staff</p>		
Totals		6 Met 0 Partially Met 0 Not Met 0 UTD

STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ol style="list-style-type: none"> 1. Use of Compass Clinician to facilitate and improve clinical and care coordination processes for target population beneficiaries. Clinician conducts on-site visits with beneficiaries (e.g., to provide case management, evaluation of needs, discharge planning) and participates in case conferences with facilities, which are tracked through a spreadsheet and Avatar progress notes. 2. Implement weekly Placement Committee meetings with key stakeholders involved in the clinical and care coordination processes of target population beneficiaries, where clinical cases are reviewed, and placement needs are discussed (PGO, Compass Team staff, and facility representatives whenever possible). The committee will maintain attendance logs and track which beneficiaries are discussed at each meeting, including their dispositions. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>A further look into the data trends in acute psychiatric hospitalization from FY 2016-17 prompted additional PIP team discussion and focus for the second year of the PIP (see data analysis section / Step 8 for more information). Similar to factors previously identified, it was determined that communication and care coordination play an important role. For example, HHSA mental health staff did not always learn about a beneficiaries' need for an acute psychiatric hospitalization until after the beneficiary had already been hospitalized or discharged. This created barriers for staff to be able to (a) facilitate timely post-discharge placement (which can impact hospitalization LOS); (b) ensure adequate discharge and safety planning and post-discharge care coordination (which can impact readmission rates); and, (c) provide preventative interventions to potentially help de-escalate beneficiaries so they can safely remain at their current level of care (which can impact admission and readmission rates). To help address these barriers and issues, two additional interventions were implemented – a Discharge Planning Clinician to collaborate and coordinate care with the Compass Team when beneficiaries are acutely psychiatrically hospitalized; and the Compass Clinician to collaborate with treatment facility staff to provide preventative de-escalation interventions / support prior to a beneficiary necessitating an acute psychiatric hospitalization.</p>

<p>3. YEAR-2 UPDATES</p> <p>1. Use of Discharge Planning Clinician who participates in the weekly Placement Committee meetings and works closely with the Compass Clinician to assist with discharge and safety planning when beneficiaries are being discharged from acute psychiatric facilities.</p> <p>Use of Compass Clinician to provide de-escalation interventions in order to prevent psychiatric hospitalizations of beneficiaries during their treatment facility stays</p>		
Totals		1 Met 0 Partially Met 0 Not Met 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input 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>A review of the indicators during the first fiscal year of intervention implementation suggests results are headed in a desired direction overall. All but two indicators met the target goal for FY 2017-18. A summary of the results for each indicator is provided below. Results were organized into the following categories of indicators:</p> <ul style="list-style-type: none"> • Number of HHSA services provided to target population beneficiaries (Indicators #7-8) • Acute psychiatric inpatient utilization (Indicators #2a-b, 3a-b, 4) • LOC transitions and LOS in Treatment Facilities (Indicators #1, 5, 6a-c) <p>All were presented in the PIP submission tool with figures and table of indicators results and analysis.</p>

<p>8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</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: _____ quarterly _____</p> <p>Indicate the statistical analysis used: _____ n/a _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____ percent _____ Unable to determine</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input 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>At the time of the last EQRO site visit in February 2018, the PIP was in the early stages of implementation. Data collection and analysis had commenced, the first intervention (Compass Clinician care coordination) was implemented at the end of Q1 if FY 2017-18 (September 2017), and the second intervention (Placement Committee) was projected to begin in Q3 (January 2018). Upon further review and analysis of the data, the PIP team identified additional meaningful indicators as well as interventions that were not included previously. In FY 2016-17:</p> <ul style="list-style-type: none"> • Nearly a quarter of the target population beneficiaries (23 percent) experienced an acute psychiatric hospitalization • 80 percent of beneficiaries who experienced an acute psychiatric hospitalization did so during their treatment facility stay • There was a 52 percent readmission rate for acute psychiatric hospitalizations • More than a third of beneficiaries (36 percent) were experiencing at least one transition in care <p>As a result, the PIP team identified the following additions for year two of the project:</p> <ul style="list-style-type: none"> • The addition of two indicators that were viewed as clinically relevant and meaningful for the study population related to acute
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		<p>psychiatric hospitalizations and transitions in care.</p> <ul style="list-style-type: none"> The implementation of two additional interventions: Discharge Planning Clinician assisting with acute psychiatric hospital discharges in Q3 (February 2018); and Compass Clinician providing de-escalation interventions aimed at preventing acute psychiatric hospitalizations in Q4 (April 2018).
<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> While it is recognized that the study population size is relatively small and statistical significance testing was not part of the PIP data analysis plan, this PIP resulted in improvements in clinical and care coordination processes for a high risk and high need beneficiary population:</p> <p><i>Conclusions regarding the success of the interpretation:</i> Therefore, the improvements observed across ten of the twelve study indicators are considered clinically significant and meaningful.</p> <p><i>Recommendations for follow-up:</i> PIP is to continue to 24 months to continue to assess and measure results.</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
Totals		<p>4 Met 0 Partially Met 0 Not Met 0 NA 0 UTD</p>

STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated? <i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>Multiple figures, tables, and data analyses were present in the PIP submission tool to inform that the same sources of data were used, and the same method of collection and same measurement tool, with same population, were used.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration Statistical significance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Clinical significance: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	

<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 checked="" type="checkbox"/> High</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input 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>While the MHP recognized that the study population size is relatively small and statistical significance testing was not part of the PIP data analysis plan, this PIP resulted in improvements in clinical and care coordination processes for a high risk and high need beneficiary population. Therefore, the improvements observed across ten of the twelve study indicators are considered clinically significant and meaningful. The PIP interventions specifically targeted barriers to clinical and care coordination processes faced by the study's target population. The significant increase in the number of HHSA services provided to the study's target population, which included the Compass clinician and discharge planning clinician interventions, as well as the increased clinical and care coordination efforts via the Compass team and placement committee interventions, appear to have contributed to the improvements observed.</p>
<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 checked="" type="checkbox"/> Strong</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input 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>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		5 Met 0 Partially Met 0 Not Met 0 NA 0 UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:
 The PIP is a completed PIP that shows reliable results. The MHP plans develop a new clinical PIP during this year.

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS**

Recommendations:

EQRO would like to see a discussion of why the MHP feels that some interventions were successful and why others were not? What were the factors that influenced the results?

- Check one:
- High confidence in reported Plan PIP results
 - Low confidence in reported Plan PIP results
 - Confidence in reported Plan PIP results
 - Reported Plan PIP results not credible
 - Confidence in PIP results cannot be determined at this time

**PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP**

GENERAL INFORMATION

MHP: Yolo

PIP Title: Quality Management Supervising Clinician

Start Date: 07/18

Completion Date: TBD

Projected Study Period: 12 Months

Completed: Yes No

Date(s) of On-Site Review: 02/12-13/19

Name of Reviewer: Lynda Hutchens

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 Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of the PIP is to ensure that Yolo County beneficiaries receive outpatient MHP services in a timely manner following initial requests for services.
 Note: This project was deemed a priority that is consistent with HHSA’s Strategic Plan Goals (i.e., improving beneficiary outcomes, making data-informed decisions). It was then adopted as one of two agency-wide QI initiatives, at which time the team added a consultant who is a QI expert trained in the Plan-Do-Check-Act (PDCA) model.

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	A PIP team was assembled based on each member's involvement in and knowledge of the study topic area: QM Supervising Clinician (Project Lead), Access and Crisis Services Manager, Access Team Lead Crisis Clinician, Support Team Supervisor, QM Information Systems Analyst and IS/IT Systems Administrator, QM clinician responsible for Beneficiary Protection and Access Line oversight, and the HHS Behavioral Health Medical Director. No beneficiaries or family members were noted as part of the PIP team.

<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	<p>During a stakeholder workgroup meeting in February 2016, consisting of multiple stakeholders throughout Yolo County’s Access system, aimed at understanding current processes for tracking access to care, the MHP discovered there are multiple access points throughout the system where beneficiaries can request and get linked to mental health services. While this was identified as a strength in terms of broadening possible entry points to access services, not having a consistent way of capturing when, where, and how beneficiaries are entering the system was identified as a barrier to ensuring beneficiaries have timely access to services.</p> <p>Additionally, over the past few years, CalEQRO has consistently given feedback and recommendations that the MHP needs to improve protocols, procedures, and Avatar mechanisms for consistent provision of valid and reliable data for all measures of timeliness of and access to services. A more in-depth review of the MHP’s business processes and primary mechanism for capturing initial requests for services (i.e., the Access Log in the electronic health record Avatar) was undertaken to more fully understand the barriers and identify strategies for improvement. Through stakeholder input and compiling the data for the FY 2016-17 EQRO Timeliness Self-Assessment, it was discovered that Access Log utilization varied greatly.</p>
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		<p>According to DHCS MHSUDS IN 18-011, “Timely access standards refers to the number of business days in which a Plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service” (page 3). The MHP recognized the need to re-evaluate their access business processes and system mechanisms in order to determine their impact on timeliness to services. Upon review of the data (discussed in PIP submission tool), the PIP team decided that additional strategies aimed at timeliness tracking and access point process improvements were necessary to fully understand and address this important issue.</p>
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Select the category for each PIP:
Non-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 type="checkbox"/> High risk conditions
<input checked="" type="checkbox"/> Process of accessing or delivering care	

<p>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></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>This study focuses on the adult (age 21+) Yolo County beneficiaries who make contact with an MHP access point to request mental health services (i.e., non-urgent, non-crisis requests). Access points include phone contacts via the 24/7 Access line, referrals, and walk-in (in person) contacts at one of the MHP’s three clinics (in Woodland, West Sacramento, and Davis). Note: The PIP team aligned the target population age range for adults with Network Adequacy reporting requirements.</p>
<p>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 checked="" 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	<p>See 1.3</p>
Totals		<p>3 Met 1 Partially Met 0 Not Met 0 UTD</p>
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 using new electronic mechanisms for tracking initial service requests and scheduling appointments, as well as increasing the MHP’s clinician capacity to conduct assessments, decrease the wait time to first offered, scheduled, and rendered mental health appointments?”</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	

Totals		1	Met	0	Partially Met	0	Not Met	0	UTD
STEP 3: Review the Identified Study Population									
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input checked="" type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	This study focuses on the adult (age 21+) Yolo County beneficiaries who make contact with an MHP access point to request mental health services (non-urgent, non-crisis requests).							
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 checked="" type="checkbox"/> Other: <Text if checked>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Access points include phone contacts via the 24/7 Access line, referrals, and walk-in (in-person) contacts at one of the MHP's three clinics (in Woodland, West Sacramento, and Davis). The study's indicators are collected and extracted from Avatar. Crystal reports are utilized to extract the data for identified indicators. Data is collected in real-time, as beneficiary contacts/requests for services are made to help ensure requests are not missed.							
Totals		2	Met	0	Partially Met	0	Not Met	0	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"> 1. Percent of offered MH appointments that met MHP standard (14 calendar days). 2. Percent of offered psychiatric appointments that met MHP standard (21 calendar days). 3. Percent of scheduled MH appointments that met MHP standard (14 calendar days). 4. Percent of scheduled psychiatric appointments that met MHP standard (21 calendar days). 5. Percent of rendered MH appointments that met MHP standard (14 calendar days). 6. Percent of rendered psychiatric appointments that met MHP standard (21 calendar days). 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<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 beneficiary-focused.</p> <p> <input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input checked="" 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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	

Totals		2 Met	0 Partially Met	0 Not Met	0 UTD
STEP 5: Review Sampling Methods					
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</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>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></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>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____N of enrollees in sampling frame</p> <p>_____N of sample</p> <p>_____N of participants (i.e. – return rate)</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				
Totals		0 Met	0 Partially Met	0 Not Met	3 NA 0 UTD

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The following data will be collected for this study:</p> <ul style="list-style-type: none"> • Date of beneficiary initial request for a mental health service. • Date of first offered mental health and psychiatric appointment. • Date of first scheduled mental health and psychiatric appointment. • Date of first rendered mental health and psychiatric service. • Mental health services detail report, showing all services for identified target population.
<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 <input checked="" type="checkbox"/> Other: Avatar</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The study's indicators are collected and extracted from Avatar. Crystal reports are utilized to extract the data for identified indicators. Data is collected in real-time, as beneficiary contacts / requests for services are made to help ensure requests are not missed.</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>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Staff collecting / entering the data into Avatar via the Access Log and Scheduling Calendar include members on the Access and Crisis teams as well as Administrative Support Staff. Representatives from these teams are on the PIP team and were involved in the development of the new electronic mechanisms for capturing service requests and scheduling appointments. Additionally, training and technical assistance has been provided to all staff who collect and enter the data using the new tracking processes in order to enhance reliability and validity.</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 <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input checked="" type="checkbox"/> Other: Avatar</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The study's indicators are collected and extracted from the Avatar. Crystal reports are utilized to extract the data for identified indicators. Data is collected in real-time, as beneficiary contacts / requests for services are made to help ensure requests are not missed.</p>

<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Reports for analyzing the study indicators will be generated quarterly at minimum. The QM Senior Analyst, who is trained in Crystal report writing and who is the MHP's primary contact for Avatar IS needs, is responsible for writing the Crystal reports and compiling the data for analysis. Data will be analyzed quarterly at minimum. In the event that results are untoward, the following contingencies will be put into place:</p> <ul style="list-style-type: none"> • The PIP team will review the data to identify factors or barriers causing the adverse results. • Results will be discussed at PIP team meetings to identify possible improvement strategies. <p>Data will be pulled, analyzed, and reviewed more frequently.</p>
<p>6.6 Were qualified staff and personnel used to collect the data? <i>Project leader:</i> Name: Amy Leino, PhD Title: Quality Management Supervising Clinician Role: Project Lead <i>Other team members:</i> Names: See narrative.</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>Staff collecting / entering the data into Avatar via the Access Log and Scheduling Calendar include members on the Access and Crisis teams as well as Administrative Support Staff. Representatives from these teams are on the PIP team and were involved in the development of the new electronic mechanisms for capturing service requests and scheduling appointments. Additionally, training and technical assistance has been provided to all staff who collect and enter the data using the new tracking processes to enhance reliability and validity. No specific names were given.</p>
Totals		5 Met 1 Partially Met 0 Not Met 0 UTD

STEP 7: Assess Improvement Strategies			
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ol style="list-style-type: none"> 1. Access point staff use New Access Log in Avatar to record and track initial service requests. 2. Access point staff use Avatar widget communication system to (a) alert other access point staff complete triage / preliminary assessment and linkage when needed, and (b) notify support staff to follow-up with beneficiary to schedule an intake appointment. 3. Access and support staff use the Avatar Scheduling Calendar to ensure that there are appointment slots available and offer first available appointments to beneficiary. 4. Offer beneficiaries an intake appointment on the following Wednesday at the Mental Health Urgent Care Clinic (when two FTE clinicians are present) if the first three offered appointments do not fit with the beneficiaries' availability, in order to meet the 14-calendar day standard. 5. Reorganized the crisis and access team, creating two (2) distinct teams – Crisis Community Response Team and Clinic Based Crisis and Triage Response. 6. Added four (4) FTE clinicians at the Navigation Center to do clinical assessments, including walk-in assessments in West Sacramento two (2) days per week and in Davis three (3) days per week. 7. Adding three (3) FTE Nurse Practitioners at the Mental Health Urgent Care Clinic to provide psychiatric services. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine		
Totals	1 Met	0 Partially Met	0 Not Met 0 UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine </p>	<p>Since the PIP is still in the early phase of implementation and data collection, the team plans on continuing to collect and analyze data quarterly at minimum through the end of FY 2018-19. At the end of the current fiscal year, the team will have a full year of data to compare to the baseline fiscal year. Given that the first interventions were implemented in Q1 of FY 2018-19, this will allow more time to assess their impact. Additionally, it is not entirely accurate or meaningful to compare only six months of data to one year of data.</p> <p>Prior to Q2 of FY 2018-19, the MHP did not have the ability to track offered appointments.</p> <p>During the first two quarters of FY 2018-19, there were a total of 2,616 access log contacts (inclusive of MH and SUD Access Line contacts), of which 1,292 (49 percent) were new beneficiary contacts. Of the new beneficiary contacts, 107 (eight percent) were identified as mental health services requests that were triaged into the MHP system (Q1=47, Q2=60), reflecting 85 unique beneficiaries.</p>

<p>8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<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? Indicate the time periods of measurements: _____quarterly_____ Indicate the statistical analysis used: _____n/a_____ Indicate the statistical significance level or confidence level if available/known: _____percent ___X___ Unable to determine</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>It is notable that through the data validation process, it became apparent that access point staff are not always utilizing the appropriate access dispositions in the Access Log. The ACCESS disposition selection helps define whether an Access Log entry is counted as a “service request”. As a result, in the absence of being able to rely on the ACCESS disposition selection, an alternative process was used for defining “service request” for FY 2018-19 data that possibly resulted in Access Log entries being included in the initial service request dataset that were not truly service requests. The MHP/team decided to err on the side of possibly including more contacts than necessary in order to try to avoid missing service requests.</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> Issues with inconsistent use of ACCESS dispositions in the Access Log.</p> <p><i>Conclusions regarding the success of the interpretation:</i> The MHP reports confidence in the interpretation of data.</p> <p><i>Recommendations for follow-up:</i> The PIP will continue for a minimum of one year to allow time to assess data.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals 4 Met 0 Partially Met 0 Not Met 0 NA 0 UTD		
STEP 9: Assess Whether Improvement is “Real” Improvement		
<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Data to be measured quarterly. Same source of data used.</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>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>This PIP is still in the early stages of implementation and data collection. In order to assess for “real” improvement, more time is needed to assess the full impact of the interventions since they were implemented during the first half of the current fiscal year (FY 2018-19).</p>
<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>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The PIP is in early stage.</p>
<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>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The PIP is in early stage.</p>

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Unable to Determine	The PIP is in early stage.
Totals		1 Met 0 Partially Met 0 Not Met 0 NA 4 UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

Reviewing the PIP data has already helped the MHP identify additional opportunities for improvement. For example, the first two quarters of FY 2018-19 data on Access Log and Scheduling Calendar utilization has revealed follow-up activities to improve data reliability and validity:

- Access point staff need training on the definition of a new beneficiary and a refresher training on using the Scheduling Calendar; it may also be beneficial to (a) make offered appointment selections required fields in the Scheduling Calendar for any appointment type, and (b) add a new beneficiary selection indicator in the Access Log (with a clear definition for staff)
 - The high percentage of Access Log service requests that did not have an offered or scheduled appointment could reflect any of the following issues: (a) the scheduling calendar is not being utilized as intended; (b) when an appointment is canceled or the beneficiary no-shows, the original scheduled appointment is being deleted from the system completely; (c) if a beneficiary walks in to an access point and is provided an intake assessment on the spot, this appointment is not entered into the Scheduling Calendar; (d) contacts were included in the service request dataset that were not actual services requests; or (e) beneficiaries are being missed.
- Access point staff need a refresher training on which access dispositions to use when a beneficiary is initially assessed, determined to meet medical necessity, and therefore referred to complete a mental health intake with HHS or Navigation Center staff. A process for monitoring ACCESS dispositions and providing feedback to staff on appropriate use would be helpful.

Through the data validation process, it became apparent that access point staff are not always utilizing the appropriate ACCESS dispositions in the Access Log. Since the ACCESS disposition selection helps define whether an Access Log entry is counted as a “service request”, it is important that this field is utilized correctly. In the absence of being able to rely on the ACCESS disposition selection, an alternative process was used for defining service request for FY 2018-19 data that possibly resulted in Access Log entries being included in the initial service request dataset that were not truly service requests. It was decided to err on the side of possibly including more contacts than necessary to try to avoid missing service requests.

**ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS:
SUMMARY OF AGGREGATE VALIDATION FINDINGS**

Recommendations:

Continue PIP study at least for this FY.

Analyze data quarterly at minimum.

Contact EQRO early and often in development of PIP study process.

Check one:

High confidence in reported Plan PIP results Low confidence in reported Plan PIP results

Confidence in reported Plan PIP results Reported Plan PIP results not credible

Confidence in PIP results cannot be determined at this time