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

## SOLANO MHP FINAL REPORT

Prepared for:

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

Review Dates:

**October 23-24, 2018**

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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 Solano County 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 — Bay Area

MHP Location — Fairfield

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 4,938

MHP Threshold Language — Spanish

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 Measures<sup>1</sup>**

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 Projects<sup>2</sup>**

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 Capabilities<sup>3</sup>**

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:

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

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

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

- 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](http://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:** The MHP is not using the Accredited Standards Committee X12 270/271 eligibility transactions, apparently because of a problem with their instance of myAvatar. This is a baseline requirement for any modern EHR system. Develop and implement a plan to correct this issue.

Status: Not Met

- Staff turnover and some long-standing vacancies were barriers in addressing this recommendation.
- The MHP added a new billing manager.
- The MHP is currently developing a plan to address this recommendation.



**Recommendation 2:** To resolve issues of access and timeliness to psychiatry services:

- Complete the work started to gather psychiatrist and non-psychiatrist outpatient appointment no-show rates for children and adults across the entire service delivery network.
- Reconsider the 19 percent no-show standard for adult psychiatric appointments as being an ineffective baseline standard. Implement an effective standard for best practice.
- Evaluate whether the MHP needs additional child psychiatrists to meet the needs of MHP beneficiaries in a timely manner.
- Implement a mechanism in the MHP's information system to accurately measure timeliness for child psychiatry. If wait times do not meet appropriate clinical standards, implement adjustments to reduce wait times.

Status: Partially Met

- The MHP established a "provider of the day" system in its clinics to allow beneficiaries to see a psychiatrist for urgent needs such as medication refills after a missed appointment.
- A nurse practitioner is available and can also provide urgent appointments.
- Psychiatrists and their support staff are contacting beneficiaries in advance of their appointments (reminder calls) in an effort to reduce no-shows.
- The MHP intends to begin using the Key Performance Indicator (KPI) Dashboard before the next EQRO review (FY 2019-20).
- A psychiatry referral form is currently being tested and is scheduled to go into production this fiscal year.
- The MHP did not reconsider the 19 percent no-show standard for adult psychiatric appointments.

**Recommendation 3:** Evaluate the effect of current Community Based Organization (CBO) service contract rates, and the associated high staff turnover, on access, timeliness, quality, and outcomes.

Status: Met

- While the MHP did not increase rates or contract amounts across all CBOs, they did provide increases between three and five percent for three of the contracted children's providers.
- The MHP changed their cost settlement process to allow for payments to CBOs if CBO costs were shown to be more than they had been paid during the fiscal year.

- The MHP recognizes the need for further work to be done in this area. However, during the shortened EQRO review cycle between the FY 2017-18 and the FY 2018-19 reviews the MHP accomplished what was possible within the limits of their existing budget.

**Recommendation 4:** Quality improvement (QI) focused data analyst staff continue to be insufficient to engage in system-wide clinical data analyses; therefore, much of this work is performed by upper mid-level managers and the executive team. While competency of those staff is improving, they do not equate with data analytically oriented staff. Data analysis and Information Technology (IT) staffing, characterized by staff as “getting by”, will be inadequate to fulfill MHP priorities and goals and to effectively support the electronic health record 24/7 environment.

- Develop a plan to grow data analysis capability.
- Explore the possibility of further increasing IT staffing.

*(This recommendation is a carry-over from FY 2016-17.)*

Status: Partially Met

- The MHP is asking for an addition of one full-time employee (FTE) for data analysis work in the FY 2019-20 budget request.
- The MHP has shifted to Netsmart hosting of their implementation and that has reduced the demands on MHP IT staff. This may allow them to contribute to data analysis work.
- A clinician on the QI clinical projects team is now dedicated to data analytics and is receiving additional training for that role.
- The MHP anticipates adding a field to identify foster care beneficiaries. This will help provide better service utilization information about children in foster care.
- An Office Assistant II with Excel skills is assisting with improving timeliness reporting.
- While the MHP has taken multiple actions to increase its data analysis capacity, there was no evidence of a plan that identified the number of resources required, and the skill sets needed, or any approach to achieving and sustaining that level of resources going forward.
- The MHP did not pursue increasing IT staffing.

## 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 calendar year (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:<sup>4</sup>

- 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.

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<sup>4</sup> Public Information Links to SB 1291 Specific Data Requirements:

1. EPSDT POS Data Dashboards:

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

2. Psychotropic Medication and HEDIS Measures:

[http://cssr.berkeley.edu/ucb\\_childwelfare/ReportDefault.aspx](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>

- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- 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.

<b>Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2017, by Race/Ethnicity Solano MHP</b>				
<b>Race/Ethnicity</b>	<b>Average Monthly Unduplicated Medi-Cal Enrollees</b>	<b>% Enrollees</b>	<b>Unduplicated Annual Count Beneficiaries Served</b>	<b>% Served</b>
White	26,470	21.4%	1,515	30.7%
Latino/Hispanic	38,279	30.9%	806	16.3%
African-American	23,896	19.3%	1,113	22.5%
Asian/Pacific Islander	15,538	12.5%	302	6.1%
Native American	668	0.5%	48	1.0%
Other	19,011	15.3%	1,154	23.4%
<b>Total</b>	<b>123,860</b>	<b>100%</b>	<b>4,938</b>	<b>100%</b>
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

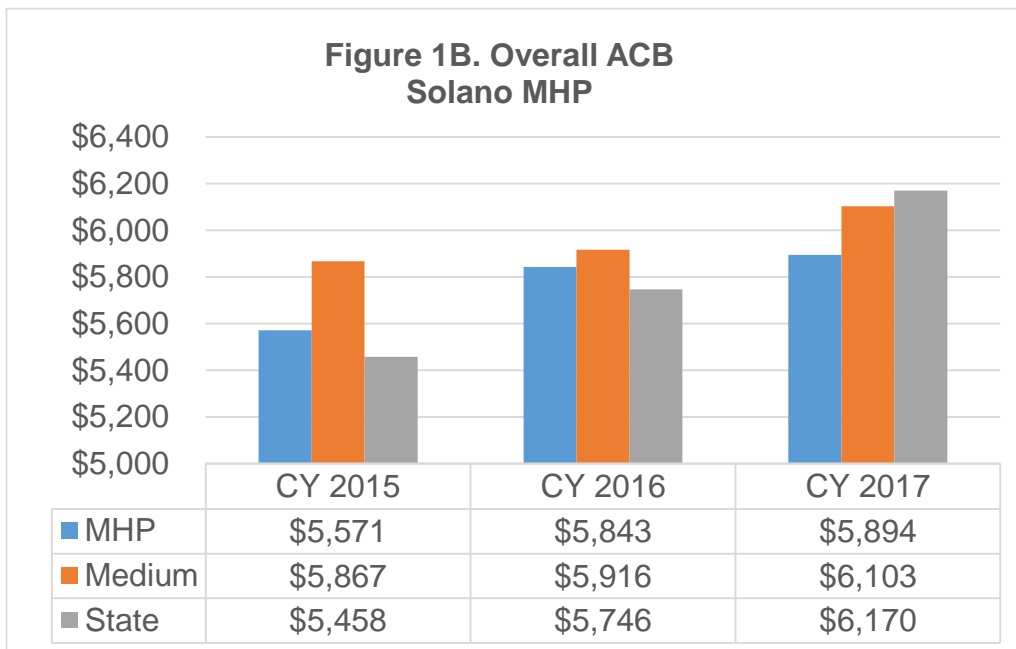
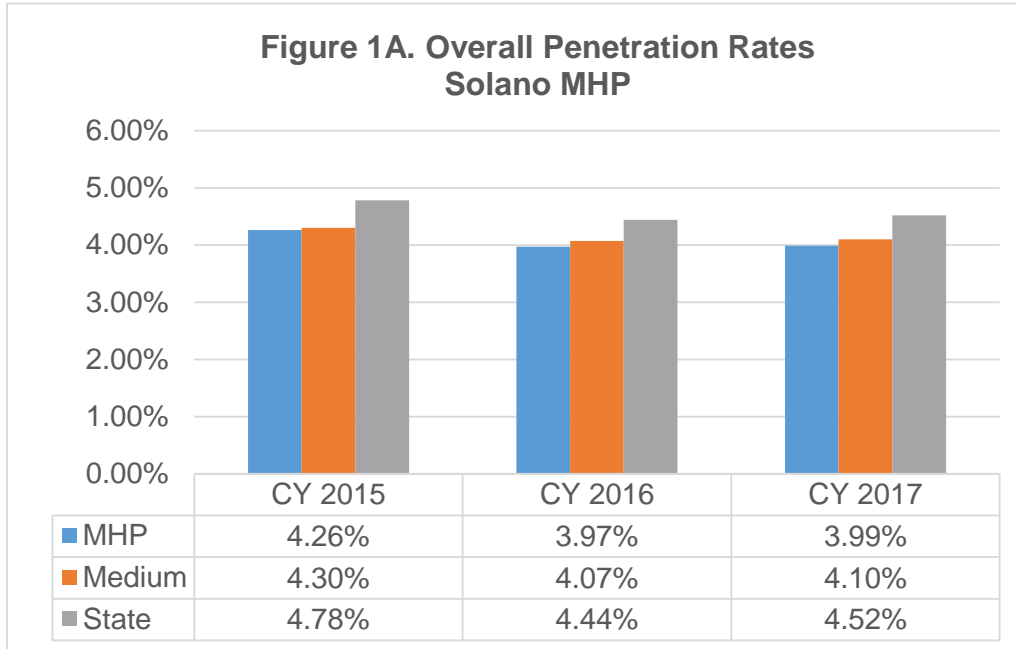
## Penetration Rates and Approved Claims per Beneficiary

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.

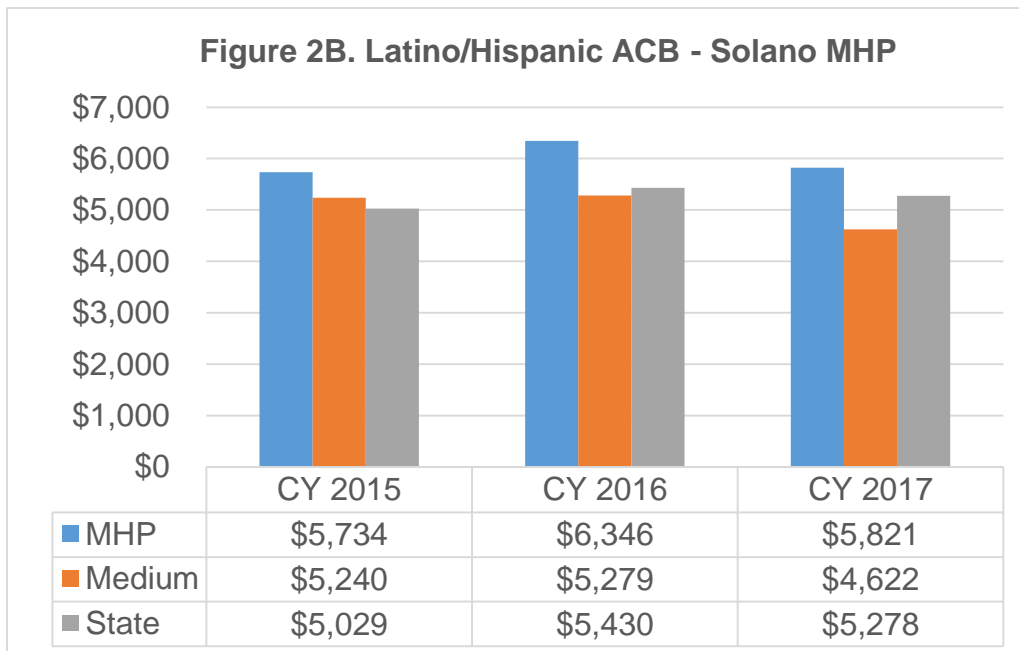
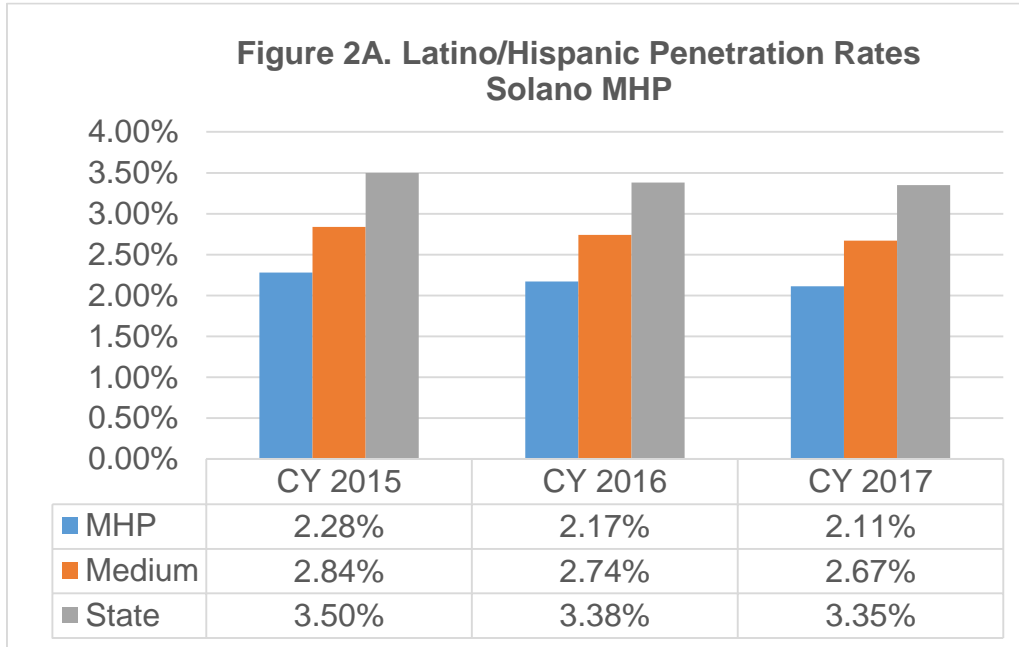
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA Penetration Rate and Approved Claims per Beneficiary.

Regarding the calculation of penetration rates, the Solano MHP uses a different method than that used by CalEQRO.

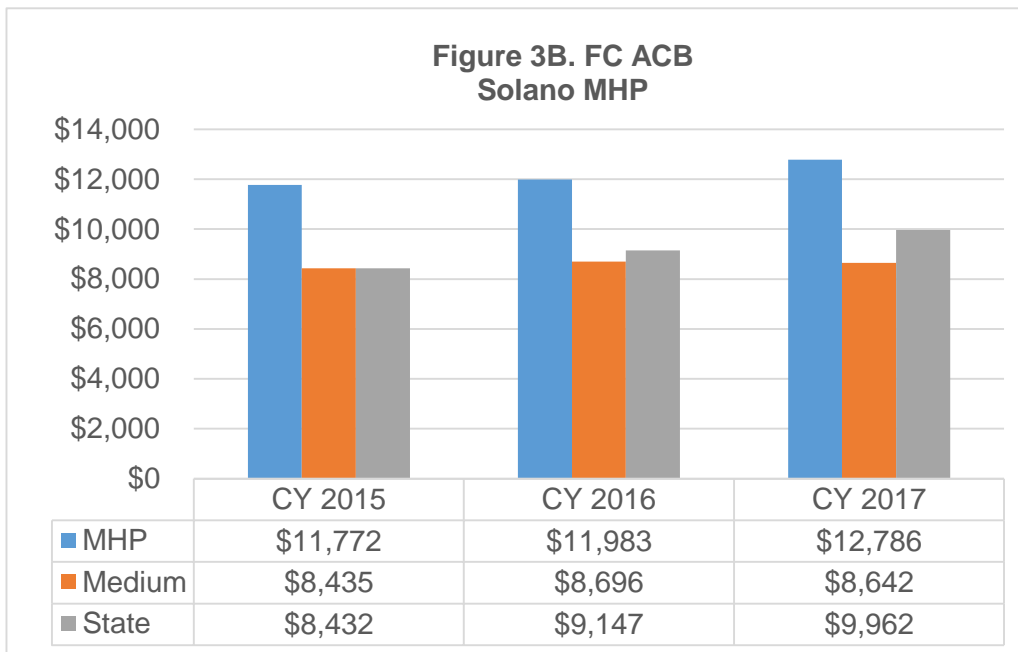
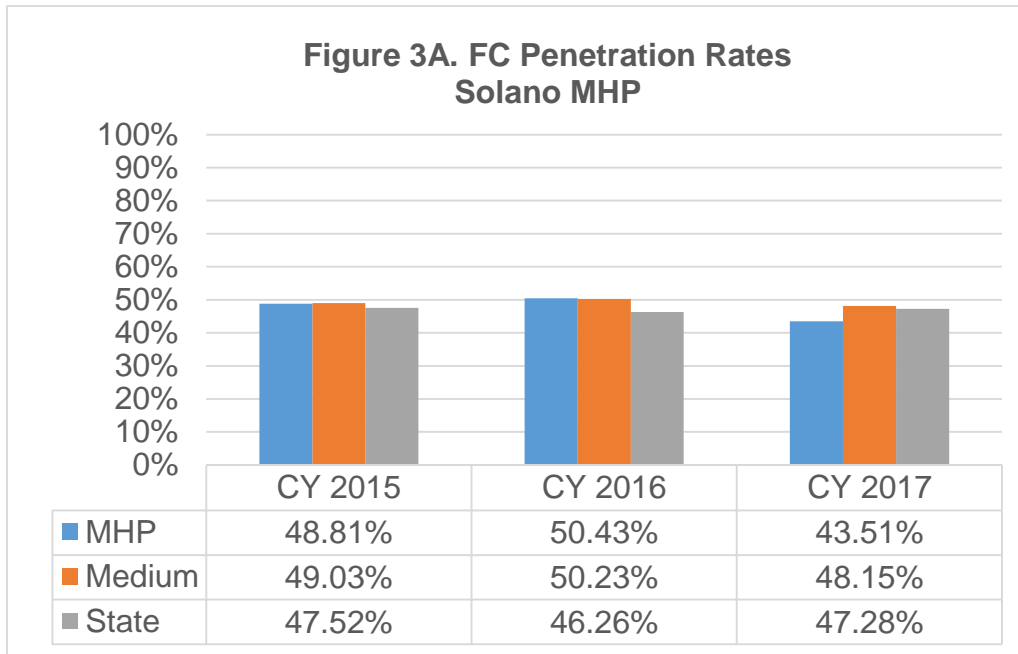
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



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 - Solano 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	181	4,938	3.67%	\$47,816	\$8,654,658	29.74%
	CY 2016	181	5,039	3.59%	\$46,713	\$8,455,005	28.71%
	CY 2015	179	5,172	3.46%	\$50,452	\$9,030,933	31.34%

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.

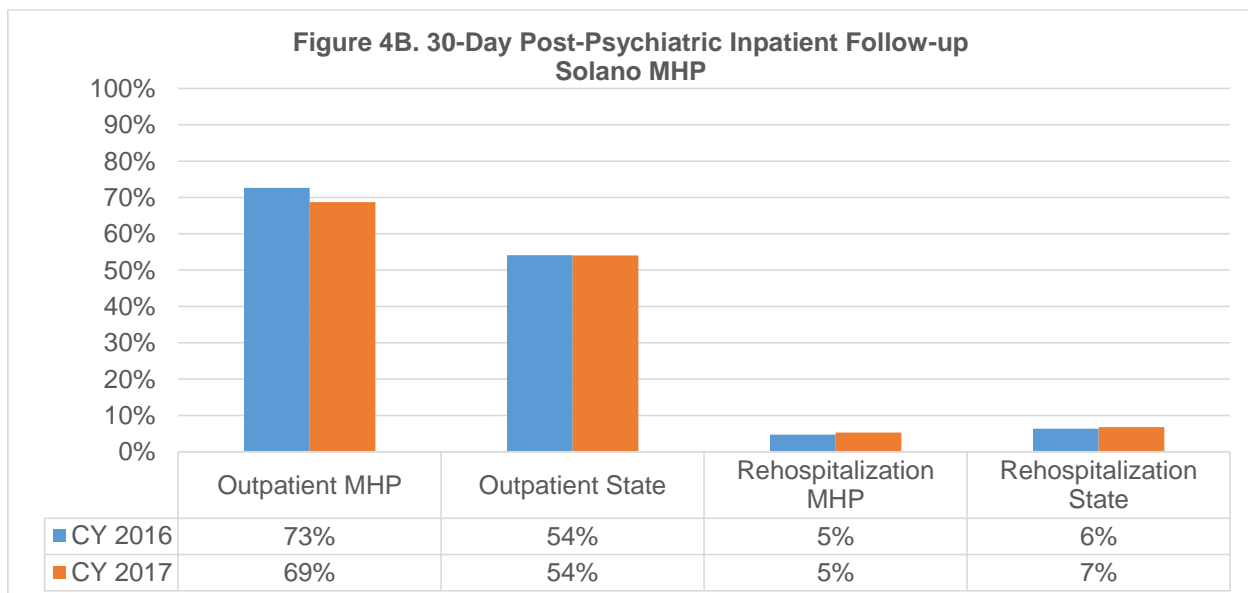
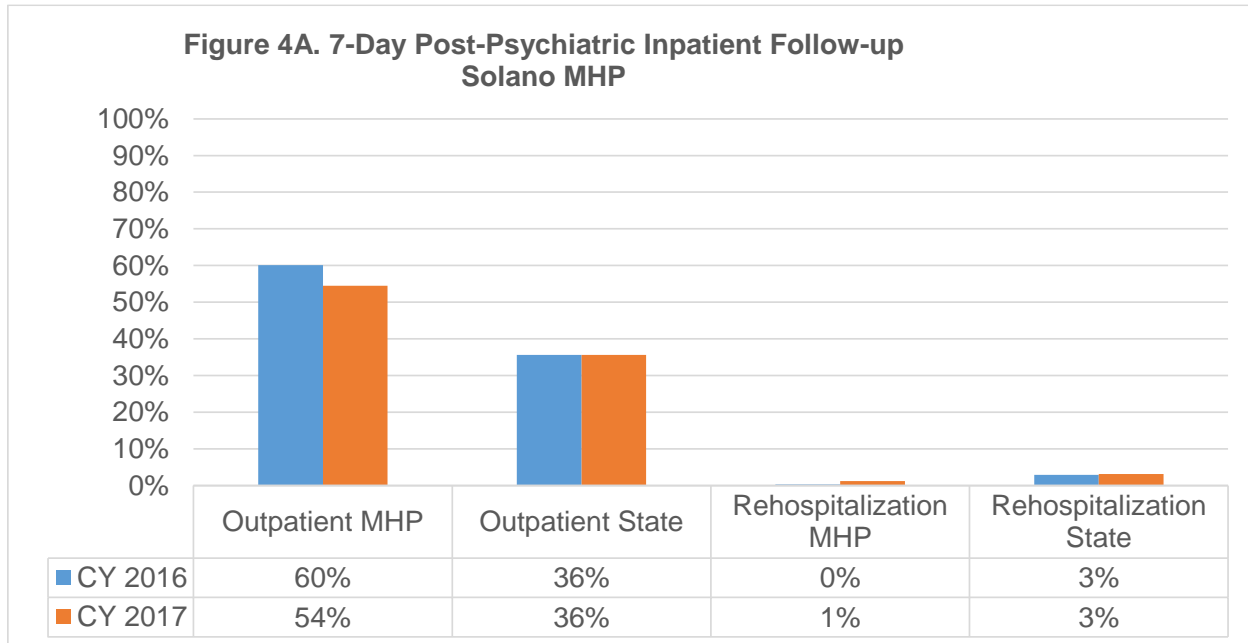
## Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-2017) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 3: Psychiatric Inpatient Utilization - Solano MHP					
Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	352	658	8.53	\$11,033	\$3,883,540
CY 2016	349	542	8.75	\$10,703	\$3,735,346
CY 2015	369	635	10.12	\$8,095	\$2,987,062

## Post-Psychiatric Inpatient Follow-Up and Rehospitalization

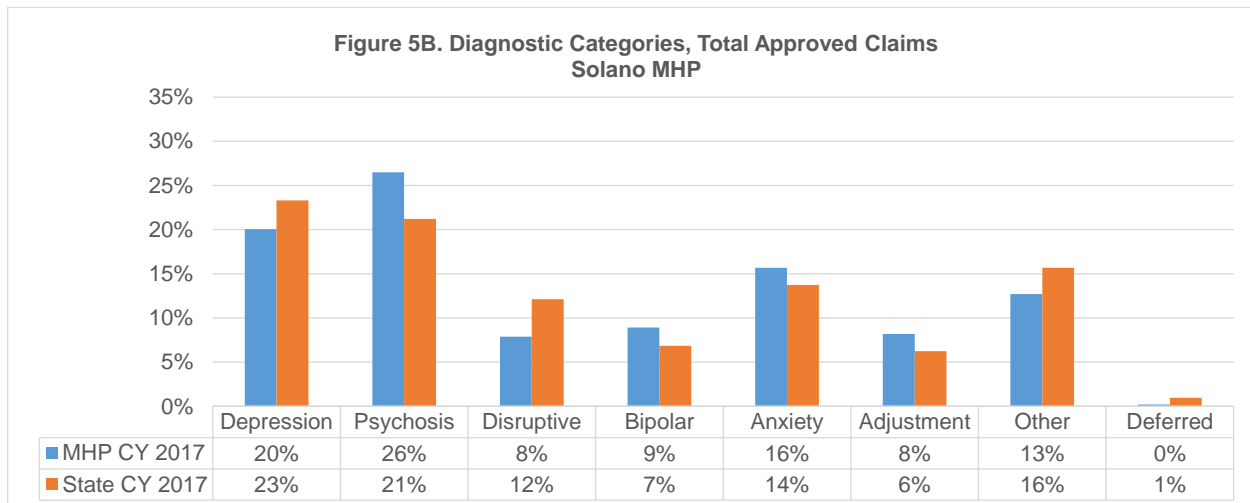
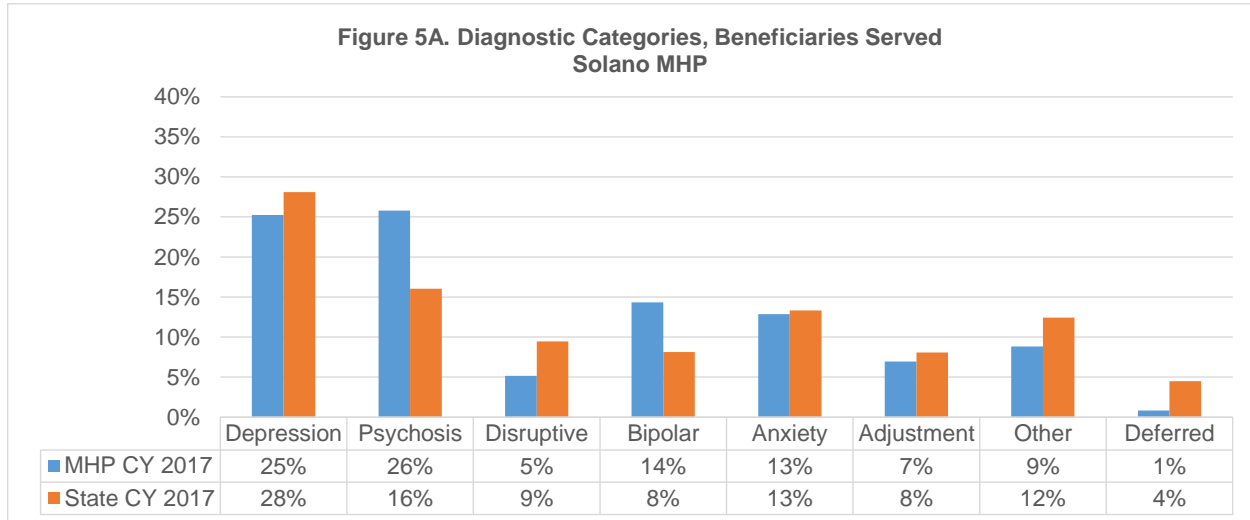
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.



## 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.

MHP self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 27.4 percent.



# 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.

## Solano County 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.<sup>5</sup>

Table 4: PIPs Submitted by Solano MHP		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Full Service Partnership Service Improvement
Non-clinical PIP	1	Engagement and Retention Project

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).

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<sup>5</sup> 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

**Table 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	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	M	NR
		1.4	All enrolled populations	M	NR
2	Study Question	2.1	Clearly stated	PM	NR
3	Study Population	3.1	Clear definition of study population	M	NR
		3.2	Inclusion of the entire study population	M	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	NR
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	PM	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NR
		5.2	Valid sampling techniques that protected against bias were employed	NA	NR
		5.3	Sample contained sufficient number of enrollees	NA	NR
6	Data Collection Procedures	6.1	Clear specification of data	M	NR
		6.2	Clear specification of sources of data	M	NR
		6.3	Systematic collection of reliable and valid data for the study population	M	NR
		6.4	Plan for consistent and accurate data collection	M	NR
		6.5	Prospective data analysis plan including contingencies	PM	NR
		6.6	Qualified data collection personnel	PM	NR

7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	PM	NR
		8.2	PIP results and findings presented clearly and accurately	PM	NR
		8.3	Threats to comparability, internal and external validity	NM	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NM	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NM	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NM	NR
		9.3	Improvement in performance linked to the PIP	NM	NR
		9.4	Statistical evidence of true improvement	NM	NR
		9.5	Sustained improvement demonstrated through repeated measures	NM	NR

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	8	NR
Number Partially Met	10	NR
Number Not Met	7	NR
Unable to Determine	0	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	NR
<b>Overall PIP Rating <math>((\#M*2)+(\#PM))/(\text{AP}*2)</math></b>	<b>52%</b>	<b>0%</b>

## Clinical PIP—Full Service Partnership Service Improvement

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

“What improvements that develop community trust and improve awareness of culturally competent, recovery-oriented services would help engage more with people in pre-contemplation/contemplation as they enter services?”

**Date PIP began:** July 2018

**Projected End date:** TBD

**Status of PIP:** Active and ongoing

The PIP intends to transition Full Service Partnerships (FSPs) to the evidence-based Acceptance and Commitment Therapy (ACT) model with a projected outcome of increasing initial engagement and successful discharges, while ensuring appropriate lengths of stays for beneficiaries.

The PIP was selected for several reasons. These include that FSPs data show a low rate of successful outcomes at discharge; the MHP noticed through review of referrals that some of the highest risk individuals were not engaging with the FSP when referred; and capacity was not optimized by the FSP programs. There appeared to be role rigidity and lack of teamwork within the programs and a lack of engagement of those in pre-contemplation by FSPs.

The beneficiaries that are the subject of the PIP are a high-need population, as individuals are generally referred to FSP when they have either: 1) Had one inpatient hospitalization (or more) within the last year and appear at risk for additional hospitalization, 2) Have had repeat visits to the Crisis Stabilization Unit within the last six to nine months, 3) Are transitioning from a discharge from a locked Institution for Mental Diseases (IMD) or an augmented board and care with daily mental health services, and/or 4) Have had criminal justice involvement in the past year. Adults in the FSPs tend to have complex symptoms and a number of psychosocial barriers (i.e., lack of stable housing, unemployment, lack of resources) that add additional complexities to their service needs.

**Suggestions to improve the PIP:** The PIP study question is not measurable as written and should be rewritten to be quantifiable. The indicators that the MHP reported as “will track but goal may not be necessary as it is determined by need” should be clearly defined as an indicator and tracked or removed. Interventions need to tie to indicators that measure barriers. Further, the baseline should be defined as it is unclear when the baseline data was taken. Data should be analyzed at least quarterly.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of discussion on rewriting the study question to be quantifiable. Per TA discussion on site, the study question will be reworded to read: “If we increase the number and type of field-based, person-centered, recovery-oriented services to Full Service Partnership (FSP) beneficiaries, will beneficiary outcomes improve at discharge by XX (to be decided) percent?” EQRO noted that all indicators need to be tracked, and if they are not needed, should be removed from the PIP as indicators.

## **Non-clinical PIP—Engagement and Retention Project**

The MHP presented its study question for the non-clinical PIP as follows: “What improvements that develop community trust and improve awareness of culturally competent, recovery-oriented services, would help engage more with people in pre-contemplation/contemplation as they enter services?”

**Date PIP began:** NA

**Projected End date:** NA

**Status of PIP:** Concept only, not yet active (not rated)

The MHP presented a non-clinical PIP on improvement of FSP services. They began planning this PIP in July 2018. However, no interventions have begun. The PIP endeavors to address engagement and retention of beneficiaries entering the system. They reviewed data regarding beneficiary drop-off from the Access call log (i.e., never showing up at the clinic) and the drop-off after the first service (assessment). Data showed that in Vallejo, 17 percent of adults and 37 percent of children referred for



services did not return after their first contact with a clinical provider. The PIP attempts to understand the factors that might affect that choice and what can be done to ameliorate the trend.

**Suggestions to improve the PIP:** In its current version, the PIP study question is not measurable. It does not contain an “if X then Y” statement in order to be measurable. It is unclear how the indicators equate to engagement. An example of a potential measurable indicator of engagement would be the number of services attended or percentage of beneficiaries who return after first contact. As written, the interventions are listed but do not show formal protocols or how each would be measured as causal for change. While the PIP seeks to address the quality of FSP services, more work is needed for it to become an effective PIP.

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 a recommendation to rewrite the proposed PIP study question to be measurable. A PIP study question must measure the effectiveness of an intervention(s). Example: “Will doing X, cause a change in Y?” Clarify how each indicator measures or is a proxy for engagement. Refine the interventions into measurable activities that affect the indicators. The proposed interventions do not address the issues stated in the PIP description that create the problem of beneficiaries dropping out before an assessment or not engaging in services after the assessment. Execute the interventions and analyze data not less than quarterly to ensure this PIP is active and ongoing.

## 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): three percent.

<input type="checkbox"/> Under MHP control <input type="checkbox"/> Allocated to or managed by another County department <input checked="" 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	45%
Contract providers	54%
Network providers	1%
<b>Total</b>	<b>100%</b>

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	Monthly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Weekly
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Monthly
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: Five

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 and Spanish speaking practitioners (not including the use of interpreters or language line).
- Approximately 26 telehealth sessions were conducted in Spanish.

## Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (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
3	0	0	0

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	0.5	0	0

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

- The 1.0 FTE in Data Analytical Staff represents multiple staff.

## Current Operations

- Clinicians report that they have an inadequate number of laptop computers available for documentation in the field.
- The MHP has expanded its QI work plan to include information system initiatives.
- All leaders and managers continue to be trained on how to access and use reports available in Avatar. The executive team and mid/upper-level managers perform much of the work related to system-wide clinical data analysis.

- The MHP continues to support the County’s Whole Person Care (WPC) grant project and is continuing discussions about service provision, outcomes and data coordination for Mental Health and Substance Use Disorder needs.
- Because of staffing constraints, some key initiatives (e.g. improve console widgets, implement Mental Health Service Act [MHSA] data collection in the EHR) are currently in pending status.

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.

<b>Table 11: Primary EHR Systems/Applications</b>				
<b>System/Application</b>	<b>Function</b>	<b>Vendor/Supplier</b>	<b>Years Used</b>	<b>Operated By</b>
AVATAR - CalPM	Practice Management	Netsmart	5	Netsmart
AVATAR - CWS	Clinical Workstation	Netsmart	5	Netsmart
AVATAR – MSO	Managed Services Organization	Netsmart	5	Netsmart
AVATAR – Order Connect	Lab Order Exchange, Prescribing	Netsmart	5	Netsmart

## **The MHP’s Priorities for the Coming Year**

- Implement Scanning/Documentation Imaging.
- Implement 270/271 Eligibility Checking in Avatar.
- Improve and implement new Console Widgets in Avatar.
- Enhance Data Warehouse - version upgrade.
- Clean up Client Service Information (CSI) Data.
- Support New State Reporting – Network Adequacy Training (NACT), Child and Adolescent Needs and Strengths-50 (CANS-50), Pediatric Symptoms Checklist (PSC-35) and CSI Assessment Records.
- Implement MHSA Data Collection in Avatar.

## Major Changes Since Prior Year

- Implemented the KPI Dashboard.
- Supported transition to new Crisis Stabilization Unit (CSU) contract provider who is using Avatar; created new forms, and currently working on a discharge form. The prior CSU vendor did not use Avatar optimally; forms were not used for the purpose for which they were created and there appeared to be inconsistent review of historical information within charts.
- Created reports for NACT.
- Supported Health and Social Services (HSS) WPC project.
- Built a referral form to facilitate child psychiatry timeliness measures and is now ready to be launched. (This was not included as an accomplishment in the ISCA but was reported in the ISCA EQRO onsite session.)
- Initiated a Data Analytics Workgroup that included QI and IT representation to support the data analytic infrastructure.
- Initiated a Level of Care/Outcome Measures Workgroup to select tools needed for appropriate assignment of services.
- Working with vendor Netsmart to develop a trauma component to the CANS-50 form.
- Added FC as a data point in the EHR, so data can be collected for this population.

## Other Areas for Improvement

- Only one of the priorities listed in last year's report was on the list of accomplishments for this current EQRO reporting period. Five of last year's identified priorities were not addressed.
- Four of this year's priorities are repeat priorities from FY2017-18 and three are repeat priorities from FY 2016 -17. One priority in this year's ISCA, implementing the X.12 270/271 eligibility electronic transaction, was a priority in FY 2016-17 but was dropped in FY 2017-18. HIE implementation was a priority for FY 2016-17 and FY 2017-18 but has been dropped from this year's priority list without being completed. (While the MHP worked for some time on HIE, it was determined that the functionality sought was being delivered through log-in to the Solano County FQHC system.) This suggests that priorities identified at the beginning of the fiscal year are being supplanted by non-planned initiatives

during the year. This appears to be a symptom of an organization operating reactively rather than proactively.

## Plans for Systems Change

- The MHP has no plans to change its information 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				X	
Assessments	Netsmart/Avatar	X			
Care Coordination				X	
Document Imaging/Storage	Perspective Document Capture			X	
Electronic Signature—MHP Beneficiary	Netsmart/Avatar	X			
Laboratory results (eLab)	Netsmart/Order Connect	X			
Level of Care/Level of Service				X	
Outcomes	Netsmart/Avatar	X			
Prescriptions (eRx)	Netsmart/Order Connect	X			
Progress Notes	Netsmart/Avatar	X			
Referral Management				X	
Treatment Plans	Netsmart/Avatar	X			
Summary Totals for EHR Functionality:		7	0	5	0
FY 2018-19 Summary Totals for EHR Functionality:		7	0	5	0
FY 2017-18 Summary Totals for EHR Functionality:		7	0	5	0

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
FY 2016-17 Summary Totals for EHR Functionality:		7	0	3	0

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

- In Table 12 above, the number of EHR functions present in the MHP has remained unchanged over three fiscal years. This suggests very incremental progress, especially when functions like Document Imaging are Not Present. However, the MHP continues to implement within categories of functionality in order to improve their use. These include:
  - Adult assessment was updated to be more user friendly.
  - Created additional progress notes for crisis residential and assessments for the CSU.
  - On prescriptions, e-prescribing for controlled substances was implemented for all providers including telehealth and locums. This was labor intensive in terms of purchasing and distributing fobs and training providers.
  - Piloted e-refills within the e-prescribe and found it to be complicated and determined that the “faxing” workflow was better.
  - Implemented electronic medication consents and client signature within Avatar.
- KPI Dashboard was implemented as a data analytics tool.
- Avatar alerts are not implemented because the MHP is unable at this time to prevent Substance Use Disorders (SUD) beneficiary alerts from being visible in the MH screen.

## 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 - Solano MHP							
Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
<b>90,070</b>	\$31,582,971	<b>1,614</b>	\$610,311	1.93%	\$30,972,660	\$3,822,391	\$27,150,269
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 <b>2.73 percent</b> .							

Table 14 summarizes the top three reasons for claim denial.

<b>Table 14: Summary of CY 2017 Top Three Reasons for Claim Denial - Solano MHP</b>			
<b>Denial Reason Description</b>	<b>Number Denied</b>	<b>Dollars Denied</b>	<b>Percent of Total Denied</b>
Beneficiary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	402	\$178,817	29%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	440	\$165,259	27%
Medicare or Other Health Coverage must be billed prior to submission of claim.	452	\$161,205	26%
<b>TOTAL</b>	1,614	\$610,311	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 reason Medicare and “Other Health Coverage must be billed prior to submission of claim” are generally re-billable within the State resubmission guidelines.

## CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted one 90-minute focus groups 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/family member 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 consumer and family member involvement. CalEQRO provides gift cards to thank the consumers and family members for their participation.

### Consumer/Family Member Focus Group One

CalEQRO requested a culturally diverse group of adult beneficiaries, including Spanish speaking, who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The group included male and female participants over the age of 25, who were all English speaking, and a mix of Caucasian/White, African-American/Black, and other identified ethnicities. All participants identified as beneficiaries and/or family members. The group was held at Transition Housing Bay Area Community Services (BACS), 345 Travis Blvd., Fairfield CA.

Number of participants: Eight

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

- All three participants concurred that the access process was easy and efficient. Case managers and other staff were helpful, caring, and welcoming, making the process easier. There were no barriers noted that interfered with accessing services.
- All three participants have a therapist, and two are still waiting to receive psychiatry services.

Participants' general comments regarding service delivery included the following:

- Participants in the focus group state that they receive their therapy and/or psychiatric appointments in a timely manner and with sufficient frequency. Appointments vary according to need, from once a week to monthly for therapy and once a week to every three months for psychiatry.
- One issue brought up in the focus group was that some participants have had one or more changes in psychiatrists in the past year due to provider turnover.

The participants view this as a negative experience in their engagement with treatment.

- All participants reported that communication with providers is adequate and that messages are returned in a timely manner.
- Asked if they receive information on medication, there was a mixed response. Some participants have medication support from their psychiatrist/nurses, while others report they were never given any information on possible side effects.
- Housing is reported as one of the largest issues. Affordable housing is at best limited, and the participants report that many board and care operators are not respectful of mental health beneficiaries.
- Caminar Wellness and Recovery Center (a contract provider) has supported several of the participants in resume' writing, money management, life skills training, and clothing for job interviews. Additionally, transportation is provided to medical appointments.
- The participants expressed appreciation for transportation support including bus fare, gas money, and rides provided by case managers. They noted that there is a toll-free number that beneficiaries can call to reserve transportation to appointments with five-day notice.
- Several participants reported that they had experienced encounters with law enforcement agencies (LEAs). They remarked that while some LEA officers are sensitive to the beneficiary's needs, some were unnecessarily aggressive. They found the situation distressing.
- Several of the participants are familiar with the Solano County website. However, they find it difficult to find program information on this site.
- All participants are familiar with and utilize drop-in/wellness centers and find them supportive of their recovery.
- All participants are familiar with surveys of satisfaction of services. Some had done surveys in contracted programs, and some the twice-yearly survey required by the state.

Participants' recommendations for improving care included the following:

- Participants agreed that they need housing support, and that there is a need for more affordable housing.
- Participants desired more compassion for beneficiaries with mental health issues. However, participants did not call out any specific place or group as not being compassionate.

- The participants would like the ability to give medical power of attorney to a family member so that if the beneficiary becomes incapacitated that person could determine treatment options for them.
- Provide Critical Incident Team (CIT) training for LEA to improve responses with beneficiaries experiencing mental health crises.

Interpreter used for focus group one: No

## **Consumer/Family Member Focus Group Two**

CalEQRO requested a culturally diverse group of Transition Age Youth (TAY) beneficiaries, including Spanish speaking, who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The MHP exercised due diligence and arranged a focus group of TAY beneficiaries, per the request. The group was scheduled for day two of the onsite review at 1:30 p.m. – 3:00 p.m. at Seneca TAY, 1234 Empire St., Fairfield, CA. Unfortunately, only one beneficiary attended and therefore no information can be shared due to concerns of anonymity.

## 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	M
<p>The University of California (UC), Davis provided training on Culturally Linguistically Appropriate Services (CLAS) which was successfully implemented. The MHP developed action plans to address its unserved/underserved beneficiaries to include Latino, Filipino, and Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) communities. These action plans are based on CLAS guidelines in order to create a more culturally appropriate and responsive mental health system. Approximately 12 action plans were created and implemented, and examples were provided to the EQRO onsite.</p> <p>The MHP continues to recruit for culturally and linguistically competent, bilingual clinicians and staff.</p>		
1B	Manages and adapts its capacity to meet beneficiary service needs	M
<p>In several sessions with staff, they reported that the complex county hiring system made it difficult to hire, especially for language/cultural competency candidates. The Open Access initiative is now in all three outpatient clinics, Fairfield, Vallejo, and Vacaville. This has been an effective effort to increase capacity and timeliness for beneficiaries requesting services.</p> <p>The MHP now has a full psychiatry staff with a combination of psychiatrists, nurse practitioners, and physician assistants, who are a mix of contract employees, and locum providers. This past year the MHP hired three FTE psychiatrists with no staff</p>		

Table 15: Access to Care Components		
Component		Quality Rating
<p>departures. Only two vacancies remain. One vacancy is due to the Medical Director's resignation in July 2018, and there is one psychiatry provider vacancy. One FTE psychiatrist is now serving as the Interim Medical Director. However, of this staff there are four FTE locum providers. The MHP plans to continue to replace these locum providers with permanent staff at the earliest possible time.</p> <p>The MHP was approved for the California Psychology Internship Council (CAPIC) internship program and they currently have one FTE intern who is providing psychological evaluation, assessments, therapy, and other services. They have also received the necessary Field Instructor Training from Stanislaus State University Master's in Social Work (MSW) program that now allows them to have MSW interns from that program.</p> <p>The MHP has instituted a "Provider of the Day" in their outpatient clinics to act as an urgent care psychiatric provider and removed this service from the CSU environment. This creates access for beneficiaries who need unscheduled psychiatry services that do not meet the level of CSU intervention (e.g. prescriptions needing immediate refill).</p>		
1C	Integration and/or collaboration with community-based services to improve access	M
<p>Evidence of integration and collaboration with community-based services was made available to EQRO on site and in documents provided in advance of review. Faith based initiatives, various programs developed as a result of the UC Davis CLAS training, and relationships with various CBOs are examples. There are regularly scheduled meetings with CBO representation to review utilization of resources and beneficiary progress towards wellness. CBOs continue to have a significant role in all step-down strategies for beneficiaries, whether from inpatient or outpatient care in the MHP. There is continued collaboration with Child Welfare Services (CWS) for CCR implementation.</p>		

## 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	M
<p>The MHP has a standard of average length of time from first request for service to first clinical assessment of ten days, with adults meeting this standard 95 percent of the time, children 72 percent, and foster care 48 percent. The means are 2.29 days for adults, 12.61 days for children, and 13 days for foster care.</p>		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
<p>The MHP does not track the length of time between initial request to first offered psychiatric appointment. The standard for length of time from first request for service to first psychiatry appointment is 30 days for adults, with the standard being met 73 percent of the time, and a mean of 25.84 days. No information was provided on the Timeliness Self-Assessment document received from the MHP concerning this data information for children or foster care beneficiaries. The MHP does not currently track the time from request for services to first psychiatric appointment for children. A referral form has been developed and is being tested at this time.</p>		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
<p>The MHP reports that urgent service requests are identified at assessments. They report there may have been an earlier crisis unit visit. The MHP standard for length of time from service request for urgent appointments to first service is three days, with adults meeting this standard 65 percent of the time, children 63 percent, and 0 percent for foster care beneficiaries. The means are 6.40 days for adults, 4.40 days for children and 11 days for foster care beneficiaries.</p>		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
<p>The MHP has a standard of seven days for follow-up appointments after hospitalization, with adults meeting this standard 65 percent of the time, children 55 percent, and foster care data was not separated out. The means are 15 days for adults and children, with no data for foster care beneficiaries.</p>		
2E	Tracks and trends data on rehospitalizations	M
<p>The MHP had a total of 742 hospital admissions in the past year with 87 readmissions within 30 days or a 12.52 percent readmission rate. Out of 636 adults admitted, 71 were readmitted within 30 days or 11.91 percent, and out of 106 children admitted, 17 were readmitted within 30 days or 17.17 percent. Foster care data was not separated out.</p>		



Table 16: Timeliness of Services Components		
Component		Quality Rating
2F	Tracks and trends no-shows	NM
The MHP did not report psychiatric or other clinician no-show rates in the Timeliness Self-Assessment or at the time of the on-site review.		

## Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 17: Quality of Care Components		
Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
<p>The MHP established a monthly consultation group for program supervisors to provide on-going in-service training to staff in vicarious trauma, resiliency, and self-care.</p> <p>Supervisors report that they participate in the Quality Improvement Committee (QIC) and quality improvement activities. They have access to and utilize data and reports produced by the IT department on an ongoing basis.</p> <p>QIC notes report ongoing quality improvement monitoring as an organizational priority.</p>		
3B	Data used to inform management and guide decisions	M
<p>The MHP utilizes data effectively to inform program decisions. The MHP has expanded its QI work plan to include information system initiatives. QI focused data analyst staff continue to be insufficient to engage in system-wide clinical data analyses, and therefore much of this work falls to upper mid-level managers and the executive team. This is a barrier to optimizing data analyses needed to inform management and guide program decisions.</p>		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
<p>One of the beneficiary employees through Caminar Wellness and Recovery Center has been asked to participate on a QI committee, and other beneficiary volunteers have been asked for input by participating in various committees and activities, such as the Mental Health Advisory Board (MHAB), fifty percent of the MHAB is comprised of beneficiaries and family members, Mental Health Month Committee, Suicide Prevention Committee, speaker events to help reduce stigma, and a Dual Diagnoses Recovery committee. No family members were present in any Consumer/Family Member focus groups to offer their input on involvement in system planning and implementation.</p>		
3D	Evidence of a systematic clinical continuum of care	PM
<p>The absence of mobile crisis is missing from the continuum of care. CIT is in place, but the full 40-hour curriculum is not there at present, only an 8-hour curriculum per LEA requests historically. The MHP is currently rebuilding the 40-hour curriculum in order to offer the full training as well as the 8-hour training.</p>		

3E	Evidence of beneficiary and family member employment in key roles throughout the system	PM
<p>Currently there is one paid peer, one paid family member, and both are contractor employees. However, there are 3.0 new FTE civil service positions for Peer Support Specialists within the MHP that are currently pending review of new classification by the Civil Service Commission in October 2018 to recruit and hire later this year. These positions were the only new positions approved by the County Administrator Office (CAO) and Board of Supervisors (BOS) last year. There were other positions approved but they were limited term and not permanent regular positions. The Consumer Liaison position is vacant due to a staff retirement and is currently being recruited. This position supervises and oversees all beneficiary employees and volunteers. Currently there is no career ladder, however the MHP is looking at this through the new civil services positions that are expected to be recruited this year.</p>		
3F	Beneficiary-run and/or beneficiary-driven programs exist to enhance wellness and recovery	M
<p>Caminar Wellness and Recovery Center is a beneficiary-run drop-in center in Vallejo. It is open Monday through Friday from 7:30 a.m. to 2:30 p.m. Circle of Friends is a beneficiary run wellness and recovery center in Fairfield. Currently there is no TAY wellness and recovery center in Solano County.</p>		
3G	Measures clinical and/or functional outcomes of beneficiary-s served	M
<p>CANS-50 and Adult Needs and Strengths Assessment (ANSA) are utilized to measure individual beneficiary outcomes across the system of care (SOC). Wellness and Recovery is one of the goals incorporated within the FY 2017-18 Quality Assessment and Performance Work Plan. Dialectical Behavioral Therapy (DBT), an evidence-based practice with outcomes measures, is used in treatment protocol with beneficiaries.</p>		
3H	Utilizes information from Consumer Satisfaction Surveys	M
<p>The biannual Performance Outcomes and Quality Improvement (POQI) Survey continues to be conducted and data reported. Aggregate beneficiary responses are compared for trending patterns. The MHP conducts various community surveys and specific program beneficiary surveys for satisfaction. Stakeholders interviewed were aware of completing this and other intermittent surveys throughout the year.</p>		

## SUMMARY OF FINDINGS

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

### MHP Environment – Changes, Strengths, Opportunities and Recommendations

#### PIP Status

**Clinical PIP Status:** Active and ongoing

**Non-clinical PIP Status:** Concept only, not yet active (not rated)

#### Recommendations:

- Clinical PIP: Rewrite PIP study question to be measurable. Remove indicators that will not be tracked according to interventions. Interventions need to tie to indicators. Define when the baseline data was taken.
- Non-clinical PIP: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. Rewrite proposed PIP study question to be measurable. Clarify how each indicator measures or is a proxy for engagement. Refine the interventions into measurable activities that affect the indicators, and are interventions directed at the probable cause of the issue of dropping out of and not engaging in services. Execute the interventions and analyze data not less than quarterly to ensure this PIP is active and ongoing.
- Consult with EQRO early and often during the continuation of both PIPs.

#### Access to Care

##### Changes within the past year:

- The number of Medi-Cal enrollees in Solano County rose from 93,323 in CY 2015 to 126,895 in CY 2016, and then declined to 123,860 in CY 2017. The number of beneficiaries served followed the same pattern, except for Latino/Hispanic enrollees and beneficiaries. Latino/Hispanic enrollees increased from 27,403 in CY 2015 to 30,813 in CY 2016, and then jumped to 38,279 in CY 2017. Again, the number of beneficiaries served followed the same pattern.

##### Strengths:

- Open Access at MHP clinics has improved early engagement with beneficiaries. Having clinicians at the clinic seeing beneficiaries under Open Access do the initial assessment rather than referring them to the Access Center is a good example of a process change that directly impacts beneficiary engagement.

### **Opportunities for Improvement:**

- There are no mobile crisis services in Solano County. This is a significant gap in the continuum of care that could reduce hospitalizations and incarcerations. Mobile Crisis Services can be very helpful to resource constrained LEA by de-escalating incidents before they become a criminal justice matter and getting people to the right level of care in timely way.
- Latino/Hispanic enrollees are an increasing percentage of the MHPs' beneficiaries served. Given this, it would be advantageous to increase the number of Spanish-speaking clinicians hired.

### **Recommendations:**

- Establish and implement mobile crisis services in Solano County in the three major population centers, starting with one city for a stepwise and successful implementation.
- Follow up mobile crisis implementation with collaboration with law enforcement agencies (LEA) to create Crisis Intervention Teams (CIT) that include the MHP and a law enforcement representative at a minimum.
- Develop and implement outreach to increase recruitment and retention of Spanish-speaking clinicians.

## **Timeliness of Services**

### **Changes within the past year:**

- None noted.

### **Strengths:**

- The MHP has data going back to July 2015 on adult timeliness. The wait time to a kept adult appointment has dropped from 21.79 days in the First Quarter of FY 2015-16 to 5.33 days in the First Quarter of FY 2018-19.

### **Opportunities for Improvement:**

- The MHP does not currently track the time from request for services to first psychiatric appointment for children. A referral form has been developed and is being tested at this time.
- Some telehealth psychiatrist providers have a high no-show rate (50 percent) but the MHP has not been able to capture or report no-show data.
- On nearly all measures of timeliness in the Timeliness Self-Assessment, children fare worse than adults, and children in foster care fare worse than children not in foster care.

- The MHP did not report psychiatric or other clinician no-show rates in the Timeliness Self-Assessment. This is a fundamental measure of how well the MHP maintains engagement with its beneficiaries.

#### **Recommendations:**

- Begin collecting and reporting no-show data for psychiatrists and other clinicians, for directly operated clinics and contracted providers. If psychiatrists and clinicians at directly operated clinics are not using the Avatar Scheduling tool, using Scheduling would be the first step in addressing this recommendation.
- Complete testing and implement in-production use of the referral form that facilitates reporting time from request for child psychiatry services to the first psychiatric appointment. This would be one step towards addressing the consistent longer timeliness measures for children and children in foster care.

### **Quality of Care**

#### **Changes within the past year:**

- The MHP has signed a Memorandum of Understanding with CWS Children Welfare Services to implement the CANS-50.
- The MHP established a monthly consultation group for program supervisors to provide on-going in-service training to staff in vicarious trauma, resiliency, and self-care.

#### **Strengths:**

- The MHP has signed a Memorandum of Understanding with Children Welfare Services to implement the CANS-50. This allows further collaboration between the two programs in delivering services to children.

#### **Opportunities for Improvement:**

- The MHP does not currently use a Level of Care (LOC) tool to assist in placing beneficiaries consistently in the appropriate level of care. They have been evaluating available tools, including Reaching Recovery and Level of Care Utilization System (LOCUS), but they have not yet decided.

#### **Recommendations:**

- Complete the LOC tool selection process, procure the tool, and initiate implementation.

### **Beneficiary Outcomes**

#### **Changes within the past year:**

- There are 3.0 new FTE civil service positions for Peer Support Specialists within the MHP that after review of new classification by the Civil Service Commission, will be open to recruit and hire later this year.

**Strengths:**

- There are two beneficiary run wellness centers in Solano County, Caminar Wellness and Recovery Center in Vallejo and Circle of Friends in Fairfield.
- The MHP is looking to increase peer support specialists within the programs across the system. This would include volunteer and paid staff. The 3.0 FTE positions is part of this plan.

**Opportunities for Improvement:**

- There is currently no TAY wellness and recovery center in Solano County.

**Recommendations:**

- Investigate the feasibility of adding a TAY wellness and recovery center in addition to the wellness centers in Solano County.

**Foster Care**

**Changes:**

- Recent trainings in collaboration with CWS include Presumptive Transfer protocol.
- The MHP and CWS co-facilitate Continuum of Care (CCR) workgroups and sub-committee groups to develop mutually agreed upon policies and procedures to effectively implement CCR regulations.

**Strengths:**

- The MHP and CWS CCR workgroup created a protocol entitled “Psychiatric Medication Child and Family Team Meeting,” which ensures that psychotropic medication is addressed at Child Family Team (CFT) meetings.
- There is an interagency committee that meets weekly to discuss complex cases as well as cases in common. Representatives from MHP, CWS, Probation, and Solano County Office of Education are members of the committee.
- The MHP, CWS, and Probation all participated in regional meetings with 12 counties held to facilitate implementation of Presumptive Transfer. Other continuum of care topics discussed include Katie A. Subclass/Pathways to Wellness. There were three such meetings in 2017, and three so far in 2018, with the next meeting scheduled for October 2018.

**Opportunities for Improvement:**

- The Timeliness Self-Assessment is not very informative about services to children in foster care because, on many measures, the number of children involved is too small to report without compromising privacy. Where the numbers did rise above the privacy threshold, foster children appointments meet the timeliness standard at a significantly lower percentage than children in general.

### **Recommendations:**

- Create capability to track all foster care children separately from other children data. Use this data to assess and correct timeliness to services for foster care beneficiaries.

## **Information Systems**

### **Changes within the past year:**

- Progress on information systems initiatives was incremental between last year's review and this review.

### **Strengths:**

- The few people the MHP has in information systems positions do an exceptional job. They handle a very broad range of responsibilities and appear quite capable and dedicated to the MHP.

### **Opportunities for Improvement:**

- In nearly every session of this EQRO onsite review, there was discussion about changing and continually increasing documentation and reporting requirements. The involvement of information systems professionals is needed to configure or develop, test, train employees, implement, and provide continuing support for these requirements. The MHP has reached a point where their information systems resources, as good as they are, are no longer adequate for the mandated challenges facing MHPs. The current resources are almost completely absorbed by maintaining day-to-day operations and routine information needs. Additional skilled staff are needed to execute go-forward projects, some of which are badly needed.
- The MHP is using the Netsmart EHR software. It is a large, complex, and powerful system, but the MHP is not getting its money's worth. There is functionality available that directly addresses some of the MHP's chronic challenges that has not been implemented, in part because no one knew it was available. In another section of this report there is reference to the broad scope of duties of existing information system resources; however, that broad scope does not allow the time and focused attention it requires to become an expert in even one module.
- The MHP does not track Help Desk calls nor do they report on the types of problems the Help Desk addresses.



- Clinicians report that they have an inadequate number of laptop computers available for collaborative documentation and documentation in the field.
- The MHP is not using the Accredited Standards Committee X12 270/271 eligibility transactions, apparently because of a problem with their instance of myAvatar.

### **Recommendations:**

- To improve IT capacity throughout the MHP, increase information systems human resources by filling the following roles: Manager; Clinical Informaticist; Financial/Claiming Systems Chief; System Administrator; Data Manager; Report and Dashboard Developer; Scriptlink and Forms Developer; Integration Manager; Integration Technician; and Help Desk Technician. Prioritize Clinical Informaticist to optimize the system for clinicians, followed by Data Manager to prepare for supervision over other additions of personnel and technology as it is obtained.
- Complete the implementation of the X.12 270/271 electronic eligibility transaction.
- As soon as it becomes available, begin using the county's implementation of Service Now to document calls to the Help Desk and the resolution of those calls. Reporting already available in Service Now should provide far more useful information than is currently available about the volume, type, and resolution of trouble calls.
- Provide a sufficient number of laptop computers for clinicians performing collaborative documentation and documentation in the field.

## **Structure and Operations**

### **Changes within the past year:**

- The MHP established the "Provider of the Day" system in clinics to allow for beneficiaries to see a psychiatrist for urgent needs such as medication refills after a missed appointment.
- The new CSU vendor uses Avatar EHR.

### **Strengths:**

- The "Provider of the Day" availability in outpatient clinics allows beneficiaries easier access to urgent care psychiatric provider and removed this service from the CSU environment. This creates access for beneficiaries who need unscheduled psychiatry services that do not meet the level of CSU intervention (e.g. prescriptions needing immediate refill).
- The new CSU vendor has increased capacity for beneficiaries who need this level of care partially due to implementation by the MHP of the "Provider of the Day" system.

**Opportunities for Improvement:**

- IT resources in Solano County are currently embedded in the QI organization. If the IT department is viewed as primarily a report development function, that is defensible. However, if technology is to be used strategically to facilitate organizational change and growth by optimizing the MHP's investment in Avatar, it should report to the Director and its leader participate in the Executive Committee.

**Recommendations:**

- When the MHP is successful in gaining approval to expand its IT organization, have the IT organization report to the Director and participate in the Executive Committee.

## Summary of Recommendations

### FY 2018-19 Recommendations:

- Pursue completion of recommendations in the Performance Improvement Project Validation section of this report. Engage CalEQRO early and often in technical assistance (TA) to ensure two active and ongoing PIPs over the FY 2018-19.
- Develop and implement outreach to increase recruitment and retention of Spanish speaking clinicians.
- Establish and implement mobile crisis services in Solano County, beginning in the three major population centers.
- Begin collecting and reporting no-show data for psychiatrists and other clinicians, for directly operated clinics and contracted providers. If psychiatrists and clinicians at directly operated clinics are not using the Avatar Scheduling tool, utilizing this tool would be the first step in addressing this recommendation.
- Complete testing and implement in production use the referral form that facilitates reporting time from request for child psychiatry services to the first psychiatric appointment. This would be a first step towards addressing the consistent longer timeliness measures for children and children in foster care.
- Complete the Level of Care (LOC) tool selection process, procure the tool, and initiate implementation.
- To improve IT capacity throughout the MHP, increase information systems human resources by filling the following roles: Manager; Clinical Informaticist; Financial/Claiming Systems Chief; System Administrator; Data Manager; Report and Dashboard Developer; Scriptlink and Forms Developer; Integration Manager; Integration Technician; and Help Desk Technician. Prioritize Clinical Informaticist to optimize the system for clinicians, followed by Data Manager to prepare for supervision over others additions of personnel and technology as it is obtained.
- When the MHP is successful in gaining approval to expand its IT organization, have the IT report to the Director and the IT leader participate in the Executive Committee.
- As soon as it becomes available, begin using the county's implementation of Service Now to document calls to the Help Desk and the resolution of those calls. Reporting already available in Service Now should provide far more useful information than is currently available about the volume, type, and resolution of trouble calls.
- Provide a sufficient number of laptop computers for clinicians performing collaborative documentation and documentation in the field.

- Investigate the feasibility of adding a Transition Age Youth (TAY) wellness and recovery center to the wellness centers in Solano County.

**FY 2018-19 Foster Care Recommendations:**

- Create capability and track all foster care children separately from other children's data. Use this data to assess and develop a remedy for slower timeliness to services for foster care beneficiaries.

**Carry-over and Follow-up Recommendations from FY2017-18:**

- Develop a plan to grow data analysis capability. Explore the possibility of further increasing IT staffing. (This recommendation is also a carry-over from FY 2016 - 17.)
- Complete the implementation of the Accredited Standards Committee X.12 270/271 electronic eligibility transactions. Staff turnover and some long-standing vacancies were barriers in addressing this recommendation. A new billing manager has been hired since the last EQRO which makes staff to address this issue more robust. (The MHP reports it is currently developing a plan to address this recommendation.)

## **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 E: 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 - Solano 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
Consumer 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
Clinical Supervisors Group Interview
Consumer Family Member Focus Group(s)
Consumer Employee/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 Consumers
Community-Based Services Agencies Group 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
Telehealth
Wellness Center Site Visit
Contract Provider Site Visit
Final Questions and Answers - Exit Interview

## Attachment B—Review Participants

### CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer  
Robert Greenless, Information Systems Reviewer  
Caroline Yip, Information Systems Reviewer  
Bill Ullom, Chief Information Systems Reviewer  
Gloria Marrin, Consumer/Family Member Consultant  
Rachel Phillips, Reporting Manager

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

Solano MHP Administrative Office Building  
675 West Texas  
Fairfield, CA 94533  
Contract Provider Sites

#### Contract Provider Sites

Bay Area Community Services (BACS) Transition Housing  
345 East Travis Blvd.  
Fairfield, CA 94533

Seneca Transitional Age Youth (TAY) Facility  
1234 Empire St.  
Fairfield, CA 94533

<b>Table B1 - Participants Representing the MHP</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Ayala	Patricia	Counselor (Substance Abuse)	Solano County Substance Abuse
Baldwin	Keith	Peer Volunteer/Counselor	Caminar
Bird-Marinucci	Meredith	Clinical Supervisor (Vallejo Youth)	Solano County Mental Health
Blair	Buffy	Peer Support Specialist	Caminar, Inc.
Briscoe	Joe	MH Specialist	Solano County Mental Health
Bramwell	Jacque	Accounting Clerk II	HSS Admin
Bristow	Kevin	Project Manager (Youth Services)	Solano County Mental Health
Buckley	Breanna	Clinician (QI)	Solano County Mental Health
Castrejon	Joy	Clinical Supervisor (Vacaville Youth)	Solano County Mental Health
Cecchettini	Paul	Clinical Director	Uplift Family Services
Coleman	Denise	Peer/Family/LMHB	Local Mental Health Board
Cook	Melanie	Manager (Fairfield Adult)	Solano County Mental Health
Crutsinger	Lauren	Program Director	Seneca Family of Agencies
Cruz	Graciela	MH Specialist	Solano County Mental Health
Davis	Amanda	Clinical Supervisor (QI)	Solano County Mental Health
De Guia Samuels	Roanne	Clinician (Outreach)	Solano County Mental Health
De La Cruz-Salas	Leticia	BH Administrator	Solano County Behavioral Health
Durrah	Eugene	Clinician (QI/Direct Service)	Solano County Mental Health
Epstein	Robert	Clinical Supervisor	Solano County Mental Health



<b>Table B1 - Participants Representing the MHP</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Esters	Cheryl	Deputy Compliance Manager	HSS Admin
Falicki	Julie	Program Director	Aldea Counseling Services
Fields	Marquettah	MH Specialist	Solano County Mental Health
Ford	Freddy	Clinician (QI/Direct Service)	Solano County Mental Health
Fulford	Joseph	Staff Analyst (Senior)	HSS Admin
George	Rob	Sr. Manager (QI)	Solano County Mental Health
Grammy	Kate	Manager (Adult Specialty Care)	Solano County Mental Health
Greco-Gregory	Judeth	Clinical Supervisor (QI Audits)	Solano County Mental Health
Greer	David	Clinician (Licensed)	Solano County Mental Health
Halpin	Danielle	Clinical Supervisor (Foster Care)	Solano County Mental Health
Harper	Cynaka	Peer Volunteer/Counselor	Caminar
Hayes	Beth	Clinician (QI)	Solano County Mental Health
Kashani	Mary	Specialist (Patients' Rights Advocate)	Solano County Mental Health
Kaufmann	Lynda	Director of Government Affairs	Psynergy Program
Kellum	Katherine	Manager (Youth Specialty Care)	Solano County Mental Health
King	Michelle	Interim Medical Director	Solano County Mental Health
Kitzes	Michael	Sr. Manager (Adult & Youth Outpatient)	Solano County Mental Health
Kughn	Chris	Caminar Executive Director – Solano Region	Caminar, Inc.
Lacey	Tracy	Sr. Manager (MHSA)	Solano County Mental Health

<b>Table B1 - Participants Representing the MHP</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Looy	Susan	Business Systems Analyst	Department of Technology
Maddox	Cutina	Clinician (QI)	Solano County Mental Health
Marino	Jack	Peer Support Specialist	Solano County Mental Health
Mauritz	Genevieve	Office Assistant (QI)	Solano County Mental Health
Mautner	Mark	Clinician (Fairfield Adult)	Solano County Mental Health
McDowell	Kim	Social Services Manager	Solano County Child Welfare Services
Naman	Laura	Clinical Director	Crestwood Behavioral Health, Inc. (PHF)
Neal	Kristin	Policy & Financial Manager	HSS Admin
Nolan	Eileen	Clinical Head of Service	Rio Vista Care
Northcutt	Cherise	Clinical Director	A Better Way
Palomo	Charlene	Staff Analyst	HSS Admin
Perswain	Lorena	Clinician (Family Advocate)	Solano County Mental Health
Ponting	Jenny	Clinician (QI)	Solano County Mental Health
Ramirez	Miranda	Clinical Supervisor (Institutional Care Svcs)	Solano County Mental Health
Ridgle	Jaylen	Peer Support Specialist	Solano County Mental Health
Rios-Klein	Cristina	Clinical Supervisor (Vacaville Adult)	Solano County Mental Health
Salassi	Anne	Clinician (QI/Presumptive Care)	Solano County Mental Health
San Nicolas Tagliaboschi	Laura	Sr. Systems Analyst	Department of Technology
Schraer	Hilda	MH Specialist	Solano County Mental Health

<b>Table B1 - Participants Representing the MHP</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Scovill	Sharon	Peer Support Specialist	Solano County Mental Health
Secrest	Joy	Administrator	Crestwood CSU
Seymour	James "Colby"	Clinician (Vallejo Adult)	Solano County Mental Health
Sinz	Sandra	BH Deputy Director	Solano County Behavioral Health
Song	Ashley	Clinician (QI)	Solano County Mental Health
Spars	Jonathan	Clinical Supervisor (Hospital Liaison)	Solano County Mental Health
Stimmann	Christina	Clinical Supervisor (Fairfield Adult)	Solano County Mental Health
Stoepler	Jim	Peer Support Specialist	Solano County Mental Health
Theaux Venezio	Heather	President, Local Mental Health Board	Local Mental Health Board
Tiongson	Marie-Fe	Nursing Manager	Solano County Mental Health
Tolentino	Diana	Clinical Supervisor (Access/CAT)	Solano County Mental Health
Uribe	Arturo	President and Chief Executive Officer	Psynergy Programs, Inc.
Urrea	Christina	Clinical Psychologist (Testing)	Solano County Mental Health
Vasquez	Yolanda	Clinician (Licensed)	Solano County Mental Health
Vela	Andrea	Clinician (Licensed)	Solano County Mental Health
Verder-Aliga	Rozzana	Sr. Manager (Adult & Youth Outpatient)	Solano County Mental Health
Voss	Sierra	Clinician (Vallejo Adult)	Solano County Mental Health
Weary	Cynthia	Clinician (Licensed)	Solano County Mental Health
Whall	Mary Kate	Clinician (QI)	Solano County Mental Health
Williamson	Andy	Manager (Substance Abuse)	Solano County Substance Abuse

<b>Table B1 - Participants Representing the MHP</b>			
<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>Agency</b>
Wilson	Eleanor	Sr. Info Tech Specialist	Department of Technology
Woodhall	Cathy	Office Coordinator (QI)	Solano County Mental Health
Yglecias	Jovan	Director of Program Operations	Bay Area Community Services
Zywiciel	Robin	Clinical Supervisor (Forensics)	Solano County Mental Health

## 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 Solano 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	34,384	1,273	3.70%	\$5,394,108	\$4,237

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 Range Solano MHP								
Range of ACB	MHP Beneficiaries Served	MHP Percent Beneficiaries	Statewide Percent Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percent Total Approved Claims	Statewide Percent Total Approved Claims
< \$20K	4,585	92.85%	93.38%	\$16,281,203	\$3,551	\$3,746	55.94%	56.69%
>\$20K - \$30K	172	3.48%	3.10%	\$4,169,489	\$24,241	\$24,287	14.33%	12.19%
>\$30K	181	3.67%	3.52%	\$8,654,658	\$47,816	\$54,563	29.74%	31.11%

## Attachment D—List of Commonly Used Acronyms

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

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

<b>YSS</b>	Youth Satisfaction Survey
<b>YSS-F</b>	Youth Satisfaction Survey-Family Version



## Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
<b>MHP:</b> Solano	
<b>PIP Title:</b> Engagement and Retention Project	
<b>Start Date:</b> 07 2018  <b>Completion Date:</b> TBD  <b>Projected Study Period:</b> 12 – 18 months  <b>Completed:</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  <b>Date(s) of On-Site Review:</b>  10/23 – 24/2018  <b>Name of Reviewer:</b> Lynda Hutchens	<b>Status of PIP (Only Active and ongoing, and completed PIPs are rated):</b>
	<b>Rated</b>
	<input checked="" type="checkbox"/> Active and ongoing (baseline established, and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	<b>Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.</b>
	<input 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
<b>Brief Description of PIP</b> (including goal and what PIP is attempting to accomplish): The PIP intends to transition Full Service Partnerships (FSPs) to the evidence-based Acceptance and Commitment Therapy (ACT) model with a projected outcome of increasing initial engagement and successful discharges, while ensuring appropriate lengths of stays for beneficiaries.	

<b>ACTIVITY 1: ASSESS THE STUDY METHODOLOGY</b>		
<b>STEP 1: Review the Selected Study Topic(s)</b>		
<b>Component/Standard</b>	<b>Score</b>	<b>Comments</b>

<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>Clinical leaders and providers currently lead this PIP: Leadership – County and Contract provider FSP program management, MH Administrator, and MH Director</p> <p>FSP/Forensic Assertive Community Treatment (FACT) Program representatives – Line staff representatives from FSP programs.</p> <p>Beneficiary/family – the MHP is working on engaging a beneficiary who may have received FSP services in past. This has not happened thus far.</p> <p>Representatives and leaders of the three adult FSP programs are included in this PIP. Each FSP is represented by a program supervisor who is responsible for overseeing the implementation of interventions, as well as a line staff person that can provide input based upon the perspective as a service provider. This includes two county-operated FSPs, the Vallejo FSP which serves adults and the FACT forensic FSP which serves probationers. The Caminar FSP serves adults and older adults. The MHP notes that they may need to break out Forensic Assertive Community Treatment (FACT) from some of the analyses because beneficiaries often drop out of service delivery as soon as they are off probation. However, this is a pattern that they hope to change through better engagement and addressing eligibility criteria.</p>
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<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</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 FSP's data shows only 25 percent of beneficiaries are discharged due to "achieving goals" from FSPs.</p> <p>The MHP noticed through review of referrals that many highest risk individuals were not engaging with the FSP. This resulted in repeat hospitalization or in some cases IMD admission. At-risk beneficiaries showed lower engagement and poorer outcomes.</p> <p>Data showed that capacity was not optimized in FSPs.</p> <p>Role rigidity and lack of teamwork approached in FSPs.</p> <p>FSP were not dealing with the lack of engagement of those in pre-contemplation in a useful way per the data.</p> <p>The MHP did not clarify how these five items were problems for the beneficiary per se.</p>
<p><b>Select the category for each PIP:</b></p> <p><i>Clinical:</i></p> <p> <input type="checkbox"/> Prevention of an acute or chronic condition    <input type="checkbox"/> High volume services  <input checked="" type="checkbox"/> Care for an acute or chronic condition        <input 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? <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>The PIP goal is to increase the frequency of face to face for beneficiaries with different team members. The MHP sees this as a way to increase engagement. Treatment plans that include co-occurring issues are lacking and the PIP addresses this. Psychiatry is not currently embedded in the treatment planning. These all effect the quality of treatment as well as engagement.</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 checked="" type="checkbox"/> Other: FSP beneficiaries in the three adult Solano County FSPs.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The population studied included approximately 250 adults in a one-year period, all high-risk with high needs.</p>
<b>Totals</b>		<p><b>2 Met 2 Partially Met 0 Not Met 0 UTD</b></p>
<b>STEP 2: Review the Study Question(s)</b>		
<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> "Can we increase the number and type of field-based, person-centered, recovery-oriented services to FSP beneficiaries in order to improve beneficiary outcomes at discharge?"</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>After TA discussion on site, the study question will be reworded to read, "If we increase the number and type of field-based, person-centered, recovery-oriented services to FSP beneficiaries, will beneficiary outcomes improve at discharge by XX (to be decided) percent?"</p>
<b>Totals</b>		<p><b>0 Met 1 Partially Met 0 Not Met 0 UTD</b></p>

<b>STEP 3: Review the Identified Study Population</b>		
<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</p> <p><input checked="" type="checkbox"/> Other: All adults referred to the three Solano County FSPs.</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>All adult beneficiaries who are FSP beneficiaries in the three adult Solano County FSPs. This is roughly 250 adults in a one-year period, all high-risk with high needs.</p> <p>The MHP also offers FSP programs to youth and TAY. This PIP will inform that service delivery, but this population is not included in this study at this time. Interventions may need to be different for teams serving youth.</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</p> <p><input checked="" type="checkbox"/> Other: Outcomes data.</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>Utilization and outcome data will be described with the indicators and baseline data.</p>
<b>Totals</b>		<p><b>2</b> Met   <b>0</b> Partially Met   <b>0</b> Not Met   <b>0</b> UTD</p>

STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ol style="list-style-type: none"> <li>1. Engagement in FSP services.</li> <li>2. Average units of service per week.</li> <li>3. Field Based Service Provision.</li> <li>4. Number of Services Per Week Enrolled</li> <li>5. Length of Service in FSP at time of discharge.</li> <li>6. FSP Throughput – discharges/ beneficiaries served.</li> <li>7. Successful outcomes at Discharge.</li> <li>8. Engaged in employment, volunteer work, or education.</li> </ol>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The indicators were designed to measure engagement and service intensity that more aligns with strategies known to be associated with successful outcomes with the Acceptance and Commitment Therapy (ACT) model utilizing the fidelity scale Tool for Measurement of ACT (TMACT) as the guide.</p> <p>The indicators have goals that are in some cases stated as not necessary to track because they are determined by need of beneficiaries. Therefore, these are not true indicators.</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</p> <p><input type="checkbox"/> Member Satisfaction              <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated?   <input type="checkbox"/> Yes   <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied?   <input checked="" type="checkbox"/> Yes   <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<b>Totals</b>		<b>0</b> Met <b>2</b> Partially Met <b>0</b> Not Met <b>0</b> UTD

<b>STEP 5: Review Sampling Methods</b>		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	<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	
5.2 Were valid sampling techniques that protected against bias employed?  <i>Specify the type of sampling or census used:</i> N/A	<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	
5.3 Did the sample contain a sufficient number of enrollees?  _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<b>Totals</b> <b>0</b> Met <b>0</b> Partially Met <b>0</b> Not Met <b>3</b> NA <b>0</b> 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>Data elements for analysis include:</p> <ul style="list-style-type: none"> <li>• Total units of service provided to beneficiary.</li> <li>• Total number of contact/services provided.</li> <li>• Number of beneficiaries served.</li> <li>• Dates of episode opening and closing.</li> <li>• Numbers referred for FSP.</li> <li>• Information whether the beneficiary is engaged in employment, volunteer work, or education.</li> </ul>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member      <input type="checkbox"/> Claims      <input type="checkbox"/> Provider</p> <p><input checked="" type="checkbox"/> Other: EHR generated reports</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 from avatar that will require some manipulation to get numbers for the indicators. These reports include:</p> <ul style="list-style-type: none"> <li>• Report 324 –provides details of all services provided within the time frame, as well as admissions and discharges. Total number of services and total units of service can be calculated from this report. Services that are non-billable, “Phone” and less than ten minutes of service are eliminated from this data set as they are most likely a phone message and documentation time. From the spreadsheet of detailed service information – run a pivot table using the beneficiary names, the number of services per beneficiary, and</li> </ul>

		<p>the number of units of service per beneficiary, then an average in table.</p> <ul style="list-style-type: none"><li>• Report 324 – the service detail also shows the location of the service. Services that are labeled “office” and “phone” are considered office related. All other location types are various field locations and inform the measure on field-based service delivery. The total units of service in the field divided by the total units provided results in the percentage provided in the field. Note a limitation in this data in that for the Vallejo FSP the psychiatry units are not included in this data set. As those visits are not in the field, this does not significantly impact this measure.</li><li>• Report 314 – date of discharge for beneficiaries who are discharged. Also includes the admission date. In determining the length of stay, this is calculated by the open date or first date of the quarter being analyzed, and the time to the end of the quarter or the close date. That provides the amount of time that a given beneficiary was open. To calculate average number of units of service by the beneficiary, by the week, it is important to consider the average length of service during the quarter being analyzed. Because of mid-quarter opening and closing, when using a numerator of total units provided or total contacts provided, the average time</li></ul>
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		<p>frame for beneficiaries being served creates the denominator. The denominator will always be something shorter than the time frame being analyzed.</p> <ul style="list-style-type: none"><li>• Report 314 – this report also shows the status at time of discharge. This will provide information regarding whether goals were reached as a result of the services provided. For the successful discharge indicator, the denominator includes all cases closed and the numerator includes those beneficiaries whose status is “reached goals” or “partially reached goals.”</li><li>• Transitions in Care database on SharePoint provides the data for the Engagement in program indicator: The referrals from TIC serves as the denominator. Clients are included in the numerator and considered engaged if they receive over six services within the first four weeks of the beneficiary episode being opened.</li><li>• Employment status is a CSI field and available in Avatar. It is accessed through KPI. The MHP will need to work with staff to make sure that this information is updated as the beneficiary’s employment status changes over time.</li></ul>
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<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>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?  <i>Instruments used:</i>  <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 reports 324, 314, SharePoint CSI field on Avatar through KPI.</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>6.5 Did the study design prospectively specify a data analysis plan?  Did the plan include contingencies for untoward results?</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>No comment of contingencies for untoward results.</p>

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i>  Name: Sandra Sinz  Title: MHP Director  Role: Compile baseline data</p> <p><i>Other team members:</i>  Names: A QI team clinician will do data analysis moving forward.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Not clear exactly how often, who analyzes and what they are expecting.</p>
<b>Totals</b>		<b>4</b> Met <b>2</b> Partially Met <b>0</b> Not Met <b>0</b> 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> <p>Revised table of Discharge Reason codes to be more oriented to goal achievement. Provided training codes through QI liaison clinicians.</p> <p>2. Training to FSP leaders and staff regarding the approach in ACT – Started with FACT.</p> <p>3. Initiate twice weekly morning team meetings to begin focusing on a team-approach for resource distribution and prioritization of beneficiaries. Include psychiatrists when possible. (FACT psychiatrist is a telepsychiatrist provider joining via video-conferencing.)</p> <p>4. Begin narrowing down the involved psychiatry providers by identifying the preferred FSP providers. This will promote teamwork and relationships among providers.</p> <p>5. Work with staff on how to address co-occurring substance abuse issues. This will include a combination of training, consultation, and coordinated work with clinicians with SUD expertise.</p> <p>6. Develop specialty roles within the team per the ACT model: vocational specialist, SUD specialist, peer specialist (TBD staff hired), housing specialist.</p> <p>7. Train staff on the ACT fidelity tool and develop methods to overcome barriers to rehabilitation approach for better</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The MHP notes that there will be more interventions as needed when determined by interim findings. There is a question as to whether any of these interventions are directly affecting beneficiaries. If so, when, how? Is there any data to support this?</p>
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<p>person-centered planning and community-based interventions.</p> <p>8. Implement discharge readiness tool so that discharge transitions are appropriately timed.</p>		
<b>Totals</b>		<b>1 Met    0 Partially Met    0 Not Met    0 UTD</b>
<b>STEP 8: Review Data Analysis and Interpretation of Study Results</b>		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>First quarter analysis was to have occurred after 9/30/2018. Did not state where baselines were from. When will measurements occur? Quarterly?</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled?</p> <p><input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately?</p> <p><input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>There is not yet an analysis narrative of meaning of data collected and analyzed.</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?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>PIP has not progressed to this point yet. First quarter analysis was to occur after 9/30/18.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p><i>Recommendations for follow-up:</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>PIP has not progressed to this point yet.</p>
<p><b>Totals</b>      <b>0</b> Met    <b>2</b> Partially Met    <b>2</b> Not Met    <b>0</b> NA    <b>0</b> 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 type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	<p>PIP has not progressed to this point yet.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?            Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration            Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No            Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	<p>PIP has not progressed to this point yet.</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?  <i>Degree to which the intervention was the reason for change:</i>  <input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	<p>PIP has not progressed to this point yet.</p>

<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?  <input type="checkbox"/> Weak    <input type="checkbox"/> Moderate    <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP has not progressed to this point yet.</p>
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP has not progressed to this point yet.</p>
<b>Totals</b> <b>0</b> Met <b>0</b> Partially Met <b>5</b> Not Met <b>0</b> NA <b>0</b> UTD		

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	Score	Comments
<p>Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?</p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<p>PIP has not progressed to this point yet.</p>

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

*Conclusions:*

The PIP only includes preliminary data currently. It is difficult to know from the Indicator table when the baseline data was taken. The PIP does not contain a quantifiable study question.

*Recommendations:*

Rewrite the study question to be quantifiable.

The indicators that MHP reported as “Will track but goal may not be necessary as it is determined by need of beneficiary” needs to be determined as an indicator and tracked or removed. Interventions need to tie to indicators.

Define when the baseline data was taken.

Data should be analyzed at least quarterly.

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:** Solano

**PIP Title:** Full Service Partnership Service Improvement

**Start Date:** NA

**Completion Date:** NA

**Projected Study Period:** unknown

**Completed:** Yes  No

**Date(s) of On-Site Review:** 10/23-24/2018

**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 PIP will endeavor to address engagement and retention of beneficiaries entering the system. The MHP reviewed data regarding the drop-off from the Access call (never showing up at the clinic) and the drop-off after the first service (assessment). Data showed that in Vallejo 17 percent of adults and 37 percent of children referred for services do not return after their first contact with a clinical provider. The PIP attempts to understand the factors that might affect that choice and to design interventions to ameliorate the trend.

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 type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data showed issues with both drop off from the point of access call and after first service. The QI team conducted an in-person survey of beneficiaries who had received services in the past to gather information on what worked and what hindered engagement.		
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data from Vallejo clinic showed 17 percent of adults and 37 percent of children referred for services do not return after their first contact with a clinical provider.		
<p><b>Select the category for each PIP:</b></p> <p><i>Non-clinical:</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Prevention of an acute or chronic condition  <input type="checkbox"/> Care for an acute or chronic condition  <input type="checkbox"/> Process of accessing or delivering care           </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> High volume services  <input type="checkbox"/> High risk conditions           </td> </tr> </table>			<input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> Process of accessing or delivering care	<input type="checkbox"/> High volume services <input type="checkbox"/> High risk conditions
<input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> Process of accessing or delivering care	<input type="checkbox"/> High volume services <input type="checkbox"/> High risk conditions			

<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 type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP focus is to find out what works at the point of assessment and what does not seem to work. Is there a cultural competence aspect that is not being appropriately addressed? To answer some of these questions, the Clinical QI team conducted an in-person survey in the community. They wanted to speak with community members who received services in past (unsuccessfully/successfully) to understand what worked and what hindered engagement.</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 checked="" type="checkbox"/> Other - Access information       </p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>This PIP applies to all youth and adults entering services in the MHP, recorded in the Access screening tree. This will begin with the Vallejo clinic.</p>
<b>Totals</b>		Met      Partially Met      Not Met      UTD
<b>STEP 2: Review the Study Question(s)</b>		
<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>          "What improvements that develop community trust and improve awareness of culturally competent, recovery-oriented services, would help engage more with people in pre-contemplation/contemplation as they enter services?"       </p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>This is not a PIP Study Question. A PIP study question measures the effectiveness of an intervention(s). Example: "Will doing X, Y cause an increase in Z?"</p>
<b>Totals</b>		Met      Partially Met      Not Met      UTD

<b>STEP 3: Review the Identified Study Population</b>		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input checked="" type="checkbox"/> Other -Requesting services through Access screening tree.</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>PIP is concept only and not completed to this point</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</p> <p><input checked="" type="checkbox"/> Other: Access screening tree</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"/> Unable to Determine</p>	<ul style="list-style-type: none"> <li>• The initial focus of the PIP will be in the Vallejo children’s and Vallejo adult programs. This is for several reasons: <ul style="list-style-type: none"> <li>○ These programs have historically shown the least engagement</li> <li>○ Vallejo has shown the largest increase in demand for services - Vallejo represents the largest growth in service demand. Between adult and child, Vallejo represents 37 percent of the new beneficiary population and this site’s programs show the most attrition at the entry of service. In prior years the Vallejo adult ICC had 60 percent of the demand of the Fairfield clinic. In FY 2017-18 the Vallejo clinic had 94 percent of the demand of the Fairfield clinic, more than a 50 percent increase in demand. It is possible that the “word is out” that the Vallejo clinic initiated Open Access in October 2017. In FY 2017-18, the Vallejo children’s clinic had the largest demand for services (10 percent more than Fairfield). Vallejo has a comparable population to Fairfield but in prior years had been under-represented in the service system.</li> <li>○ Vallejo is the most culturally diverse community and has the greatest poverty in the county; it is most</li> </ul> </li> </ul>
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		<p>impacted by the psychosocial barriers that affect the ability to keep an appointment</p> <ul style="list-style-type: none"> <li>○ This allows for simultaneous efforts in adult and child programs without taking on all adult and children’s programs.</li> </ul>				
<b>Totals</b>		<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; text-align: center;">Met</td> <td style="width: 25%; text-align: center;">Partially Met</td> <td style="width: 25%; text-align: center;">Not Met</td> <td style="width: 25%; text-align: center;">UTD</td> </tr> </table>	Met	Partially Met	Not Met	UTD
Met	Partially Met	Not Met	UTD			
<b>STEP 4: Review Selected Study Indicators</b>						
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ul style="list-style-type: none"> <li>• Show rate for child assessments – Vallejo</li> <li>• Show rate for child service post-assessment - Vallejo</li> <li>• Show rate for adult assessments - Vallejo</li> <li>• Show rate for post-assessment psychiatry visit – Vallejo</li> <li>• Wait time for adult psychiatry Vallejo</li> <li>• Wait time for child therapy visit after assessment</li> <li>• Rate of beneficiaries with 2 or fewer services in EQRO approved claims</li> <li>• Reduce adult disparity by ethnicity in Kept Service to Did Not Keep service ratio.</li> <li>• Reduce child disparity by ethnicity in Kept Service to Did not Keep service ratio.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Met</li> <li><input type="checkbox"/> Partially Met</li> <li><input type="checkbox"/> Not Met</li> <li><input type="checkbox"/> Unable to Determine</li> </ul>	<p>PIP is concept only and not completed to this point. How do these measurements equate to engagement? Wouldn’t engagement be measured by number of services attended? Or something similar?</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 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 type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Unable to Determine</p>	<p>PIP is concept only and not completed to this point. It is unclear that the indicators are true proxies for engagement which would equal beneficiary satisfaction.</p>
<b>Totals</b>		Met      Partially Met      Not Met      UTD
<b>STEP 5: Review Sampling Methods</b>		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?  b) Confidence interval to be used?  c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable  <input type="checkbox"/> Unable to Determine</p>	<p>PIP is concept only and not completed to this point</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> N/A</p>	<input 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>PIP is concept only and not completed to this point</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 type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP is concept only and not completed to this point</p>
<b>Totals</b>		Met    Partially Met    Not Met    NA    UTD

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data that will be collected includes the data which builds the indicators; all comes from the Report 333 which is used routinely to monitor both timeliness and engagement. This report shows all calls made to Access that resulted in a referral for an assessment somewhere in the system. Those calls include those that are “new to service” or were served long enough ago that their case was closed. Clients who are currently in services and were referred for additional (non-assessment) services or referred back to their provider are not included. Calls that are essentially a repeat of a recent Access call are eliminated for duplication.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member      <input type="checkbox"/> Claims      <input type="checkbox"/> Provider</p> <p><input checked="" type="checkbox"/> Other: See notes to right.</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Report 333 timeliness data with Access screening tree data.</p> <p>Cultural Competence plan, CLAS work plan, which may be interwoven with this project.</p>
<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The data which builds the indicators all comes from the Report 333 which is used routinely to monitor both timeliness and engagement. This report shows all calls made to Access that resulted in a referral for an assessment somewhere in the system.</p>

<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey      <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool      <input type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other: Report 333</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"/> Unable to Determine</p>	<p>PIP is concept only and not completed to this point.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan?</p> <p>Did the plan include contingencies for untoward results?</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"/> Unable to Determine</p>	<p>PIP is concept only and not completed to this point</p> <p>No data analysis plan with or without contingencies for untoward results was presented.</p>
<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name:</p> <p>Title:</p> <p>Role:</p> <p><i>Other team members:</i></p> <p>Names:</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"/> Unable to Determine</p>	
<b>Totals</b>		<p>Met      Partially Met      Not Met      UTD</p>
<b>STEP 7: Assess Improvement Strategies</b>		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p>	<p>PIP is concept only and not completed to this point</p> <p>Where is the formal call program described in Step 1?</p>

<p><i>Describe Interventions:</i></p> <p>Begin conversations with people in the community (potential beneficiaries and referring parties) about how our system’s services have improved over the last few years. This includes alerting people that wait times are not like in years past and that 99.9 percent of Access calls are answered by a live person. There are now also Spanish and Tagalog speakers on the Access line. These are always pieces of information that surprise partner agencies. This intervention began as part of the community survey done in-person by two staff with stakeholders.</p> <p>As part of CAT assessments, instead of providing the parent with information on the clinic supervisor’s name/contact, clinicians begin advising the parent to “call me back” if they don’t hear from the clinic with an appointment within the expected time frame. Parents are more likely to call the clinician they met than the supervisor of the clinic.</p> <p>Discuss how/why distinguished assessors for Children’s and if helping or not (36 percent no f/u for tx) and what’s working or not for Adults (17 percent no f/u for tx).</p> <p>Review reasons why CAT was put in place (also look at data at time).</p> <ul style="list-style-type: none"> <li>• Timeliness</li> <li>• Screen better level of care.</li> <li>• Objectivity to not keep beneficiaries not meeting level of care (at the time, there was no LOC/or good assessment tools at the time).</li> </ul>	<p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The interventions are a “to do” list that does not show formal protocols or how each would be measured as causal for change made in indicators.</p>
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<ul style="list-style-type: none"><li>• Review impact on CANS-50 implementation of LOC for children and implementation of LOC tool for Adults.</li></ul> <p>Providing staff with more tools to support beneficiaries in accordance with psychosocial rehab with multiple, complex needs that get in the way of treatment-ensuring staff can document, bill and intervene to reduce barriers to engage in treatment (i.e., training staff to provide psychiatric rehabilitation to address transportation issues).</p> <p>Leverage the work begun in the ICC customer service committee. Work with staff on providing more “welcoming environments.” A CLAS plan dovetails with this.</p> <p>Connect with the CLAS project focused on MHP survey, bilingual pay differential, attracting more cultural/linguistically competent staff- cultural impact around screening, conversations, timeliness.</p> <p>Survey beneficiaries before and after an assessment to help gauge level of comfort with engagement in the assessment process and afterwards about assessing barriers for returning to the appointment – i.e., seeing a different treating clinician/specialist after intake, not returning because of trauma trigger/rehash with new person, wait times (See handout- DRAFT).</p> <p>Discuss ways to address staffing shortages and review team-based approach to share clinicians, efficiency to maximize clinician support across programs- establish a pool to pull from when needed, keep</p>		
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<p>clinical/cultural relevance, draw in lived experience, maintain connection with daily work.</p> <p>Discuss impact of productivity - adjustments around indirect service, mandated trainings- and physical location of teams/clinics</p> <p>Transportation barriers: Advertise transportation services available via Partnership Health Plan as well as one-time taxis vouchers via Clinics during access phone call for medical eligible members. Office assistances and clinic staff should also provide additional education about transportation services (ex. routinely asking people if they need transportation to appointments during reminder calls or initial appointments). Data gathered during our community survey indicated this was a barrier to mental health treatment.</p> <p>Support for Families: Advertise family support groups at access and at each clinic, specifically during calls or referrals that are initiated by family members on behalf of a loved one (i.e. parent, significant other, friend, etc.).</p> <p>Improve communication: Peers recommend the county updates its website with current support group information. Peers also recommend support groups are advertised via pamphlets at each clinic in both English, Spanish, and Tagalog. Peers also recommend the county to develop videos about services offered with captions to support the deaf/hard of hearing population in English, Spanish, and Tagalog.</p>		
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<p>Sharing the load: Staff expressed interest in a shared responsibility for Access such as having a rotating schedule amongst clinicians at each adult clinic. Staff also shared interest in having a representative from access at each clinic to establish a more personalized process to help educate individuals about the services they provide and to better match beneficiaries with specific providers.</p>		
<b>Totals</b>		Met      Partially Met      Not Met      UTD
<b>STEP 8: Review Data Analysis and Interpretation of Study Results</b>		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP is concept only and not completed to this point Analysis pending after end of the quarter.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately?</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	<input 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>PIP is concept only and not completed to this point. Baselines given, with no date obtained. Goals also given.</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?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine</p>	<input 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>PIP is concept only and not completed to this point.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p><i>Recommendations for follow-up:</i></p>	<input 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>PIP is concept only and not completed to this point.</p>
<b>Totals</b>		<p>Met    Partially Met    Not Met    NA    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 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>PIP is concept only and not completed to this point.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?            Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration            Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No            Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input 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>PIP is concept only and not completed to this point.</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?  <i>Degree to which the intervention was the reason for change:</i>  <input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input 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>PIP is concept only and not completed to this point.</p>

<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?  <input type="checkbox"/> Weak    <input type="checkbox"/> Moderate    <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP is concept only and not completed to this point.</p>
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>PIP is concept only and not completed to this point.</p>
<b>Totals</b>		<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA <input type="checkbox"/> UTD

<b>ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)</b>		
<b>Component/Standard</b>	<b>Score</b>	<b>Comments</b>
<p>Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>PIP is concept only and not completed to this point.</p>

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

*Conclusions:*

The proposed PIP study question is not quantifiable.

The indicators are unclear in how these measurements equate to engagement. Would engagement be measured by number of services attended or something similar?

The interventions are in a “to do” list that does not show formal protocols or how each would be measured as causal for change made in indicators.

While the PIP seeks to address a useful issue to resolve, more work is needed for it to become an effective active and ongoing PIP.

*Recommendations:*

Rewrite PIP study question to be measurable. A PIP study question must measure the effectiveness of an intervention(s). Example: “Will doing X, Y cause an increase in Z?”

Clarify how each indicator measures or is a proxy for engagement.

Refine the interventions into measurable activities that affect the indicators.

Execute the interventions and analyze data not less than quarterly to ensure this PIP is active and ongoing.

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