Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SAN DIEGO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 9-11, 2018

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SAN DIEGO MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 41,939

MHP Threshold Language(s) —Spanish, Arabic, Vietnamese, Tagalog, Farsi

MHP Size — Large

MHP Region — Southern

MHP Location — San Diego

MHP County Seat — San Diego

Introduction

San Diego is located in the southwest corner of California, and is the second most populous county in the state, the fifth most populous in the United States. The Mental Health Plan (MHP) is identified as the Behavioral Health Services (BHS) division of the Health and Human Services Agency, and operates in an area of significant urban and rural populations that include diverse languages, ethnicities, and immigrants from Mexico, Africa, the Middle East, Asia, and other regions.

During the fiscal year 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the MHP and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

In addition to the five threshold languages, many other non-English languages present that create challenges in services and create needs for interpreters and culturally competent services. Diverse clinical challenges also exist in serving significant populations of traumatized individuals, such as survivors of torture and sex trafficking and sexual exploitation of children. Both strengths and challenges are found in the circumstances that have approximately 84 percent of all services delivered by contract organizational providers, which is a 10 percent increase over the prior year. There are seven Medi-Cal Managed Care Organizations (MCOs) that also deliver mental health services to the mild-to-moderate eligibles.

During the last year, the MHP/BHS engaged in a 100-million-dollar expansion of services, the increase accomplished through contract organizational providers. The MHP's penetration rates remain above the average for large counties and the statewide averages for almost all parameters. The service expansions targeted needed service areas either related to intensive services, such as the Children's Emergency Screening Unit, or cultural/ethnic needs, which would include the

Transition Age Youth (TAY), Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Plus (LGBTQI+) specific clinical services and drop-in centers. Commitment of resources is linked with data-driven identification of need.

Optum provides the services of the access and crisis line, and manages the provider network, as well as furnishes a broad support function which includes electronic health record (EHR) training and reporting. Optum also supports the MHP's communication efforts with a website presentation that publishes data reporting and update communications related to compliance. The provider panel managed by Optum has added a number of psychiatric nurse practitioners over the course of the past year, with physician assistants also being considered for inclusion.

Practitioner retention has been a long-term issue, particularly with contract organizational providers. These programs have faced long periods of little or no increases year over year, and cannot offer the salaries or benefits of county positions nor the other health care organizations that are competing for licensed personnel. The MHP has engaged in service expansions throughout the geographic areas served and, in particular, with high-risk consumers such as the homeless, forensically involved individuals, veterans, and high intensity programming such as crisis residential and stabilization.

Timeliness

The MHP has set a high standard for initial timeliness, using eight-days for adults and five-days for children and youth as the expected parameter. The data reflects actual access times for adults as half that standard, while children and for youth approaching nearly double the standard.

The standard for initial psychiatry access is 30 days with the largest challenge existing with children and youth timeliness, which still presents an average which usually meets standard.

Quality

With 84 percent of services provided by contract programs, the MHP has a large burden of contract monitoring and communication to sustain. The MHP provides various forums and venues to engage providers and obtain input, and provide information. The MHP has beneficial partnerships with the University of California San Diego (UCSD) and other entities to assist with performing extensive data analysis and reporting. Optum houses the web location for information and communication information circulated by the MHP, including the Up To The Minute information newsletter.

Changes to the local psychiatric residency program have resulted in an increased focus upon community psychiatry, improved integration of residents with community programs, and with the possible future positive impact upon hiring and retention of these needed professionals.

Outcomes

The MHP is in the process of preparing to convert to the State of California Department of Health Care Services (DHCS) required outcome instruments for children and youth. This will result in the

MHP reducing the number of children and youth instruments presently in use. Quarterly reports related to Mental Health Services Act (MHSA) outcome data is provided by UCSD, and summaries of outcome data is furnished by the annual quality management plan annual evaluation.

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 programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan.

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 FY17-18 findings of an EQR of the San Diego MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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. The eight PMs include:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;

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

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

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 discussed in detail later in this report.

MHP Health Information System Capabilities[4]

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

Validation of State and County Consumer Satisfaction Surveys

CalEQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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:

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

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[3] 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.

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

- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which 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 FY16-17

Recommendation #1: The MHP's capacity to provide care and deliver quality and continuity of care would be well served by establishment of a system-wide initiative involving both directly operated and contracted programs to identify and remedy the issues relating to recruitment and, in particular, retention of psychiatrists and other prescribers as well as other licensed staff.

Status: Partially Met

- The MHP has participated with UCSD on the transformation of the community psychiatry program for residents/fellows and psychiatric nurse practitioners. The community psychiatry track has changed from a fellowship to a residency track.
- Numerous training strategies have been implemented to address key focus areas of clinical knowledge and cultural competence, improving both knowledge and job satisfaction of staff.
- Child, Youth & Family (CYF) programs have the biggest challenge with psychiatry turnover and coverage. In response, MHP is setting up a centralized program for

telepsychiatry. A focus area will be post-acute medication management for CYF consumers stable on medication. This will be a community-wide resource, and is expected to serve about 200 consumers with two full-time psychiatrists.

- Despite these significant efforts at recruitment and retention, turnover is a persistent issue. MHP leadership acknowledged that salary competition is part of the problem. Salaries have recently been increased for residents in the Community Psychiatry Program at UCSD, and the MHP is considering raising rates for contracted psychiatrists.

Recommendation #2: The MHP's non-English speaking beneficiaries would benefit from efforts to increase the numbers of multi-language capable telepsychiatry providers.

Status: Partially Met

- The MHP explored telepsychiatry and interpretive services within the health care area. The numerous agencies contacted by the MHP reported availability of services that mirror the MHP's own efforts in working with locum tenens agencies. However, none were able to provide services on demand.

- The MHP is considering augmenting on-demand interpretive services rather than consider specific coverage arrangements with telepsychiatric provider services.

- The MHP will be improving capture of non-English utilization of services within the EHR, which will improve data collection of linguistic capacity need, and continue to enhance linguistic capacity of telepsychiatric services.

Recommendation #3: The use of collaborative documentation would benefit from study to determine if local experience demonstrates improvement of consumer outcomes and improves timeliness of documentation.

Status: Partially Met

- The MHP has been exploring the implementation of collaborative documentation (CD), which was initially focused on a specific contract provider that has extensive experience with this approach.

- The Quality Review Council (QRC) has considered implementation of CD, and has considered the training and equipment needs that will be required. Contract monitors are discussing and encouraging the use of this approach.

- The MHP is also looking at mechanisms for tracking improvement in consumer outcomes and timeliness of services will occur with the CD approach.

Recommendation #4: The MHP would benefit from a system-wide effort to assess and improve the role of individuals with lived experience, working with contractors and supporting the development of a standardized career ladder in AOA, TAY, and with family advocates in CYF services. This would likely include system-wide efforts to obtain baseline information from a survey of these individuals.

Status: Met

- In July of 2017, the MHP conducted a web-based survey of individuals with lived experience. The survey produced information regarding the interest in career advancement of these individuals, and the perceived barriers of degree and credentialing requirements, criminal history, and others. Of the respondents, 74 percent were interested in career advancement.

- Due to local requirements, the MHP is unable to create county positions specific and exclusive to individuals with lived experience. Some contract providers such as RI International and National Alliance on Mental Illness (NAMI) employ numerous individuals with lived experience and also provide advancement opportunities. The MHP includes requirements of peer positions or strongly recommends them within relevant contracts.

- The MHP has tracked the training of peer support specialists since 2008, which shows 785 have been trained. In FY16-17 alone, 80 peer specialists graduated, with 88 percent subsequently moving into paid or volunteer positions. The MHP would improve its understanding of the outcomes of this training if the data on achievement of paid employment was broken out from the volunteer/paid combination results.

Recommendation #5: The MHP's efforts to continue implementation work with its Service Journal, Treatment Plan, and Progress Note projects have the potential to improve efficiency of staff and increase availability of clinical time. As these are implemented the MHP needs to assess how these pieces impact its timeliness reporting and formally publish its findings to inform relevant stakeholders.

Status: Partially Met

- The Service Journal captures detailed data regarding service engagement at the program level. Its starting point is the first contact with an individual or family member following a referral from the Optum call center. It is currently in final testing and full production use will begin July 1, 2018.

- EHR treatment plan and progress note upgrades have been implemented. The progress note upgrade has generated a considerable number of calls to the support desk as people adjust to the new software.

- It is too early to assess the impact of these changes to the EHR and this should be a followed in the coming year, with a focus on timeliness of documentation and timeliness of access to care.

Recommendation #6: The MHP should work with its targeted vendor IBM on expediting the development of data exchange architecture and solution that will improve the accessibility of medical information to psychiatrists and PNPs.

Status: Partially Met

- This remains a work in progress and will be a follow-up item for the FY18-19 EQRO Review.
- The statement of work (SOW) to begin the work of integrating the Cerner EHR with ConnectWellSD, the local Health Information Exchange (HIE), is in final review and expected to be issued shortly.

Changes in the MHP Environment and Within the MHP—Impact and Implications

Discussed below are any changes since the last CalEQRO review that were identified as having a significant effect on service provision or management of those services. This section emphasizes systemic changes that affect access, timeliness, and quality, including any changes that provide context to areas discussed later in this report.

Access to Care

- The MHP has engaged in expansion of long-term care options, including the addition of 64 beds at Crestwood, an Institute for Mental Disease (IMD)/Mental Health Rehabilitation Center (MHRC), and the addition of a seven-bed contract expansion with Changing Options, Inc., a Behavioral Health Residential Treatment Program that operates an open, recovery-focused, residential program with onsite services.

- Project One For All is a wraparound of services provided to homeless individuals who are eligible for supportive housing, with a goal of serving 1250 individuals. A total of 625 assertive community treatment slots were added in the last year. Additional outreach workers were added to assist with case management and referral processes. This past year approximately 900 individuals were served.

- Targeting the needs of the youth LGBTQI+ population, in September 2017 Our Safe Place began offering behavioral health treatment services to youth under the age of 21 years. The program has the capacity of serving 160 youth, and also offers four drop-in centers across the county.

- In another targeted expansion, in September of 2017, the I CARE program started offering behavioral health treatment to youth up to age 21 who are at risk or victims of sexual exploitation. The program also has a 7-day per week drop-in center.

- The CYF Emergency Screening Unit was relocated from Chula Vista to a more central San Diego site, which also expanded the capacity to 12, a threefold increase.

- As of July 1, 2017, CYF adjusted its protocols to be in compliance with AB1299, so that foster care youth with out of county Medi-Cal who reside in San Diego County have access to locally offered services.

- The County of San Diego's Drug Medi-Cal Organized Delivery System (DMC-ODS) Implementation Plan was approved by DHCS on October 5, 2017, with anticipation that the Fiscal Plan will be approved by January, 2018, with preparation for a July 1, 2018 launch of services. Multiple work teams are meeting weekly.

- The Continuum of Care Reform (CCR) has catalyzed more integrative efforts between the MHP/BHS, Probation, and Child Welfare Services (CWS). Probation has initiated a

regular interagency placement committee meeting, and participates in the Pathways to Wellbeing training subcommittee. Numerous actions and activities are geared toward improving coordination among partner agencies and developing the resources. This includes processes to support creation of the Short-Term Residential Treatment Program (STRTP), and Therapeutic Foster Care (TFC) services in coordination with BHS, CWS, and Foster Family Agencies (FFAs).

- The MHP is in the process of setting up two different programs with a telemental health component. An Innovation project aims to connect youth and adults discharged from a psychiatric hospital episode to outpatient services. This program will be countywide, and is projected to serve 250 youth and adults. The second program is The Center for Child and Youth Psychiatry, which provides a medication clinic for children and youth that is projected to serve 510 children annually.

Timeliness of Services

- Additional psychiatry resources are anticipated to improve the timeliness to care. In addition, there is some discussion about increased same-day access availability becoming another tool in improving initial care.

- The MHP is looking to begin tracking and reporting time from assessment to first clinical appointment, in order to improve the understanding of any capacity issues that may exist in the process from request to provision of treatment.

Quality of Care

- The MHP's Quality Improvement (QI) and Management Information Services (MIS) is working with an Outsource Provider, DXC, to build the requirements for an interoperability system that will support the capture of data exchange elements necessary to support claiming from disparate systems and alleviate double-entry which impacts approximately ten percent of contract providers. The statement of work and work order are anticipated to be completed between January and February of 2018. Individual systems will be phased in as they can accommodate to this interface.

- The hepatitis A outbreak in San Diego became a foundation for extensive cross-agency collaboration in identification of at-risk individuals, treatment of the infected, and the development of vaccination strategies and public health environmental interventions. These actions have further facilitated an ongoing BHS and Public Health agency relationship that will not only serve the current health crisis but serve to support response to others that may emerge in the future.

Consumer Outcomes

- The MHP has been preparing to meet the July 2018 start date for the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC-35)

instruments implementation. These will replace many of the current tools utilized by the CYF system of care.

- The BHS/MHP sought out input through various mechanisms during 2017. Approximately 400 individuals participated in community forums, a community tele-town hall, three population-specific focus groups, one innovative population-specific focus groups, and one frontline worker tele-town hall. The targeted participants included clubhouse members, homeless members, justice involved individuals, justice partners, and frontline staff. The results of these sessions are being aggregated and will be presented in the winter of 2018.
- The Behavioral Health Workforce Collaborative brings a focus to developing and sustaining a culturally competent and diverse workforce, converging on the needs of consumers and family with a wellness-driven approach. The intent includes development of careers for people with lived experience.
- In 2017, the TAY work group began shifting to a TAY Council format with bylaws and efforts to recruit membership in process.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of TBS Beneficiaries Served Compared to the 4% 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 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; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). 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 detail on beneficiaries served by race/ethnicity.

Table 1: San Diego MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	198,672	21.7%	13,491	32.2%
Latino/Hispanic	338,736	37.0%	10,866	25.9%
African-American	58,403	6.4%	4,074	9.7%
Asian/Pacific Islander	139,892	15.3%	3,687	8.8%
Native American	4,150	0.5%	380	0.9%
Other	176,762	19.3%	9,441	22.5%
Total	**916,614**	**100%**	**41,939**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

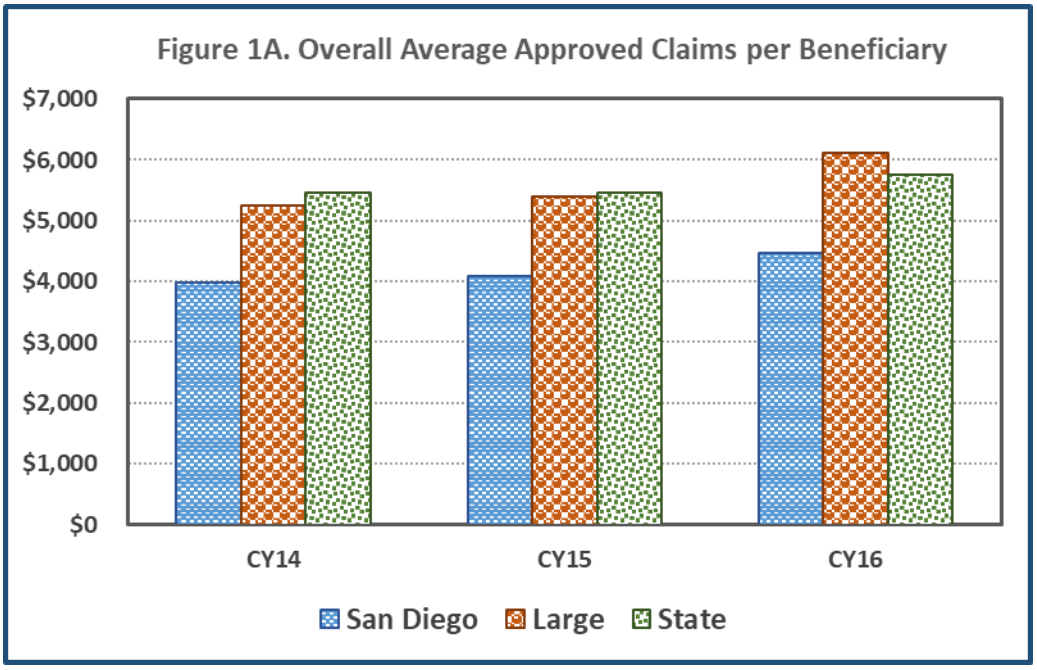
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

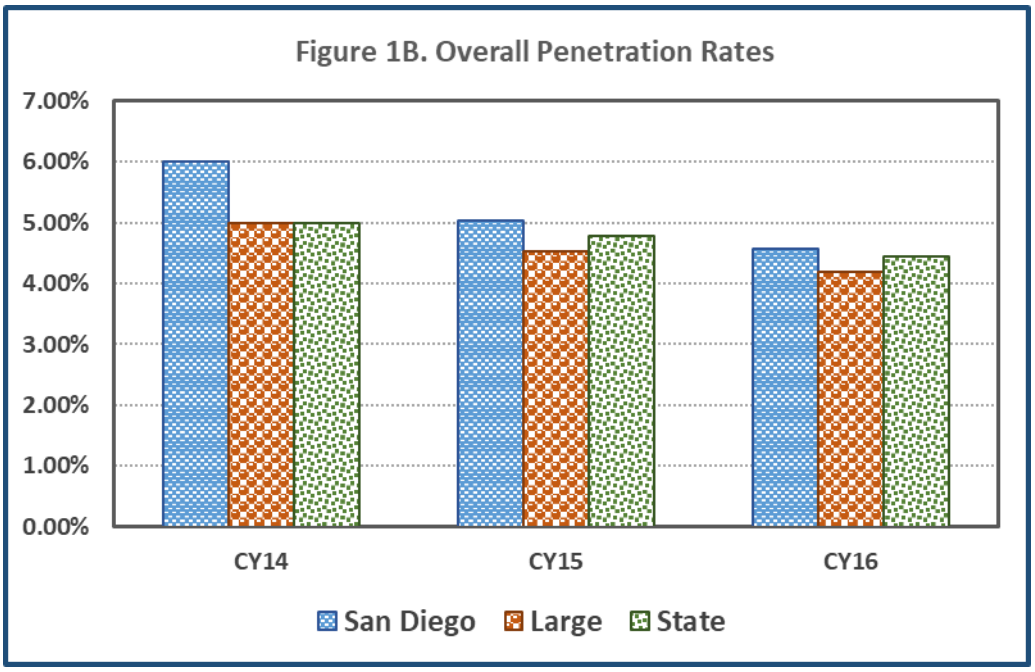
Penetration Rates and Approved Claim Dollars per Beneficiary

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

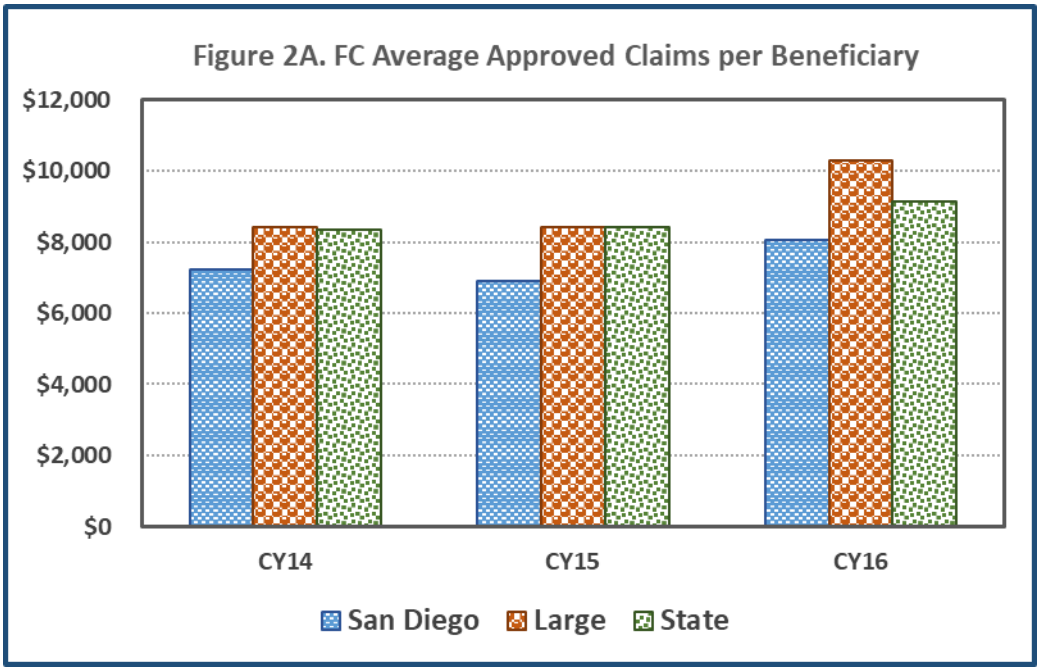
Regarding calculation of penetration rates, the San Diego MHP uses the same method used by CalEQRO.

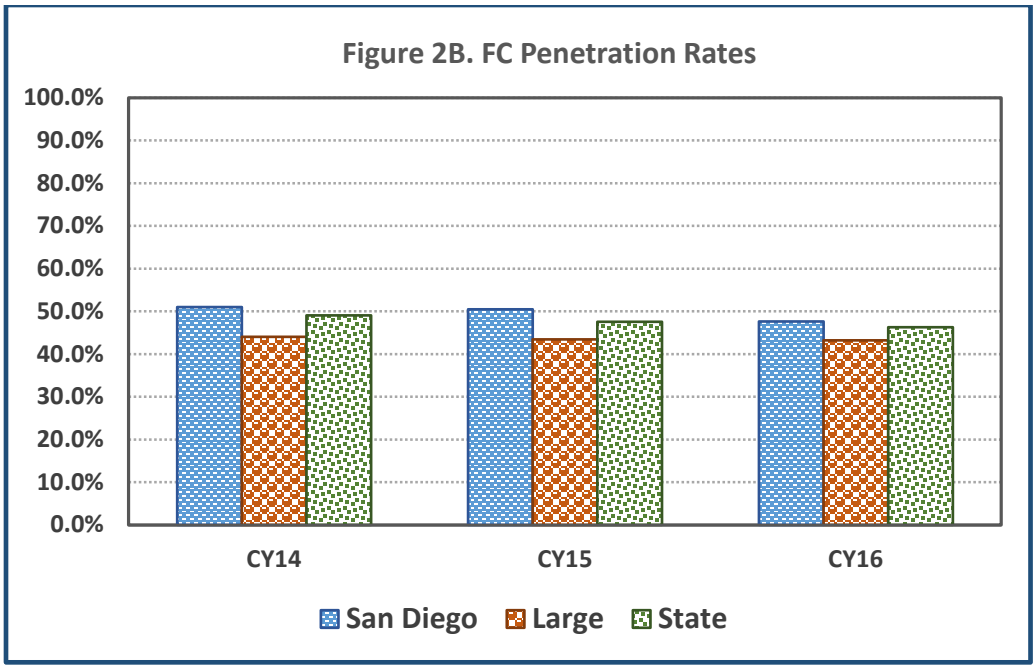
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



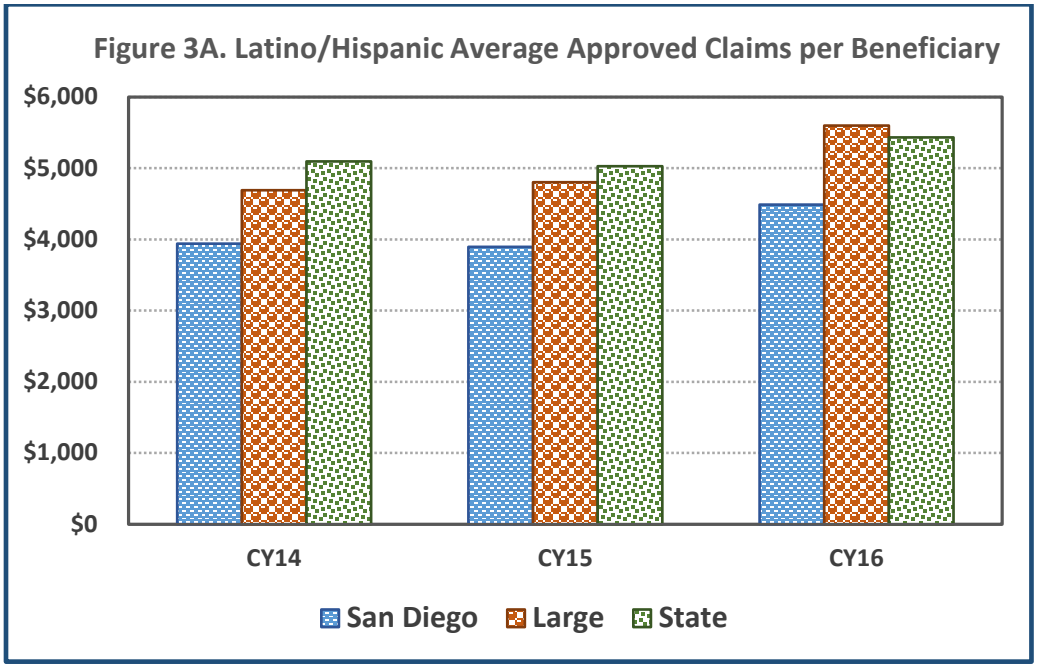


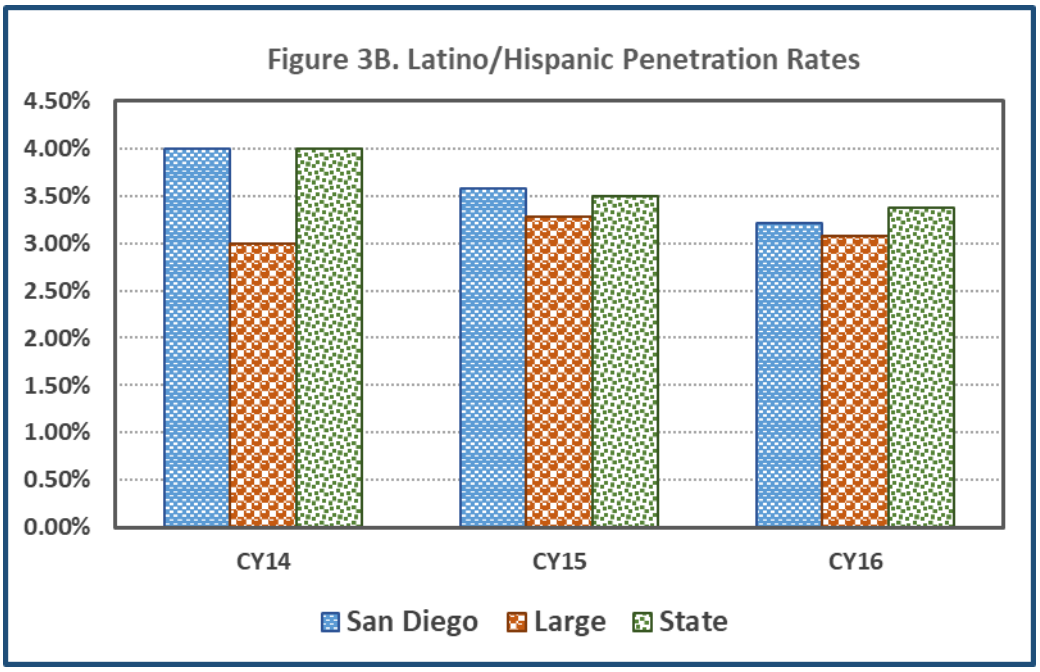
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries for CY16 with the MHP's data for CY16, 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: San Diego MHP High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
San Diego	CY16	1,012	41,939	2.41%	$45,107	$45,647,939	24.33%
	CY15	883	43,739	2.02%	$47,284	$41,751,346	23.32%
	CY14	517	34,410	1.50%	$42,172	$21,802,775	18.12%

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

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

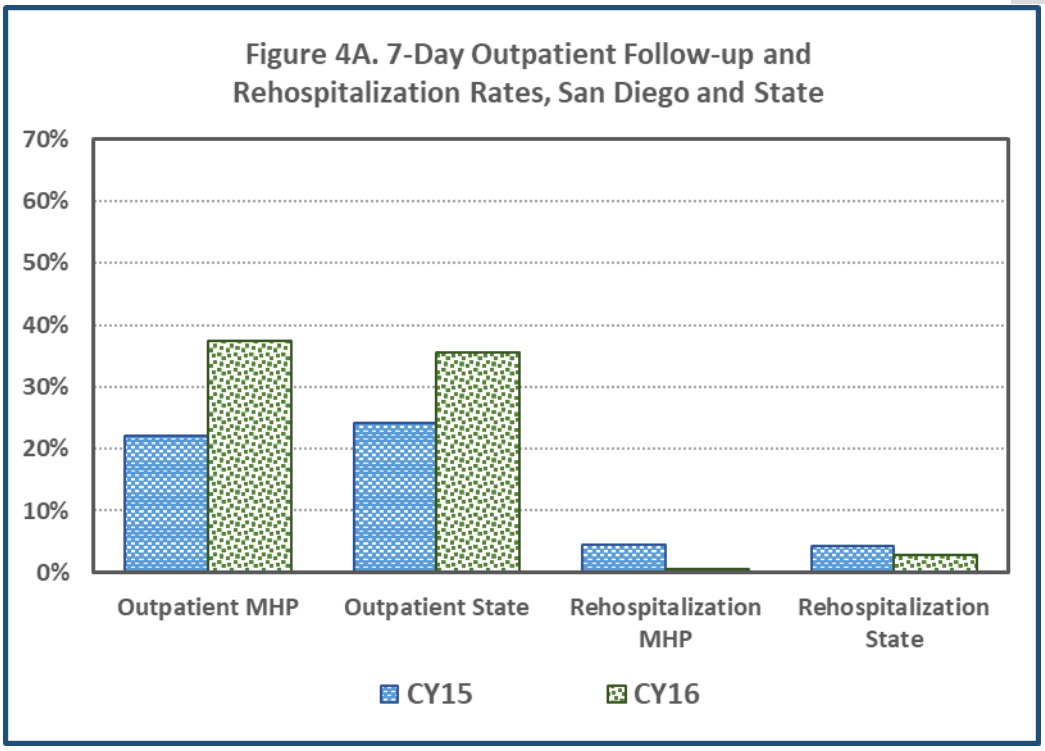


Figure 4A. 7-Day Outpatient Follow-up and Rehospitalization Rates, San Diego and State
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY15
CY16

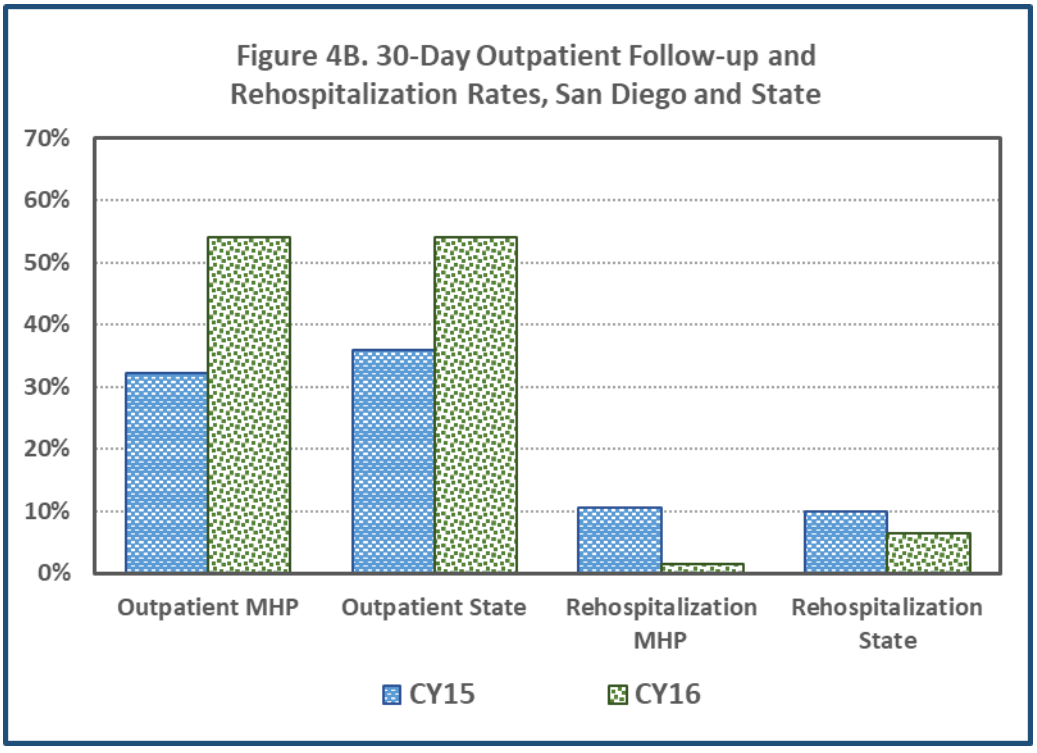
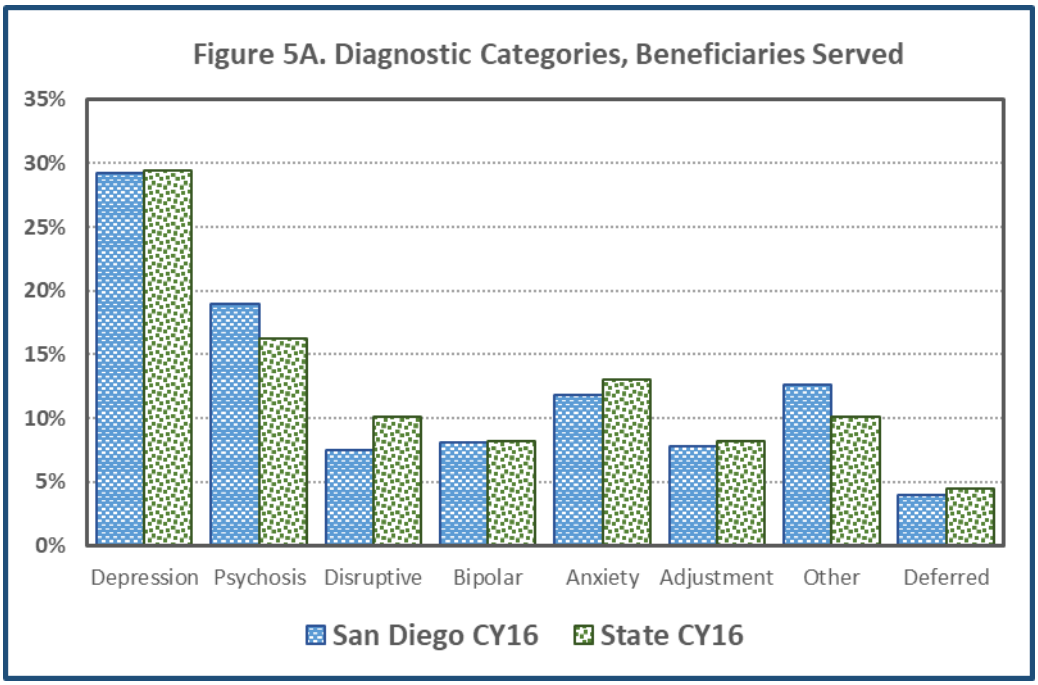


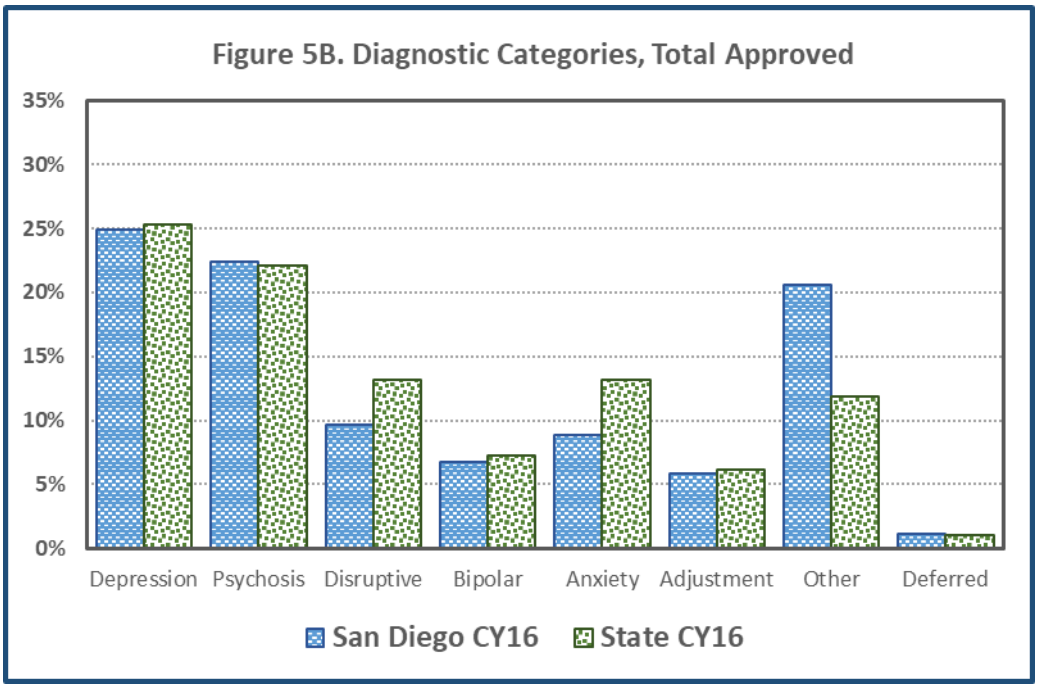
Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, San Diego and State
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY15
CY16

Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 35.2%.





Performance Measures Findings—Impact and Implications

Access to Care

- Penetration rates for most parameters are equal to or greater than other large MHPs and the statewide average.
- The MHP's overall approved claims per beneficiary remains significantly less than other large MHPs and the statewide average.
- The high cost beneficiaries (HCB) percentage has increased significantly between CY14 and CY16, but remains below the statewide rate. During that same period the number of HCBs has nearly doubled.

Timeliness of Services

- Seven- and thirty-day post hospital discharge follow-up appointment rates have both improved noticeably since last year's report

Quality of Care

- The MHP's rehospitalization rates were about equal to the statewide average in the prior CY15 data year, are now below the statewide rate in the CY16 data. The decline in the rehospitalization rate from CY 15 to CY 16 is an important improvement that may reflect the improvements in engaging consumers post-hospital discharge.

Consumer Outcomes

- None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year.

San Diego MHP PIPs Identified for Validation

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

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by San Diego MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Therapeutic Homework
Non-clinical PIP	1	Client Engagement after Discharge from Psychiatric Hospital

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review

				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	M
		8.2	PIP results and findings presented clearly and accurately	M	M
		8.3	Threats to comparability, internal and external validity	M	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	M
		9.3	Improvement in performance linked to the PIP	M	M
		9.4	Statistical evidence of true improvement	M	PM
		9.5	Sustained improvement demonstrated through repeated measures	PM	PM

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	24	22
Number Partially Met	1	3
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**98%**	**94%**

Clinical PIP—Therapeutic Homework

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

"Will increased use of therapeutic homework following supervisor training precede a 10% reduction on the internalizing and externalizing Child and Adolescent Measurement System scales and a 10% decrease in length of time in treatment?"

Date PIP began: April 2016

Status of PIP: Active and ongoing

Following a study on the outcomes of care and duration of treatment for the CYF population, the MHP made the determination that the local results were demonstrating limited positive benefits from therapy, as evident by literature comparison (FY11-12 and FY14-15). The MHP determined it would be appropriate to seek outcome improvement for CYF consumers. Statistical analysis was also conducted on the outcomes of those consumers who had received Therapeutic Homework (TH) as an adjunctive intervention to treatment. The initial findings were that these individuals demonstrated better behavioral and emotional outcomes.

Considering literature and local findings, the MHP determined that TH could be a useful adjunctive intervention to obtain improved results from treatment.

The first year of this PIP involved providing education regarding TH and development of a mechanism to capture the use of this intervention. The first-year pilot served 693 youth consumers, or 5 percent of the MHP served CYF population. The second year of the project incorporated efforts to target the top three barriers to TH: Lack of a structure to support TH, consumer non-compliance, and absence of technology to support TH. The latter resulted in the

addition of an application-based mechanism for youth to complete their homework. As many of this population is oriented to the digital universe, this application approach is reportedly helpful engaging consumers in their treatment and TH.

The MHP has utilized a number of strategies to collect information about these practices, and accomplished a data analysis of the information to date. The information considered included: a clinician online survey, analysis of consumer race/ethnicity, primary diagnosis distribution, and age and gender of consumer. The performance indicators included therapist frequency of TH assignment, caregiver report on disruptive behavior, caregiver report of depression/anxiety, and duration of treatment.

Thus far improvements have been demonstrated, but were determined not to be statistically significant from T-test results.

In the Spring of 2018, the TH intervention will be rolled out to all CYF programs, and this PIP will be ended and final data analysis will occur.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussion of winding up the PIP, summarizing the data, and potential topics for the next clinical PIP.

Non-clinical PIP—Client Engagement after Discharge from Psychiatric Hospital

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

"Will the development of a standardized process for acute hospital discharged, new consumers (new to the system or not currently active with the SDCBHS) – which includes an aftercare appointment within three days of discharge and a reminder call – improve outpatient engagement by 10% to 30% and reduce readmissions by 10% to 30%?"

Date PIP began: April 2016

Status of PIP: Active and ongoing

The MHP became focused on the low aftercare engagement rate of consumers discharged from a psychiatric hospital stay for those who were not open to outpatient services at the time of inpatient admission. The MHP determined that improving engagement of these non-open consumers with outpatient care would be an appropriate topic for a non-clinical PIP.

The approach taken to interventions was to arrange a specific aftercare appointment instead of making a walk-in referral. The PIP also included tracking of achievement of aftercare services at 7,

30, and 90-day periods. Also tracked were the readmission rates at corresponding 7, 30 and 90-day intervals.

The initial interventions focused on provision of a specific aftercare appointment, and from the first-year experience added follow-up reminder calls, and provision of an informational flyer.

Analysis and discussion provided for the current EQR onsite identified positive impacts on the 90-day rehospitalization rates, showing a reduction in readmissions, which, while not constituting a statistically significant amount, demonstrated improvement.

As the MHP moves to conclude this PIP and broaden the application of this practice to other hospitals, it may be helpful to consider other additional interventions that support completion of aftercare follow-up appointments.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussion of winding up the PIP, summarizing the data, and potential topics for the next clinical PIP.

PIP Findings—Impact and Implications

Access to Care

- The non-clinical PIP provides emphasis and support to critical post-hospital discharge rapid access to care.

Timeliness of Services

- Timeliness of post-hospital follow-up is targeted by the non-clinical PIP, tracking 7-, 30- and 90-day follow-up periods.

Quality of Care

- The TH clinical PIP promotes a practice that improves engagement and clinical results from treatment, and utilizes a tech-supported approach that improves acceptance by the targeted population.

Consumer Outcomes

- Therapeutic homework outcomes of treatment for youth consumers appear to be improved, as rated by parents and caregivers, and has the potential for shortening the length of treatment.

- The non-clinical PIP focusing on the aftercare appointment, supported by information and follow-up calls, has produced results that currently reflect improvements of 90-day rehospitalization rates.

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

Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 6: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M
The MHP's CY16 approved claims penetration rate continues to be at or above those of other Large MHPs and the Statewide averages for the majority of parameters reviewed. A large expansion has occurred during this last year, targeting specific areas of need. The expansion increased the percentage of contract services from 74 to over 84 percent. The expansion includes services to exploited youth victims of sexual trafficking, providing both clinical services and drop-in support availability, and provides assistance with employment and furthering of education. The LGBTQI+ population now has dedicated clinical services which also includes drop-in centers throughout the county. These are but two of many examples of massive efforts to improve services to special populations and also augment high-level services, as is apparent in the CYF Emergency Screening Unit move of location and expansion from four to twelve beds. The overall expansion has occurred completely through contracted service		

providers, and totals 100 million dollars.

For this current review, the EQR team visited a Middle Eastern/Chaldean service provider and consumers in East County, and Hispanic, primarily Spanish speakers in South County who are served by a provider who specializes in this population.

The MHP operates with a Cultural Competence and Three Year Strategic Plan dated 2017.

1B	Manages and adapts its capacity to meet consumer service needs	M

The MHP continues to explore mechanisms for recruiting and retaining psychiatrists and other prescribers. Participation in the community mental health residency program will offer more sustained exposure to the community mental health program for residents, and likely improve the ability of BHS to retain these individuals after completion of their advanced clinical work. Optum has added a number of psychiatric nurse practitioners to the provider network panel during this last year, and anticipates adding physician assistants going forward.

The broad variety of languages that are found within the MHP's area of responsibility are many times greater than the threshold language criteria. As such, reliance upon interpreters is a continued expectation, as clinicians who speak all languages that present in the county is simply not practical.

The MHP continues to work on CCR and with CWS on the conversion of group homes to STRTPs. Treatment access for individuals placed in San Diego county from another has been put into place, along with processes for presumptive transfer. Numerous other changes have occurred in this area, including CCR oversight bi-monthly meetings, a Group Home and FFA and many other activities to improve the process.

The South Bay area experiences a very high Hispanic penetration rate, with treatment resources that are supported by clubhouses tailored to the served population.

Prevention and Early Intervention programs maintain spreadsheet of any referral made – track follow-up – creating first annual report. The MHSA programs are also supporting the capture of race/ethnicity data that providers a more granular picture of the overly inclusive Asian, Pacific Islander construct, and captures Chinese among some other subsets of that grouping.

Other MHSA programs, an Innovations development, provides mobile outreach to those who reside in one of the 19 reservations, and support partnering with Federally Qualified Health Centers (FQHC), with services that, in one instance, includes psychiatry. These services include Native American health workers, and promotes addiction screening as an important component.

The MHP has examined cultural competence tools used in system of care, and determined that new instruments were needed.

Service expansion includes improved access to those who are not connected, through a pilot of telemental health at the home, supported by a case manager or therapist. This improves follow-up because the issues of transportation or child care are resolved barriers. Follow-up of the

homeless and those released from jail is an ever-present challenge for which specific interventions are developed.		
1C	Integration and/or collaboration with community-based services to improve access	M
With more than 84 percent of services contracted out, the MHP engages in collaborations in serving all populations and in all regions. Through the contracting process, providers with an existing presence in a region have an opportunity to become part of the MHP's system of care. This results in cultural and linguistically appropriate services, and faith-based services for those who find this as an avenue of support. Contract providers include statewide entities such as Telecare Corporation, which has deep experience and expertise in the provision of full service partnerships, crisis residential, and mental health rehabilitation programs.		

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components

Component		Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	PM
Providers track requests for service to their program and report out monthly to the MHP. The MHP is developing a mechanism to track new beneficiaries to the system through the EHR. The MHP anticipates that in early 2018 it will be able to track any follow-up appointment to the initial request, and will also include tracking to first kept appointment and time between first and second clinical appointment. The MHP utilizes initial access standards of five days for CYF and eight days for adults and older adults (AOA). Achievement of standard is 70 percent for CYF and 91percent for AOA, with a mean of 9.2 days for CYF and 3.8 days for adults. The AOA data demonstrates an improvement in timeliness, halving the time it took in the previous year. CYF reflects a fractional improvement in timeliness, and remains significantly longer than the standard. Consumers and parents/caregivers interviewed during this review provided mixed feedback regarding timeliness of initial access during this last year. Some experienced timeliness that		

aligned well with the MHP's data, others reported much longer delays. For quite a few, initial access took a number of weeks, and psychiatry often much longer.

In the review of the prior work plan timeliness results (FY16-17), the MHP found CYF consumers who waited longer than the system average of 9.5 days had a preferred language of Spanish, Tagalog, and unknown/not reported.

Initial access for AOA consumers requesting services in languages other than English ranged from 3.0-4.1 days compared to the AOA system average of 4.0 days. Cantonese and Hmong speakers experienced a very small variance from the system average in access days (0.3 and 0, respectively).

Feedback from clinical line staff during this review indicated an awareness for data and standards set by the MHP. It seems clear the standards are broadly communicated and best attempts made to meet them.

2B	Tracks and trends access data from initial contact to first psychiatric appointment	M

The MHP utilizes a 30-day initial psychiatry access standard for both the CYF and AOA populations. CYF experiences a 21.2 day mean, and 79 percent achievement of standard. AOA has an 11.1 day mean, with 99 percent achievement of standard.

2C	Tracks and trends access data for timely appointments for urgent conditions	NM

The MHP is working to have this functionality available in early 2018, but was not available at the time of this review.

2D	Tracks and trends timely access to follow-up appointments after hospitalization	M

The MHP uses a standard more rigorous than the HEDIS 7-day metric, and expects post-hospital follow-up to occur within 3 days. CYF experiences a mean of 5.08 days, with a 54.8 percent achievement of standard. AOA experiences a mean of 6.14 days, with a 53.6 percent achievement of standard.

2E	Tracks and trends data on rehospitalizations	M

The MHP tracks psychiatric hospital admissions that occur at all facilities, totaling 9,868 for both populations. The readmission rate is 15.6 percent for CYF and 25.4 percent for AOA. These values reflect an increase of five percentage points for AOA, and approximately two for CYF.

2F	Tracks and trends no-shows	M

The MHP has not established no-show goals for psychiatry or non-prescriber clinicians.

Psychiatry no-shows are averaging 9.5% for CYF, and 18.7% for AOA. Non-psychiatry clinicians average 3.5 % for CYF, and 7.3% for AOA.

All values represent slight increases over the prior review.

Quality of Care

In Table 8, 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 8: Quality of Care Components

	Component	Quality Rating
3A	Quality management and performance improvement are organizational priorities	M

The MHP devotes significant resources to quality improvement, assurance and compliance, which includes an Executive Quality Improvement Team (EQIT), which staffs the QI Unit and responds to recommendations and initiates QI priorities; a Quality Improvement Performance Improvement Team, which works with the research centers in tracking and analyzing data and leading PIPs; a Quality Management (QM) Team, engaged in audits, reviews; a Management Information Services (MIS) team, responsible for activities relating to the Cerner EHR system and other electronic interface linkages; the Quality Review Council (QRC), which includes consumer and family participation as well as other regional stakeholders that furnish input. The activities listed are a fraction of all specific responsibilities for quality and compliance that are within quality functions of this department.

The MHP's annual evaluation of the prior work plan results included a discussion of a 56 percent increase in grievances between FY15-16 and FY16-17. The MHP believes the spike may be the result of efforts to refresh criteria for grievances and improve general awareness. The area with the greatest increase was that of quality of care, which usually reflects negative consumer response to a specific clinician or physician. The MHP plans to closely track this area going forward in order to determine if this is an aberration or reflective of a trend.

Another area that is extensively reported and tracked since FY 12-13 is the suicide rate comparison between BHS consumers and the overall county incidence. The MHP notes that overall the system of care suicide rates decreased by 17.4% from the FY15-16 through FY17-18. The portion of all countywide suicides that were comprised of MHP open or recently closed

Table 8: Quality of Care Components		
Component		**Quality Rating**
consumers dropped slightly during the same time period, from 34.9% to 28.8%. The MHP has also developed an action plan to target suicide risk going forward, which will include emphasizing current factors rather than the previous focus upon history. This change will be supported by the development of a prospective risk analysis tool, which is to be imbedded in the EHR and be available to all programs that serve any individual. The above two items are two examples of the numerous and extensive quality tracking analysis examined by the MHP in the annual evaluation of the prior work plan. Additional items included review of goals set for permanent housing with the homeless/Project One For All, post-hospital discharge outpatient follow-up metrics, and improved children's outcomes from treatment presented another area of focus. The ESU children's unit was another area for which targeted outcomes have been set, monitored and evaluated, with an expectation of a 70% diversion rate.		
3B	Data are used to inform management and guide decisions	M
The MHP's use of data is greatly assisted by the partnerships with external analytic resources including UCSD and Optum San Diego, which hosts data postings on its website. In many cases, not only is data analytic reporting provided, but also conclusions regarding the results are furnished. Both AOA and CYF systems of care are supported by these partnerships. As previously mentioned in item 3A, data is routinely collected, reported, and analyzed by this MHP in all areas. An example was provided by the MHP's tracking of assessment results for homeless individuals, which was found that after assessment occurs only 12% were connected with routine services, 39% received an emergency intervention next, and 24% received no other service. From this information, the MHP increased the outreach workers to help ensure continuity and engagement with this vulnerable population. The MHP has examined the issue of timeliness of access and the related data. Potential changes in access model are being considered, with consideration of wider spread open access or same-day service availability at more than the current two sites that offer walk-in services.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
As in previous reviews, communication is both a strength and a challenge for this MHP. With over 84% of services delivered by contract partners, the MHP has increasing communication responsibilities. Many different mechanisms are utilized for communication, with the		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Contracting Officer Representative (COR) key to interfacing with contractors. The Up To the Minute QI newsletter is an often-cited helpful communication mechanism of the MHP, which furnishes updates in the form of a newsletter. Additionally, compliance and Quality Assurance/Quality Improvement have interactions with providers as related to documentation requirements, changes in claiming, and data collection and reporting. Each subsequent EQR process is usually met with actions taken on recommendations, many related to improving communication, as was the case in this current review. The feedback of review participants underscored the existence of communication mechanisms at all levels, including participation in QIC meetings, emails, individual and group contractor meeting. Providers acknowledged the efforts of the MHP to improve communication during this last year. It might be of benefit to request the organizational providers to craft a survey instrument so as to ensure capture of the types of information most important to them. Surveys designed by the MHP certainly hit some of contractors' concerns but miss others. The feedback requested slower implementation of changes, and to consider preview of anticipated changes with contract program leadership programs, and to obtain feedback as to impacts envisioned by the contractors. Depending on response, the MHP might selectively develop a planning meeting with providers in advance of formal rollout. In addition, more complex and impactful changes may benefit from an in vivo training rather than reliance upon email notification alone. A key and recurrent issue is the complexity of documentation. Efforts to improve documentation are often perceived to result in increased complexity rather than simplification. Complexity of documentation inevitably takes away from time for services to consumers, and contributes to staff burnout as they attempt to deliver the same quality of services while also meeting the documentation requirements. Broader direct contractor involvement also relates to the development of the Cerner EHR forms, so that the needs of programs and line staff have greater inclusion.		
3D	Evidence of a systematic clinical continuum of care	M
This MHP has been consistently expanding all levels of service availability, and within the last year demonstrated an increase from four to twelve beds of CYF Emergency Screening Unit slots. This program has greater availability both in more central geographic siting and capacity.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Current data reflects a 70% diversion rate. The MHP is consistently examining the process of transitioning consumers from higher levels of care to lower levels and back to either health-based care or network providers. Throughout the review participants expressed an awareness of this process, and had greater concerns about the availability of step-down options within the community. Medi-Cal only consumers seemed to face the greatest challenges in transitioning to lower levels of care and obtaining a suitable practitioner or psychiatrist, whereas the Medi-Medi and privately insured possess greater options. The MHP's contracting process establishes goals for consumer step-down percentages. The most recent EQR retention data perhaps is reflective of that process, with lower than statewide average for greater than 15 services, and lower percentages for other high service level parameters. The transition process was often discussed during this review, and reflected the efforts to provide warm-handoffs to other providers, and also to provide a treatment bridge when those lower level (strength based) providers had lengthy transition times for accepting new consumers.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The local county government requirements do not permit the establishment of positions specifically for and exclusive to individuals with lived experience. However, the MHP has established within its contracting process requests and/or requirements for consumer-employee positions. These include parent-partner/mentor, peer support specialist, and TAY mentor roles. The programs which hire consumer and family most often have incorporated positions that include benefits and career ladder opportunities. While it is clear that these individuals appreciate their opportunities for employment and perform valuable functions, the do not operate as part of routine outpatient services, such as AOA adult clinics. Perhaps as a result, at times they find themselves to be excluded, and not viewed as other clinical staff might be. The MHP would likely benefit from efforts to incorporate consumer-employees hired into contract programs via colocation with directly operated and other adult programs. The current operational separation is a barrier to full acceptance and stigma elimination for these individuals.		
3F	Consumer run and/or consumer driven programs exist to enhance	M

Table 8: Quality of Care Components		
Component		**Quality Rating**
	wellness and recovery	
The MHP does not utilize the wellness model programs, but instead operates with a clubhouse model, which tends to focus on recovery, education, and employment attainment for consumers. There exist 14 total clubhouse programs in the county, many have a specific focus; there also exist clubhouses for some of the ethno-cultural groups present within the county.		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP tracks numerous parameters of consumer progress, which are quarterly summarized and reported. The CYF system is preparing for the transition to the Child and Adolescent Needs and Strengths survey (CANS) in the summer of 2018. Within the adult system of care, the Milestones of Recovery Scales (MORS) is administered every six months, or more often if clinical status change occurs. Older adults receive the Illness Management and Recovery (IMR) instrument. The MHP's analytic partner UC San Diego provides quarterly reporting on the outcomes data furnished by the various instruments in use. The reporting goes beyond basic data summaries but includes analysis of the data and identifies key takeaways. The data also includes process information, such as the timeliness of instrument administration, and error rate reporting. This also serves to support contract monitoring in that fidelity to administration process is also addressed and data broken out by each individual program. In addition to those already mentioned, the AOA instruments in use include the Recovery Markers Questionnaire, Substance Abuse Treatment Scale, along with the MHSA required instruments. The FY16-17 CYF summary notably indicated that higher levels of positive outcomes were reported by clinicians as compared to consumers and caregivers of youth discharged. Positive outcomes were reported for nearly three-quarters of the discharged youth consumers. The MHP's outcome objective of eighty percent was unmet, which was explicitly stated.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The MHP provided information regarding the consumer perception/satisfaction surveys from Spring 2017. Within the CYF population, 97.7% reported receiving services in their preferred language. The AOA population reported the approximately the same results with 97% receiving preferred language services. An action taken in response to this information was the expansion of threshold language to include Farsi and translate beneficiary materials into that language. Extensive analysis of the consumer perception surveys for CYF and AOA was performed, including a strong focus on substance use trends.		

Key Components Findings—Impact and Implications

Access to Care

- The growth in the rate of contracted services, now more than 84 percent, enables the MHP to cultivate contract agency providers which have expertise in specific populations, as is the case with the TAY LGBTQI+ clinical services and drop-in centers, the Middle-Eastern populations of East County, and the Latino/Hispanic population of South County. This adaptability is reflected in the high penetration rates for most populations served.

- The MHP's efforts to improve recruitment and retention of psychiatry practitioners, particularly challenging with the child psychiatry sub-specialty, is apparent in its work with UC San Diego and the development of a community mental health residency program, as well as other efforts to incorporate mid-level practitioners in the continuum of services. Telepsychiatry is also being piloted in efforts at improving access to care for select consumers.

- Collaboration with community partners has been evident in the MHP's support for the creation of a crisis stabilization unit in a North County private hospital, and the expansion of the Emergency Screening Unit by threefold, followed by its relocation to a more accessible area.

- The topic of staff turnover emerged throughout the review as an issue that impacts quality and consistency of care as well as consumer satisfaction. Frequently cited by consumers was the turnover of psychiatry and other clinicians, which was reinforced by program leadership. Conflicting information was received regarding the extent to which significant turnover of staff in programs occurs. Significant numbers of staff and program leadership expressed concerns about turnover affecting services, including psychiatry, clinicians, nursing, and case managers. The MHP would benefit from efforts to specifically track turnover by category of staff, and at minimum for contract agencies. The lack of contract amount increases for longstanding programs was cited as a major factor in this turnover.

- The MHP has adapted to the AB1299 provisions for providing mental health services to foster care youth placed in another county, and requirements of presumptive transfer of eligibility. Work is being done with CWS on the conversion of group homes to STRTPs. The integration of probation representatives in the process brings another key stakeholder into the process of service for foster care youth.

Timeliness of Services

- The MHP utilizes two different standards for initial access: Five days for CYF, and an eight-day standard for AOA. The data indicates AOA consumers experiencing initial access that is less than half the established standard (3.8 days), whereas CYF consumers experience wait times nearly double the established standard (9.2 days). Many MHPs utilize a single initial timeliness standard for both AOA and CYF populations. Staff participants in review sessions seemed highly aware of a three-day post-hospital standard. In some instances, it seems this standard could result in ongoing care consumers having an appointment rescheduled. The awareness of clinical staff for the time frame requirements associated with routine presentations was not universal.

- The MHP has a 30-day initial psychiatry access standard for both CYF and AOA populations. The data indicates means of 21.2 days for CYF and 11.1 for AOA. These figures did not reflect the recollection or experience of line staff participating in review sessions, who thought it was somewhat longer. Consumer and parent/caregiver focus group participants varied significantly in their responses, with some having short wait periods and others much longer.

- Timeliness reporting will likely be improved with the addition of EHR elements that support electronic, automated tracking and reporting. Urgent care tracking may also be facilitated by this addition. The current system of spreadsheet monthly data submissions will be replaced by a more accurate, automated process.

Quality of Care

- The MHP has an extensive QI/QA and compliance function that includes training, monitoring and performance improvement activities. The support of analytic partners at Optum and the UCSD provides the MHP comprehensive data analysis, including quarterly outcome measure reports relating to MHSA measures.

- The MHP's communication efforts are significant in scope and detail. Contract providers acknowledge the efforts made to obtain feedback and to improve communication. The scope and frequency of both internally and externally driven changes would potentially benefit from a process which provides the MHP with direct guidance of its service partners. Development of a provider-driven ongoing survey process could present a first step in better understanding the needs of contractors, particularly where it applies to updates or changes in procedures.

- Evident during this review cycle, the MHP continued to address gaps in service and deliver expansion of capacity. These activities improve the clinical continuum of care. The voice of consumers and caregivers heard during this review indicated an overall positive view of the quality and welcoming of the majority of programs and staff.

Consumer Outcomes

- The MHP summarizes the MHSA outcomes annually, and receives quarterly reports from UCSD on the AOA and CYF instruments. The data reviewed indicated a consistent high level of positive response to treatment by discharged consumers.
- Consumers who unitized the clubhouse services were very positive about the impact upon their lives. Not all consumers were aware of the programs.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted three 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 8 to 10 participants each, the details of which can be found in each section below.

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

Consumer/Family Member Focus Group 1

The requested focus group consisted of a group of adult beneficiaries the majority of whom have initiated services within the previous 6-12 months, conducted at the Chaldean and Middle Eastern Social Services (CMSS) Behavioral Health Program that primarily serves the Middle Eastern/Chaldean population, located at 436 South Magnolia Avenue, #201, El Cajon, CA 92020.

Number of participants: 18

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

- Initial access took no more than two months.

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

- All participants visit a case manager and also receive psychotherapy regularly.
- The participants are very complimentary about the staff of CMSS and feel treated as if they are family.
- During a crisis these consumers will contact the therapist or use 911. The linguistic challenges exist until they make contact the CMSS workers who can converse in their preferred languages.

Conclusions and recommendations:

- The largest challenge for these participants is the lack of interpreters when receiving care outside of CMSS, and includes when seeking physical health care.

- Participants are concerned that if they seek medical services, they might have to change psychiatrists because of the managed health care plans utilizing a provider network.
- Provision of early information when health care changes are occurring would be helpful so that the consumers could evaluate the options and consequences of possible changes.
- Information on housing and leasing and Section 8 housing is necessary for these individuals to understand concepts that are new to them.

Interpreter used for focus group 1: Yes Language(s): Chaldean and Arabic

Consumer/Family Member Focus Group 2

This focus group consisted of a culturally diverse group of Spanish-speaking parents/caregivers of child/youth beneficiaries the majority of whom have initiated services within the previous 6-12 months. This session was conducted at the Community Research Foundation Nueva Vista Program, 1161 Bay Blvd., Suite B, Chula Vista, 91911.

All participants were primarily Spanish speakers, but were sufficiently fluent in English to participate without an interpreter. These parents/caregivers were female and all had teenagers who were receiving services currently. One participant is a foster parent for six children, two are receiving services from the Community Assistance Support Team (CAST). Two others receive therapy from Nueva Vista, two others will be starting treatment soon.

Number of participants: 4

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

- The time from first contact to assessment ranged from three weeks to one month.
- The time to therapy was less than one month.
- The time to first psychiatry service varied from very fast for one participant, and more than one month for another, with longer to obtain actual medications.

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

- Response to services is generally very positive, with one parent noting improvement since services began.
- Another parent observed that medication and services have resulted in positive changes, and with referrals to other services also occurring.
- Another parent observed that therapy and support has helped the child make progress.

- For one parent, mental health referral information was obtained from a primary care physician, and another parent learned about services from a relative who works at a mental health clinic.
- No barriers to service access were identified by participants.
- Service frequency is weekly, reported all participants.
- Some of the parent/caregivers receive individual therapy for themselves.
- The frequency of psychiatry services is monthly, with one individual not starting these services yet. Psychiatry is considered beneficial by all.
- Half of the participants receive case management services, one is awaiting these services. The frequency is usually several times each month.
- All had crisis services knowledge. One participant needed crisis services, called the line, and received services quickly. In some cases, individuals may call the case manager when urgent needs arise, an option in addition to the crisis line.
- All participants experienced involvement with the treatment plan development process.
- The parents/caregivers understood the process involved for changing a clinician or a psychiatrist. An example of a successful psychiatrist change was given during the group, with a positive result. In all other cases, there was no interest in changing of clinicians or doctors in this group.
- The MHP's wellness services, locally in the form of clubhouses, were known to half of the participants, but only one participant had visited a clubhouse. Participants learned about these resources from their therapists.
- Assistance with transportation has not been needed by the group participants. However, staff do offer assistance if needed.
- With regard to meeting cultural and linguistic needs, the focus group participants state staff are bilingual, and no translation services have been required.
- Therapeutic Behavioral Services (TBS) has been utilized by half of the participants, one currently. The observation about TBS is that it takes a significant commitment of time on the part of the caregiver. Also, TBS can result in proliferation of coaches, at times too many.
- As to the information about services, one attends QPI meetings. None have accessed the MHP's website. All have participated in the MHP's survey process.
- One foster parent was unclear as to who must approve therapy and other interventions for the foster child.

Conclusion and Recommendations:

- These parents and caregivers were generally very satisfied with services, feeling the care was above and beyond what was expected. Children come home happy following therapy.
- Therapists teach the children many coping skills, which the parents learn about from their children.
- One program in the South Bay area was identified by the participants for an unsupportive approach.
- Services that help the parents/caregivers to manage their stress, such as massage, were suggested.

Interpreter used for focus group 2: No

Consumer/Family Member Focus Group 3

The requested session consisted of a culturally diverse group of adult Hispanic, Spanish-speaking beneficiaries the majority of whom initiated services within the previous 6-12 months. This focus group was conducted at the Community Research Foundation South Bay Guidance Wellness and Recovery Center, 835 3rd Ave., Suite C, Chula Vista, CA 91911.

Number of participants: 7

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

- Initial access took three days for an assessment session.
- The time to therapist first clinical appointment was three days.
- Initial psychiatry/prescriber access ranged from two days to one month. Follow-up psychiatry sessions occur on an every one to two month frequency.
- For those reliant upon public transportation, making the scheduled appointment was difficult and a few appointments were missed because of not being able to get to the clinic.

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

- Initial access to care was generally described as positive. Participants generally felt supported.

- Those who have been receiving long-term services felt positive about the care. Services have improved over the years, now including support groups and effective medications.
- Initial information about services has occurred through a variety of ways including friends, therapist, and a referral from crisis services.
- The frequency of therapist contact was split between weekly and monthly. Some would like to see their therapist more frequently than once weekly.
- All participants receive the services of a clinician, case manager, and psychiatrist.
- The majority participate in support groups.
- Regarding urgent or crisis needs, the majority know who to call and what to do. Several have a pre-established safety plan. When unsure, participants know they can go to an emergency department.
- About 20 percent have a Wellness and Recovery Action Plan (WRAP), and the majority knew of WRAP.
- None of the participants recall having received information about medication but would like it. Some have asked the psychiatrists for medication information. Some have researched on their own.
- Only one participant has needed to change therapist.
- These participants were aware of the clubhouse programs, with several having attended and coming away with positive experiences. Casa del Sol received a favorable mention.
- Transportation was identified as an issue for participants, with assistance provided, sometimes by staff.
- Linguistic access was not an issue for these participants.
- Information about services has been obtained from the MHP website by one of the participants. The remainder have not accessed website information.

Conclusions and Recommendations:

- All participants feel better for having received services, finding it helpful to have someone to talk to about problems.
- Greater stability in provider/practitioner, particularly in psychiatrist, is desired by these participants. They identify challenges with repeatedly telling one's story many times.
- Additional classes are desired, such as yoga, to help with breathing and focus.

- Participants mentioned frustration with other services, such as obtaining referrals through 211, programs being rude on the phone, and obtaining Supplemental Security Income (SSI).

Interpreter used for focus group 3: Yes Language(s): Spanish

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- The majority of participants receive psychotherapy, psychiatry and case management services. They did not identify any barriers to care.
- Frequency of psychiatry services ranges from every two weeks to monthly for most.
- Some parents and caregivers are provided a parent mentor to support the treatment.
- Many participants were aware of the clubhouses, but the programs were not utilized by many.
- Approximately half of the parent/caregivers reported receiving the support of TBS, and find this beneficial but time-consuming and may result in too many coaches at one time.
- Transportation assistance is offered, but not needed by these focus group participants.
- All who have needed interpreting services have received them.
- Nearly a quarter of the participants have a Wellness and Recovery Action Plan (WRAP) in place.

Timeliness of Services

- Initial access varied significantly among the various focus groups:
    - The Latino/Hispanic adult consumers experienced initial access times during the last year of three days at most.
    - Parents and caregivers reported initial access times ranging from three weeks to one month.
    - Middle Eastern consumers reported initial access times of approximately two months.
- The time to first therapy appointment ranged from three days to one month.

- Initial psychiatry access ranged from several days to one month or more.

Quality of Care

- Overall, all participants were highly satisfied with services.
- The parents and caregivers are very satisfied with services, noting that clinicians go above and beyond what was expected.
- Greater stability of providers with less turnover would improve care, particularly with psychiatry.
- The majority of participants are aware of clubhouse programs.
- Many of the participants would like to receive more education and information about the medication they are prescribed.
- All participants have been involved in the development of their own treatment plan.

Consumer Outcomes

- The majority of participants reported significant progress resulting from treatment.
- Parents and caregivers reported surprise and pleasure at the progress and resultant happiness of their children from therapy.

INFORMATION SYSTEMS REVIEW

Understanding an MHP's information system's capabilities 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.

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	7.04%
Contract providers	84.5%
Network providers	8.46%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): 5.8%

- ☐ Under MHP control
- ☐ Allocated to or managed by another County department
- ☒ Combination of MHP control and another County department or Agency

The budget determination process for information system operations is:

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 68

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

- ☐ Hiring healthcare professional staff locally is difficult
- ☒ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☒ To serve consumers temporarily residing outside the county
- ☐ Reduce travel time for healthcare professional staff
- ☒ Reduce travel time for consumers

Telepsychiatry services are available with English. Information on telepsychiatry services provided in other languages was not available at the time of the review, but the ability to track the language in which telepsychiatry services were provided was added to the EHR in July 2017 and that information should be available for future reviews.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
SDCBHS – 7	0	0	0

CalEQRO review are shown in Table 10.

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
53*	9	6	2

*Includes employees of OPTUM who perform data analysis work under a contract.

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

- The 5.8 percent of MHP budget reported as dedicated to information technology reflects a change in methodology since last the prior FY16-17 when it was reported that 3.3 percent of budget was spent for IT. It does not mean that there was a large increase in the funding available for IT. Since the IT resources used by the MHP are spread out over the County, the Health and Human Services Agency, OPTUM, and its EHR vendor, reporting only the percentage based on resources within the MHP MIS group doesn't provide the whole picture. This year's number is intended to reflect all MHP IT spending regardless of where it is spent.
- San Diego Behavioral Health near the top of the spending scale among California MHPs as a percentage of budget.
- Seven people identified as MHP technology resources initially appears low for a program of the scale of San Diego County, however, the MHP also receives technology services through the County (infrastructure, desktop hardware and support), the Health and Human Services Agency, OPTUM, and its EHR vendor. The MHP MIS group also supports the Substance Use Disorders program that uses a variant of the WITS application rather than CCBH.
- During the review there were no reports of IT being a bottleneck or otherwise constrained on resources. The training program appeared exemplary, there were abundant data analytic resources (and abundant reports produced by them), and a list of active projects that were substantial and forward-thinking.
- The MHP has a very substantial pool of data analysis resources that included MHP employees, OPTUM employees, and UC San Diego resources. The large pool of resources is consistent with the extensive use of data within the MHP to track care delivery performance, and identify and address gaps in the service delivery network.

Current Operations

- The percentage of MHP services delivered by contract provider increased from 74.1 percent in the FY 16-17 review to 84.5 percent in this review. The MHP stated that the budget had been expanded by $100M in the interim and that all of it was added to contracted services.

- Contract providers continue to do double data entry as there is currently no mechanism to electronically transfer information in the contract provider's EHR to the MHP's Cerner system.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner Community Behavioral Health (CCBH)	Client Data and Managed Care for billing /reporting	Cerner	9	CoSD
CCBH	Scheduler for appointment scheduling	Cerner	8	CoSD
CCBH	Clinical ATP Assessments	Cerner	7	CoSD
CCBH	Clinical ATP for Client plans and progress notes	Cerner	6	CoSD
CCBH	Doctor's Homepage e-Prescribing and meds management	Cerner	5	CoSD

Priorities for the Coming Year

- Complete SOW for interoperability with disparate provider systems utilizing ConnectWellSD
- Implement interoperability module Ultra-Sensitive Exchange
- Implement Electronic Prescription of Controlled Substances
- Implement, provide access, and monitor the Patient Portal
- Implement Access to Services Journal
- Implement roadmap of CCBH into Millennium
- Special projects (Data integrity monitoring, etc.)
- MHP is in final testing of the Service Journal that will provide much better data regarding timeliness of access to services when implemented at provider sites.

Major Changes Since Prior Year

- Implemented ConnectWellSD Phase I - Referral Management System Backend Connection
- Implemented Progress Note Rewrite
- Distributed signature pads (Note: This was reported as an issue in the last review and it is now resolved.)
- Implemented Client Attachments

Other Significant Issues

- After the ISCA was submitted for this report, the MHP put a new release of the Cerner Progress Note into production use. The MHP was a Test Partner with Cerner and had input into the changes to Progress Notes. The new module is still in the learning curve stage of the implementation, but is expected to be a more streamlined experience once mastered.
- Cerner Community Behavioral Health system is reported to be scheduled for transition by Cerner, although there are varying reports about the date. The identification of the MHP as a Test Partner for the integration of behavioral health into the Cerner Millennium (CM) product, which will replace CCBH, suggests migration to CM is Cerner's intent. The MHP is positioned to influence how behavioral health will function within the CM product.

Plans for Information Systems Change

- The MHP has no plans to change its current system vendor.
- The planned transition from CCBH to CM is more than a version upgrade; it involves migration to a hospital information system into which behavioral health functionality is being introduced as an add-on from a system designed specifically for behavioral health.

Current Electronic Health Record Status

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

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	CCBH		X		
Assessments	CCBH	X			
Care Coordination	CCBH	X			
Document imaging/storage	CCBH	X			
Electronic signature—consumer	CCBH	X			
Laboratory results (eLab)	N/A			X	
Level of Care/Level of Service	CCBH	X			
Outcomes	CCBH	X			
Prescriptions (eRx)	CCBH	X			
Progress notes	CCBH	X			
Referral Management	CCBH	X			
Treatment plans	CCBH	X			
Summary Totals for EHR Functionality:		10	1	1	0

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

- Service Journal now in final test with a target production use date of July 1, 2018.
- The latest Cerner release of Progress Notes is now in production use as of December 2017.

- There are still no lab results or hospital release documents posted to CCBH electronically. MHP states this functionality will arrive with the implementation of Cerner Millennium in 2019.
- The CCBH Personal Health Record module is in very limited pilot use primarily as a learning exercise, but the intent is for the Personal Heath Record (PHR) to be fully implemented when Millennium is installed rather than introduce something broadly now that they know will be changing very soon.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

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

☐ Yes ☒ No

Cerner Patient Portal - Intellichart

If no, provide the expected implementation timeline.

☒ Within 6 months ☐ Within the next year
☐ Within the next two years ☐ 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:

Excel or Access

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: San Diego MHP Summary of CY16 Short Doyle/Medi-Cal Claims							
Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
830,652	$157,381,265	**8,113**	$1,954,597	1.24%	$155,426,668	$1,753,980	$153,672,688
Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017. The statewide average denial rate for CY2016 was 4.48 percent. Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.							

- Denied claim rate was exceptionally low for the large number of submitted claims and number of county-operated programs and contract provider entities.

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: San Diego MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Other coverage must be billed prior to submission of this claim	3,258	$754,014	39%
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	2,060	$469,870	24%
Missing, incomplete, invalid ICD-10 diagnosis or condition	978	$371,866	19%
Total Denied Claims	8,113	$1,954,597	100%

- Denied claim transactions with reason "Missing, incomplete, invalid ICD-10 diagnosis or condition" are generally re-billable within the State resubmission guidelines.

Information Systems Review Findings—Implications

Access to Care

- The inability of the MHP to capture the language in which telepsychiatry services were delivered means critical information about non-English speakers' access to appropriate services is unavailable. The Service Journal implementation scheduled for July 1, 2018, should correct this gap in data. This is an item for follow-up in the FY18-19 EQRO.

- The recent innovation by the Access Center to establish secure Internet texting shows an astute awareness of potential consumers and their communication preferences. TAY eligibles especially are accustomed to communicating via texting and, so far, anecdotal reports suggest this has opened an important new channel for reaching potential consumers.

- There is a new Innovations project to offer tele-mental health services at the client's home as an option for people coming out of inpatient treatment, but who have not been seen as an outpatient within 30 days of discharge. This is a promising approach to

engage people who might otherwise fail to receive planned follow-up and relapse and require crisis or emergency department care.

Timeliness of Services

- The implementation of the Service Journal in July 2018 is expected to improve information available on timely access to services, including time from first contact with a service provider to the first offered and first scheduled appointment.

- The JV220 form is processed for children in foster care who are prescribed psychoactive medications. There is a multi-step review and approval process that is presented to the judge overseeing the case. Most approvals are completed within two weeks, but the process is known to take as long as eight weeks. The current paper process takes time and is vulnerable to lost or misplaced documents. Creation of an electronic JV220 process could offer the participants virtual access, and potentially reduce the review time to days rather than weeks, and reduce time to medication access. The state Judicial Council has been made aware that the process would benefit from the creation of an electronic process for the JV220, and it would take their involvement and approval.

Quality of Care

- Recovery-based treatment models, when they are successful, move people from higher levels of care to lower levels of care as they progress in their recovery. For many, this ultimately means a transition to continuing care by a primary care provider or an FQHC. This approach is most successful when information flows through the levels of care with the consumer. That is not yet the case in this MHP currently, but projects underway are laying the ground work for improved communication of clinical information between providers involved in a consumer's care.

- MHP reported an 87 percent increase in PERT calls Countywide and about 50 percent of those calls lead to hospitalization. In sessions involving clinicians or program managers, it was reported that clients are presenting with a higher level of acuity in recent years, in part driven by people presenting with dual substance use/mental health diagnoses.

Consumer Outcomes

- In general, MHP penetration rates are above the average for large counties and statewide overall. On the other hand, the average cost per beneficiary is low compared to peer counties and the statewide average and the number of sessions per beneficiary skews lower. While these process indicators provide useful information, a sharper picture would be provided if these were clearly tied to specific outcomes.

SITE REVIEW PROCESS BARRIERS

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

- The number of focus group participants for the two southern region events were less than requested, and might have improved with additional strategies.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- The MHP continues to focus on the acquisition and retention of prescribers, including psychiatry and psychiatric nurse practitioners.
- The recent expansion of crisis services reflects the MHP's use of data to identify an area of need and then acting on it to address the need.
- The two new programs for commercially sexually exploited children and LGBTQI+ youth are serving populations that have lacked specific and relevant services.
- The MHP has the resources to analyze data effectively across a range of subject areas and an organizational culture that is accustomed to using data to assess situations and guide decision making.

Opportunities:

- Feedback indicates continued need for more step-down beds that provide structure and services, at and below the level of crisis residential services.
- Access to psychiatric services in the consumer's preferred language continues to be significantly reliant upon interpreter services rather than bilingual speakers, particularly with all threshold languages. Currently the MHP is capturing the language in which a telepsychiatry session was conducted to capture the language needs, but its value will continue to be limited if psychiatrists with the appropriate language skills cannot be recruited and retained.

Timeliness of Services

Strengths:

- The MHP's initial access timeliness for the AOA service population bests the 8-day standard set by the MHP, averaging 3.8 days.
- The MHP utilizes a 30-day standard for initial psychiatric access. Both AOA, and CYF populations are better than the standard, with the AOA nearly one-third of that standard.

Opportunities:

- The MHP sets a very brief 5-day initial access standard for CYF, and averaged 9.2 days during this past year.
- The implementation of the Service Journal has the potential to provide more and better data about timely access to care, including better data about language preference.
- The MHP is evaluating contract provider reimbursement rates after 10 years or more without raising rates.
- The readmission rates for AOA increased by approximately five percentage points over the prior year. The efforts and resources to improve post-hospital follow-up with a PIP are well placed.

Quality of Care

Strengths:

- The MHP's quality management process is extensive and complex, with numerous elements all focused on improving quality and compliance. Data analysis is a core element of this process. A current focus on prospective risk analysis as a clinical tool for prevention of successful suicides reflects the MHP's concerns relating to reduction of negative outcomes.
- The MHP's partnerships with Optum and UC San Diego help to provide extensive analytic capacity and reporting, and provides easily understood information.
- Provider stakeholders identify the numerous mechanisms for communication that have been created by the MHP, including imbedded requests for feedback within email messages from the MHP. Participants also noted changes during the last year that added other options for input.

Opportunities:

- While communication efforts have improved, a significant feedback asserted that current methodology may not provide the best format for capturing key contract provider concerns. It was suggested that the questions do not help identify the challenges and recommendations of providers.

- A recurring theme is a need for greater attention to change management, and to carefully pace updates and compliance change rollouts that are experienced throughout the direct and contracted service delivery systems.

- Contract organizational providers would like end-users have greater participation in ongoing Cerner EHR forms development.

- Collaborative Documentation appears to be a promising practice that is currently at an early stage of adoption for directly operated MHP sites and is being encouraged at CP sites. Recommendation #3 from last year's EQRO Report suggested identifying ways to demonstrate consumer outcomes and improved timeliness of documentation as the result of Collaborative Documentation.

- Provider feedback indicates that their experience of high clinician and psychiatry turnover rates may relate to static contract rates for as much as 10 years, which may have an impact on quality of care. There were reports of employee turnover rates as high as 45 percent per year at some provider sites.

- Quality of care is facilitated when clinicians have timely and reliable access to the information they need to make clinical decisions. In a system of care so heavily dependent upon contract providers and with such a wide range of business partners, integration of clinical information across provider types and systems is the next major step to improving the efficiency and quality of service delivery.

- Although the MHP routinely tracks the number and type of EHR support calls, providers report system lag times, with entry being slow and crashes also occurring. They system slowness in generally considered a persistent and unchanging issue. The positive comments are that automated saves of work in progress are more effective with the latest releases.

- The MHP would benefit from the tracking of staff turnover and including this as an element of the QI Work Plan. It would be helpful to separately report AOA from CYF turnover, and separate directly operated results from contract organizational providers, also tracking by discipline of staff.

Consumer Outcomes

Strengths:

- The MHP's UCSD partners provide quarterly analysis of the MHSA related Data Entry System information.

- The MHP performed an analysis of Children's Functional Assessment Rating System (CFARS) outcomes for the annual Quality Management Work Plan Evaluation conducted for FY16-17. The results supported the positive outcomes that occurred from the PIP involving the use of Therapeutic Homework.

- The MHP is preparing for implementation of the CANS, which will be entered into the Cerner system starting in the Summer of 2018.
- Clubhouse programs and the newly developed drop-in centers for LGBTQI+ TAY consumers offer supportive services and improve potential for community re-integration with positive outcomes.
- Opportunities for paid employment for individuals with lived experience exist within many of the contractor operated programs.

Opportunities:

- The relationship between high penetration rates, lower cost per beneficiary, and number of sessions per beneficiary and consumer outcomes warrants further analysis to assess whether or not patterns persist across demographics or service modalities, and if they are linked to consumer outcomes. The MHP has a formidable array of process measures and they do respond when the process measures suggest something needs attention.
- Even though currently below the statewide average, the escalation in the percentage of high-cost beneficiaries (>$30k/year) may serve a useful topic for the MHP to closely monitor and track in order to determine if this is the result of planned or unplanned (crisis/emergency) service utilization.
- The absence of lived experience employees in directly operated programs merits deeper review and consideration. The prohibition on the creation of county positions for lived experience does not prohibit contract hired peers from being placed within MHP clinics. Other MHPs with similar challenges have successfully utilized this approach and therefore would benefit from review.

Recommendations

- Continue efforts to understand the communication issues with contract organizational providers and implement effective remedies for improvement. Consider the development of a provider-designed survey instrument which will identify the key topics and provide responses guidance to an improved change process. Consider increased contractor involvement in Cerner/EHR forms development and changes, with a focus on reduction of complexity.
- Continue to assess the impact of Collaborative Documentation on the engagement of consumers in treatment, including retention and improved treatment outcomes as well as timeliness of documentation.
- Along with reviewing contract provider reimbursement rates, evaluate the impact of reimbursement rates on quality and availability of care and retention of staff. A component of this would include tracking the turnover of personnel in, at minimum,

contract programs, tracking by discipline/license, as well as other key characteristics such a bilingual status.

- Prioritize system-to-system integration between the MHP and its contract providers to streamline documentation processes and provide better and timelier access to clinical information.
- Analyze the association between penetration rates, costs per beneficiary, number of servicers per beneficiary, and consumer outcomes to better understand the relationship between these indicators to system efficiency, quality and effectiveness.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (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 - San Diego MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Prescriber/Medical Session
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations & Quality
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services. (Sexually exploited/abused children and youth; Emergency Screening Unit (ESU)/crisis stabilization for children/youth)

Attachment B—Review Participants

CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer, Consultant
Gale Berkowitz, Quality Reviewer
Bob Greenless, Information Systems Reviewer, Consultant
Nosente Uhuti, Consumer-Family Member, Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

San Diego County Behavioral Health Services (BHS)
1 Father Junipero Serra Trail
San Diego, CA 92119

San Diego BHS
3255 Camino del Rio South
San Diego, CA 92108

Contract Provider Sites

Optum San Diego
3111 Camino Del Rio North
San Diego, CA 92108

Optum San Diego – Annex
3160 Camino Del Rio South
San Diego, CA 92108

Community Research Foundation (CRF)
Casa Del Sol Clubhouse
1157 30th Street
San Diego, CA 92154

CRF
Nueva Vista Program

1161 Bay Blvd., Suite B
Chula Vista, CA 91911

CRF
South Bay Guidance Wellness and Recovery Center
835 3rd Avenue, Suite C
Chula Vista, CA 91911

Chaldean and Middle-Eastern Social Services
436 South Magnolia Avenue, #201
El Cajon, CA 92020

Recovery Innovations International
3838 Camino del Rio North
San Diego, CA 92108

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Adams	Robyn	Assistant Program Director	CRF - IMPACT
Aguirre	Jessica	Team Lead/Supervisor	Telecare Pathways
Aguirre	Alfredo	BH Director	BHS
Alcorta	Miguel	SB Analyst	Optum
Anderson	Kathi	ED	Survivors of Torture, International
Arguelles	Brenda	Office Assistant	BHS
Badilllo	Bernice	Clinician Lead	County/SEBTT
Bailey	Michael	Medical Director	Optum
Beck	Christina	HHSA/CWS Policy Analyst	CIOS
Black	Charlene	Clinician, IMF	Child, Youth Family, CRF – MAST
Black	Elle	Program Manager	Incredible Families
Bonaparte	Deaundra	MHRS-Case Manager	Telecare Corporation
Boyle	Trey	Vice President	Community Research Foundation
Briones-Espinoza	Ana	Director of Finance & Operations OPS	Optum
Buland	Michele	Assistant Director	CRF- South Bay Guidance
Camacho	Ernesto	Pre-Licensed Therapist	Pathways Kickstart
Camerino	Eric	AAII	BHS
Carlisle	Brandon	Sr. Mental Health Researcher	CASRC
Carranza	Sandra	Lead Clinician	CRF – MSW RC

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Chairez	Leonor	PWB Liaison	BHS
Chan	Chevk Lam Billy	Case Manager	MHS North Star ACT
Clark Manson	Minola	Program Manager	Behavioral Health Education and Training Academy (BHETA)
Conlow	AnnLouise	Sr. MIS Manager	BHS
Cookson	Renee	Directory Community Development	National Alliance on Mental Illness (NAMI)
Cooper	Fran	BHDC	BHS
Dahdouh	Dasha	Research Analyst	BHS
Danque	Anselma	Assoc. Accountant	BHS
Eaddy	Yasmin	Clinical Lead Therapist	San Diego Center For Children
Ephraim	Veronica	Clinical Supervisor – APD	CRF – MAST
Esposito	Nicole	Asst. Medical Director	BHS
Evans Murray	Cara	BHPC	BHS
Fierro	Stephanie	Program Supervisor	MHS – N Star ACT
Finley	Sarah	PSRII/ASW	CRF – Senior Impact
Galvan	Michelle	Executive Director	Optum
Garcia	Piedad	Deputy Director, AOA	BHS
Gomez	Rosa	MHRS, IMF	Telecare Agewise
Gray	Jennifer	Lead Counselor	UPAC/ Addiction Treatment
Green	Mike	Program Manager	Child Welfare Services (CWS)
Gruss	Dawn	Data Analyst Training	Optum
Guevara	Christopher	AAJ BHS QI PIT	BHS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Guingab	Amelia	Principal Analyst	BHS
Gutierrez	Carlos	Research Analyst	BHS
Hansen	Stephanie	Admin Analyst	BHS
Hayes	Skylar	Manager of Reporting	Optum
Herrera	Angel	IMF/Therapist	FFAST-SDCC
Holder	Judi	Administrator	Recovery Innovations (RI) International
Jella	Steven	AED	SD Youth Services
Johnson	Veronica	Analyst	BHS
Jones	Kristi	Manager of Utilization Mgmt.	Optum
Jones	Steve	QM Program Manager	BHS
Kargacos	Jenelle	Clinical Supervisor	San Diego Center for Children
Kaufman	Mandy	Program Manager	PWB/BHS
Kemble	Derek	Administrative Analyst I	BHS
Kiefaber	Bridget	Team Lead/Supervisor	CRF – Senior IMPACT
Kim	Heeyoung	Program Manager	UPAC - CTC
King	Delona	Probation Officer	Probation
Kingkade	Maria	Program Manager	Psychiatric Emergency Response Team (PERT)
Knight	Betsy	Behavioral Health Prog. Coordinator	BHS
Koenig	Yael	Dep Director - CYF	BHS
Krelstein	Michael	CDO	BHS
Lance-Sexton	Amanda	Program Coordinator	BHS
Lang	Tabatha	Chief, QI Unit	BHS

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Lenier	Becky	CWS Supervisor	CWS
Loyo-Rodriguez	Raul	Dept. Budget Manager	BHS
Maccia	Dan	Vice President	Community Research Foundation (CRF)
MacDougall	Debbie	QM Supervisor	BHS
Maramba	Wendy	Chief, CYF	BHS
McGill	Debon	Manager	CRF
Miles	Liz	Principal Admin Analyst - PIT	BHS
Miller	Michael	Program Coordinator	BHS
Mockus-Valenzuela	Danyte	Prevention Planning Mgr.	BHS
Mohler	Edith	Administrative Analyst III	BHS
Morgan	Maria	BHPC	BHS
Mullen	David	BHPC	BHS
Mynderse	Barent	Director	Rady Children's Hospital
Nacario	Cathryn	CEO	NAMI
Nickelberry	Melinda	Deputy Director, Admin Services	BHS
Olaoshebilcan	Shola	Program Supervisor	UPAC – ATR
Paauwe	Karen	Clinical Director	Telecare Gateway
Palid	Anna	Chief CDO	BHS
Parson	Heather	QM Supervisor	BHS
Penalba	Chona	Principal Acct.	BHS
Penfold	Bill	Sr. IT Manager	Optum
Post	David	AAII	BHS
Preston	Kristie	Clinical Director	Optum

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Quach	Phuong	BH Program Coord.	BHS
Raby	Michelle	Program Manager	BHS-ECMHS
Ramos	Nilanie	Health Planning & Program Spec	BHS
Raymond	Rebecca	BHPC	BHS
Rendon	Hermia	Clinical Therapist	Southbay Community Services
Reyes	Laura	Program Director	CRF
Richards	Serena	Supervisor Utilization Management	Optum
Richardson	Linda	PR Off Dir	Next Steps-NAMI
Riedesel	Ava	Lead Clinician	MHS – North Coastal Mental Health Center
Rincon	Norma	Deputy Director	CWS
Rowe	Jeff	Supervising Psychiatrist	BHS
Rupp	Kristine	Lead Clinician	MHS BPSR VISTOI
Salazar	Holly	Assistant Director	BHS
Sarkin	Andrew	Evaluator	UCSD – HSRC
Scherr	Cherelynne	Director/Clinical Supervisor	South Bay Community Services
Scolari	George	Behavioral Health Program Manager	Healthy San Diego
Smith	Stephanie	Intake Coordinator	Incredible Families BHS
Southfox	Suzette	CYF Liaison Program Mgr.	NAMI San Diego
Stark	Tamara	VP	Exodus Recovery
Swaggerty	Delrena	Vice President	Mental Health Systems

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Taing	Kathleen	Pre-Licensed Therapist, IMF	Pathways-Cornerstone
Tally	Steve	Director, Research	Health Services Research Center (HSRC)
Terrell	Justin	Training Manager	Optum
Thornton-Stearns	Cecily	BH Program Coordinator	BHS
Tran	Phuong	BHC Admin Analyst I	BHS
Umanzor	Krystle	Admin Analyst II	BHS
Vleugels	Laura	Supervising Psychiatrist	BHS-CYF
Wheeler	Mary	CP of Clubhouse (CRF)	Community Research Foundation
White-Voth	Charity	BH Program Coordinator	BHS
Woods	Rose	Asst. Program Manager – Education & Training Academy	BHS
Yancey	Adrienne	MHSA Coordinator	BHS
Yates	Judith	Senior VP	Hospital Association of San Diego and Imperial Counties (HASD&IC)

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 eleven (*). 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 approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: San Diego MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	$611,752,899	$4,310
Large	1,778,582	67,721	3.81%	$318,050,214	$4,696
San Diego	260,420	11,748	4.51%	$44,275,380	$3,769

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

Table C2: San Diego MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	39,941	95.24%	94.05%	$117,815,828	$2,950	$3,612	62.81%	59.13%
>$20K - $30K	986	2.35%	2.83%	$24,118,303	$24,461	$24,282	12.86%	11.98%
>$30K	1,012	2.41%	3.12%	$45,647,939	$45,107	$53,215	24.33%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Diego	
PIP Title: Therapeutic Homework	
Start Date (MM/DD/YY): April 2016 **Completion Date** (MM/DD/YY): Spring 2018 **Projected Study Period** (#of Months): **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 1/9-11/18 **Name of Reviewer**: Rob Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP initiated a study on the outcomes of services and the duration of treatment in the CYF system of care. The resultant data created concerns for the MHP when compared to literature data regarding the amount of improvement usually seen from treatment. As a result, the MHP looked for approaches that	

would help improve treatment results and hopefully result in shorter lengths of treatment. To that end, the MHP examined the topic of therapeutic homework, an intervention aimed at improving the engagement of youth with their treatment. The MHP implemented this PIP and interventions in phases, starting with a pilot site that included 693 youth consumers.

The PIP involved the training of clinicians in the use of therapeutic homework, and various information systems changes to assist with capture and tracking of this activity. The outcomes were tracked by the Parent and Child Outcomes Instrument (PCAMS) which has both parent/caregiver and youth self-rating elements, which contains both internalizing and externalizing rating elements.

From the results of this PIP the MHP has determined to roll-out therapeutic homework on a systemwide basis with the youth population. The PIP will be completed in Spring of 2018.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP was reviewed by a youth advocated, who provided input.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP opted to focus on this issue after examining the changes reported by caregivers related to therapy with children and youth, which were rated as small to moderate improvement. (Effect size - FY11-12: d=.39 for internalizing; d=.49 for externalizing; FY 14-15 d=51, internalizing, d=.56, externalizing. The latter were slight improvements). The MHP considered literature and also provided training on evidence-based practices. The MHP was still not satisfied with the degree of improvement and sought to see its consumers experience a greater effect from therapy.

Select the category for each PIP:

Clinical:

☐ Prevention of an acute or chronic condition ☐ High volume services

☒ Care for an acute or chronic condition ☐ High risk conditions

Non-clinical:

☐ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Started with a pilot implementation including 693 and rolled out in 2019 to all children and youth programs.
Totals	**4** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will increased use of therapeutic homework following supervisor training precede a 10% reduction on the internalizing and externalizing Child and Adolescent Measurement System scales and a 10% decrease in length of time in treatment?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals	**1** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Youth receiving treatment in San Diego County.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP performed analysis of the pilot results and identified that the pilot and related sample had a higher prevalence of depressive disorders than exist in the overall MHP youth population.
Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Percent of sessions in which clinicians assigned therapeutic homework Parent Child and Adolescent Measurement System (PCAMS) - Caregiver report externalizing scale change score (discharge minus intake scores) PCAMS - Caregiver report internalizing scale change score (discharge minus intake scores) Treatment Length (Close date – open date) for discharged clients	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
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?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ 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)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

	Totals	**0** Met **0** Partially Met **0 N**ot Met **3** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? Online Clinician HW survey (*provider data*) Pilot Program Therapeutic Homework Tracking Form (Attachment II) Parent Child and Adolescent Measurement System Treatment Length (c*laims data*)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☒ Other: PCAMS, clinician survey about HW use	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Clinicians, family, length of treatment from EHR.
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?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☒ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☒ Other: PCAMS	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Emily Trask, Ph.D., Senior Mental Health Consultant, UCSD Tiffany Lagare, M.P.H., Research Assistant, UCSD Anh Tran, B.S., Research Assistant, UCSD Bill Ganger, M.A., Data Manager, SDSU Shellane Villarin, M.P.H., Research Associate, Rady Children's Hospital-San Diego	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals	**6** Met	**0** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *Adding "use of HW" to medical records review* *Adding "used HW" checkbox to progress note* *Presentations on the importance of using HW at CSOC, PM Meetings up to* *Provision of handout via email on importance of using therapeutic homework to all SDBHS clinicians and program managers the minute, SIT committee, training committees* *Online follow-up clinician survey on their use of HW* *Presentation on rationale for using therapy HW with pilot program clinicians* *Trained pilot program to track and enter therapy HW data in their data entry system* Year Two Provided pilot program support with completing and entering the homework tracking data Completed therapeutic homework training with pilot program supervisors Provision of app-based homework assignment list to pilot program supervisors and clinicians Follow-up consultation with pilot program supervisors Develop Systemwide Implementation Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: every six months data summarized. Indicate the statistical analysis used: Percentage and T-test Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	October 2016 to January 2017 February to June 2017 Statistical significance was not met due to slight amount of change.

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? *Limitations described:* **Changes in scores and length of treatment were not of sufficient magnitude for statistical validation.** *Conclusions regarding the success of the interpretation:* **While not statistically significant, positive change has occurred.** *Recommendations for follow-up:* **Continue to evaluate the results of HW as the numbers of consumers and clinicians utilizing it increase.**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals		**4** Met **0** Partially Met **0** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Determination of clinical significance is difficult to make at this time. Greater application of the HW intervention will be required before a conclusion.

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? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	**4** Met **1** Partially Met **0** Not Met **0** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Although not statistically significant, there has been an improvement is PCAMs scores and decrease in length of treatment.		
Recommendations: Continue application of the HW intervention to the broader youth treatment population.		
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 FY17-18 NON-CLINICAL PIP

GENERAL INFORMATION

MHP: San Diego

PIP Title: Client Engagement after Discharge from Psychiatric Hospital

Start Date (MM/DD/YY): April 2016

Completion Date (MM/DD/YY): Spring 2018

Projected Study Period (#of Months):

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY):

Name of Reviewer: Rob Walton

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 MHP was aware of the poor aftercare follow-up of individuals discharged from an acute psychiatric hospital stay who were not open to outpatient services at the time of admission. The initial change was to provide a specific aftercare appointment. They considered the rate of actual follow-up and readmission rates within 7, 30, and 90 days. The MHP added follow-up reminder calls to the process. This PIP involved piloting of the process at the MHP's Psychiatric Hospital, and once there were positive results, the plan became to extend to other contract/partner hospitals.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A multi-functional team was assembled for the purposes of developing and implementing the PIP, including subject matter experts and staff from the San Diego County Psychiatric Hospital (SDCPH), County of San Diego Behavioral Health Services (SDCBHS) staff members, clinicians and staff from select Outpatient programs, and contracted Research Centers. Additionally, we have recruited staff from the Innovations Program "Next Steps" to consult on the design of further interventions in the follow-on phases of this PIP. Next Steps is a program that works to increase linkages and engagements to services after discharge using Peer Specialists. Clients: Clients were interviewed from peer-based "Next Steps" program. Next Steps is a peer-based program that utilizes peer support specialists to facilitate linkages to services after discharge from inpatient facilities. As such, Next Steps staff have unique insights into the barriers to linkage encountered by clients discharging from hospitalization. Program staff: Program staff from SDCBHS programs. Clinicians: Clinicians from both the SDCPH and participating outpatient clinics. Hospital staff: Staff from the SDCPH included the Clinical Director, and both clinical and administrative staff.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Routine analysis of no-show data as well as review of client engagement patterns after discharge from SDCPH revealed the pattern. Additionally, as part of the previous PIP, a review of Serious Incident Reports demonstrated that among clients who committed suicide in FY 2013-14, a high percentage of these suicides occurred within 90 days of their last service received in the Behavioral Health Systems of Care. Analyses of SDCBHS client data revealed that upon discharge from the SDCPH only 26% (605/2,312) of clients who were new to the system, or who had previously been in the system but later had closed cases, connected with services within 30 days of discharge. This compares with approximately 45% of clients who were currently active in the SDCBHS system. Furthermore, the data before and after psychiatric hospital discharge for FY 2015-16 showed that 11% of connected discharges were readmitted within 30 days compared to 15-22% for those who did not connect with services. Additionally, non-connected discharges had an average of one more EPU or PERT service prior to admission compared to connected discharges since 1/1/15. High rates of readmission and emergency visits are linked to high costs of healthcare.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Assuring aftercare for hospital discharged individuals who were not connected with outpatient prior to the hospitalization.

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)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All hospital discharges not connected to outpatient at the time of admission.
Totals	**4** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the development of a standardized process for acute hospital discharged, new consumers (new to the system or not currently active with the SDCBHS) – which includes an aftercare appointment within three days of discharge and a reminder call – improve outpatient engagement by 10% to 30% and reduce readmissions by 10% to 30%?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals	**1** Met **0** Partially Met **0** Not Met **0** UTD	
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All individuals who were admitted to the MHP's Psychiatric Hospital and were new or closed at the time of hospitalization.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Individuals who have been in the MHP psychiatric hospital and discharged, and who were either closed at the time of admission or new to MHP services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The population was initially limited to the MHP's Psychiatric Hospital consumers with consideration of expansion to contract hospitals eventually.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Connection with services after discharge – 7, 30, 90 days Readmission rates – 7, 30, 90 days	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Follow-up and readmissions are indicators of outcomes.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 5: Review Sampling Methods		
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?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP describes the approach as sampling, however all individuals meeting the criteria of not open at admission are included. Therefore, it is not using a classic sampling approach to this population. Sampling could relate to all hospital admissions. For the pilot involved in this PIP, the MHP used a subset of all hospitals that serve the MHP's consumers. This is a more reasonable approach and will create more consistent testing of interventions.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ 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)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **3** Not Applicable **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	o Demographic information as follows: ▪ Age ▪ Gender ▪ Preferred Language ▪ Race/Ethnicity ▪ Educational Level ▪ Employment Status ▪ Insurance Status ▪ Living Situation ▪ Diagnosis ▪ Substance Use Diagnosis ▪ Treatment Level of Care o Connection with services after hospital discharge: This is defined as having a service at a SDCBHS outpatient or case management clinic within 7, 30 or 90 days after discharge. Readmission data for 7, 30, and 90 days after discharge.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: See far right	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Upon discharge, hospital staff will work with the new clients to make an appointment at one of three participating clinics servicing a broad geographic region. The clinic staff will keep logs (Appendix A) documenting clients' date of discharge and date of scheduled appointments as communicated from the SDCPH. These logs were submitted to SDCBHS on a monthly basis. The UCSD contractors used these logs to pull additional client information from the SDCBHS MHS, Cerner Community Behavioral Health (CCBH) system to look at the service utilization post-discharge. The information pulled from CCBH included demographics and a list of all services used. This method of data collection assures that the most accurate data is collected about all of the clients who participate in this PIP intervention.

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?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Each clinic used an Excel log to keep track of PIP intervention clients. Any issues related to the use of the logs were discussed during regular meetings with representatives from each of the three participating clinics, SDCPH, SDCBHS, and contractors from UCSD to assure accurate and consistent data collection over time. The information collected included: o Client ID o Client name o Date of discharge o Date of birth o Date of appointment Status of appointment (e.g., no-show, etc.)
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Excel spread sheets	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data analysis plan entailed: • Calculation of engagement and readmission rates for new clients as described in Step 5 above. • Analytic comparisons of demographics and other defining characteristics for new clients and existing clients during the PIP year. This will help determine if person-level characteristics (beyond status as an existing client) may perhaps differ between these groups. This will help explain unexpected or low-level results. Data was summarized, reported, and reviewed at least quarterly.
6.6 Were qualified staff and personnel used to collect the data? *Project leader: Liz Mile and Steve Tally* o Administrative staff at SDCPH: Psychiatric Social Worker Coordinator – Stephanie Sambrano, MS, LMFT; Mental Health Case Management Clinician – Nancy Nguyen, MSW. County-operated Outpatient Clinics: North Central Program Manager – Elene Bratton, MS, LMFT; East County Program Manager – Michelle Raby, LMFT; Southeast Program Manager – Diana Cobb.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**6** Met **0** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Providing an appointment to an appropriate service provider (along with specific contact information) to clients who are discharged from a psychiatric hospital (and are not currently active in the SDCBHS system). Once the appointment is made, providers will provide a follow-up reminder phone call and an informational flyer regarding the program.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The two key intervention elements were a specific follow-up appointment time at discharge, and a reminder phone call. Since this PIP is intended to have a significant impact, the MHP would have provided more improvement opportunities by creating a list of additional interventions that were identified and prepared for implementation, pending the results of periodic data review. Some of these added interventions could have been in the form of additional reminders – perhaps considering secure text messages if results were not as planned – or querying consumers about transportation needs and developing strategies to assist with that potential need.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP's response below: The data analysis plan involved the calculation of engagement rates. The comparison of rates and proportions by means of statistical methods and hypothesis testing was not a planned part of the process at this point due to the small sample size. However, it should be noted that given the outcomes for those clients who do not engage with the referred clinic (e.g., usage of emergency or jail services), the practical and clinical significance of any increased engagement is already evident, even if statistical significance is not attained.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: monthly tracking FY summarizing and reporting Indicate the statistical analysis used: Percentage Indicate the statistical significance level or confidence level if available/known: NA XX Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	MHP's analysis indicated insufficient numbers for statistical significance determination. However, improvement did occur. Noted was the decrease in rehospitalizations at 90 days in particular.
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? *Limitations described:* Limited numbers of participants *Conclusions regarding the success of the interpretation:* Promising practice *Recommendations for follow-up:* Continue extension of this practice to other hospitals and consumers	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP also performed follow-up of outcomes of those who did not engage and found that subsequent contacts were often with crisis or law enforcement.
	Totals	**4** Met **0** Partially Met **0** Not Met **0** NA **0** UTD

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
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? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Simple percentage, no statistical significance evident.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP's PIP is nearly completed but there remains another data review and summarization to occur in the Spring of 2018.

Totals	**3** Met **2** Partially Met **0** Not Met **0** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

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

Conclusions:

The MHP engaged in a set of logical actions to improve follow-up and reduce re-hospitalization following hospital discharge.

Recommendations:

Consider expansion of this approach to a broader population and all hospitals.

Check one:

☐ High confidence in reported Plan PIP results
☒ Confidence in reported Plan PIP results
☐ Confidence in PIP results cannot be determined at this time
☐ Low confidence in reported Plan PIP results
☐ Reported Plan PIP results not credible