FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

San Diego

Conducted on

January 10-12, 2017

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SAN DIEGO MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—32,923
- MHP Threshold Language(s)—Spanish, Arabic, Vietnamese, Tagalog
- MHP Size—Large
- MHP Region—Southern
- MHP Location—San Diego
- MHP County Seat—San Diego

Introduction

The Mental Health Plan (MHP) operates in the southernmost region of California, with complex urban and rural populations that include diverse languages, ethnicities, and immigrants. In addition to the threshold languages, there are a number of other language needs in which services are delivered. Both strengths and challenges are found in the circumstances that have nearly three-fourths of all services delivered by contract organizational providers. There are currently five Medi-Cal Managed Care Organizations (MCOs) that deliver mild-to-moderate behavioral health services with which the MHP contracts and coordinates; two more MCOs will be added at the beginning of FY17-18.

Access

The MHP contracts with Optum, a United Healthcare company, to furnish its access and crisis line service; manage the provider network, which has licensed clinicians and psychiatry practitioners; and provide data reporting and EHR training. Practitioner retention has been a long-term issue, particularly with contract providers, but of late, increasing with directly employed staff. Contract providers have faced long periods of no or very limited contract increases year over year, and cannot offer the salaries or benefits of county positions. This has worsened as local Medi-Cal health plans have implemented services to the mild-to-moderate beneficiaries, and have been able to offer higher salaries and more desirable working conditions to licensed staff. The MHP has engaged in service expansion in numerous geographic areas and, in particular, with high-risk consumers – the homeless, forensically involved individuals, veterans – and high intensity programming such as crisis residential and stabilization.

Timeliness

In most areas of initial access, the MHP has experienced a slightly longer wait times than found in the previous review. The efforts with Cerner to create a service journaling function is expected to improve accuracy and frequency with which various service data elements can be monitored. The MHP does place importance on the results of its monitoring.

Quality

The MHP has a long history of partnering with UC San Diego to assist with the interpreting and reporting of data findings, inclusive of outcomes, service delivery profiles and a wealth of other reports which are usually posted on the web and are available for general stakeholder perusal. As an MHP that extensively contracts out service delivery, the MHP is staffed to provide high level monitoring and interpreting activities.

Outcomes

The MHP has determined that evidence-informed service delivery approaches are, for most programming, the most effective way of achieving positive outcomes. In this manner, it is able to extract the benefits of evidence-based practices (EBPs) without the associated personnel training and fidelity assurance burdens that are typically required. Through the Performance Improvement Project (PIP) process, the MHP is currently targeting the use of Therapeutic Homework as an adjunct to an EBP practice and seeking to improve outcomes of care. In addition, its Collaborative Documentation represents another effort to improve the engagement of consumers in their care.

INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the FY16-17 findings of an EQR of the San Diego MHP by the California EQRO (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **eight Mandatory Performance Measures (PMs)** as defined by DHCS. The eight performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

[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) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when the MHP has either:
  - made clear plans, and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Maintain two active PIPs; one Clinical and one Non-Clinical. The MHP should consult with EQRO early in the process for technical assistance on topic development and methodology.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In April 2016, the MHP started its "Therapeutic Homework" Clinical PIP targeting Children, Youth & Family (CYF) services with improved homework utilization and improving clinical outcomes.

  Also in April of 2016, the MHP initiated a Non-Clinical PIP targeting "Client Engagement After Discharge From Psychiatric Hospital," which should improve linkage with aftercare and reduce acute hospital readmissions.

  - On several occasions since the prior review, the MHP sought and received consultation regarding the development of its PIPs.

- Recommendation #2: Implement the "*services journal*" to accurately track all "initial contacts", urgent versus emergency services, and "No Shows" to standardize timeliness measures. Publish the methodology (i.e. numerator, denominator and data elements used from the Health Record Layout for each timeliness measure) for each timeliness measure to support the proposed "1915(b) Data Dashboard".

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has been methodically moving toward the implementation of this recommendation. It is still in the process of implementation and will not be ready to roll out to end users until sometime in the summer of 2017.
  - The MHP has had to integrate a number of projects to enhance and expand EHR and reporting functionality that had to be taken into account for this project. Additionally, getting the project approved though County IT proved to be an extended process.

- Recommendation #3: Investigate and remediate the differing perceptions between MHP administration and service providers concerning the clinical and administrative benefits and liabilities of the current level of clinical documentation, data collections and outcomes tools used.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP convened a number of workgroups to directly address the existing workflow. Stakeholders reported delight that they were consulted and their expertise utilized to streamline the documentation workflow within the EHR and reduce unnecessary redundancy and inefficiencies.
  - The MHP has produced a streamlined treatment plan and progress note design as a result of these projects and has sent them to the vendor for implementation. As with the previous recommendation, this work should be able to be operationalized this summer.
  - While these projects set the stage for positive impacts, the MHP has further work to do examining the total amount of data collected during the therapeutic process. Of particular interest to multiple stakeholders is the elimination or reduction of all non-clinically oriented requirements. Further work with stakeholders will be important in this area to ease time constraints on front-line clinical staff.

- Recommendation #4: Investigate how to better use externally provided telepsychiatry to supplement psychiatric capacity. As models, the MHP could consider Office of the National Coordinator (ONC) for health information exchange) best practice recommendations and the experience of local peers like Kern to serve as guides.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - Currently, the MHP's telepsychiatry service use is primarily in the redistribution of existing capacity within its system of care. The MHP should be commended for how much of this it is doing. The MHP has yet to broadly explore the use of telepsychiatry resources for targeted service enhancement such as the provision of linguistically competent service brokered through an outside resource when internal resources prove insufficient. Given the significant number of languages that the MHP deals with on a regular basis, this would seem to be a logical next step.

- Recommendation #5: Move towards implementation of HealtheIntent (or ConnectWellSD if more appropriate) in collaboration with Optum, HHSA, Healthy San Diego, and Cerner, to create interoperability for referral and scheduling of consumers between the MHP and Healthy San Diego/FQHCs.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - While further work needs to be done, the MHP made significant progress with this recommendation. Evaluations and stakeholder processes led the MHP to select ConnectWellSD as the most viable option for its needs.
  - The MHP is currently in discussions with IBM about a solutions framework to interconnect the highly disparate fiscal, clinical, medical, and support systems data silos that permeate service provision in this large county. The process will likely be multi-year but the MHP has made significant headway to date.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS

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

- Access to Care
  - Assertive Community Treatment (ACT) expansion occurred in the last year, with an increase of 100 ACT/FSP slots. This expansion targeted the North Coastal and North Inland regions, which were determined to have inadequate capacity. Much of this expansion focused on the populations of homeless, co-occurring disorders, and recently jailed individuals.
  - The shortage of high-level resources in the North Inland region was addressed with the opening of a Crisis Residential program in Escondido, the seventh such program in the county. This program offers, for some, an alternative to hospitalization as well as a step-down from acute care.

- Timeliness of Services
    - The expansion of Psychiatric Emergency Response Teams (PERT) and the development of crisis stabilization and residential programs in underserved areas have improved access timeliness for crisis consumers.
- Quality of Care
    - Suicide prevention was promoted by the MHP/County through a broad information and awareness campaign called "It's Up To Us." Another campaign, targeting veterans and their families, called "Courage To Call," also targeted reduction of stigma and efforts to reach those post-service who have mental health problems.
    - Twelve countywide community feedback forums were conducted by the MHP in the months of August through October 2016. The specific focus of the 2016 sessions was CYF behavioral health, under and unserved populations, and care coordination. Another six focus groups were conducted which targeted previously identified stakeholder groups, including justice partners and consumers, Native Americans, and a southeast region group. The results of these sessions were compiled, analyzed and incorporated in MHP planning.
    - Affordable housing for the homeless was improved with the renovation of the downtown San Diego Hotel Churchill, a collaborative activity between the Housing Commission and Housing Development Partners, and resulted in the creation of 72 units.
- Consumer Outcomes
    - Seven full-time Employment Specialist positions were placed at a Clubhouse and the six outpatient clinics having the highest presence of consumers seeking employment.
    - Transition Age Youth (TAY) and adults and older adults with serious mental illness are experiencing greater supported employment opportunities through a Mental Health Services Act (MHSA) program called Noble Works.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following performance measures as defined by DHCS:

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

TOTAL BENEFICIARIES SERVED

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

Table 1—MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity
San Diego

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	126,671	19.3%	10,341	31.4%
Hispanic	290,168	44.3%	10,632	32.3%
African-American	41,968	6.4%	3,306	10.0%
Asian/Pacific Islander	77,885	11.9%	2,317	7.0%
Native American	2,698	0.4%	247	0.8%
Other	116,118	17.7%	6,080	18.5%
Total	655,505	100%	32,923	100%

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

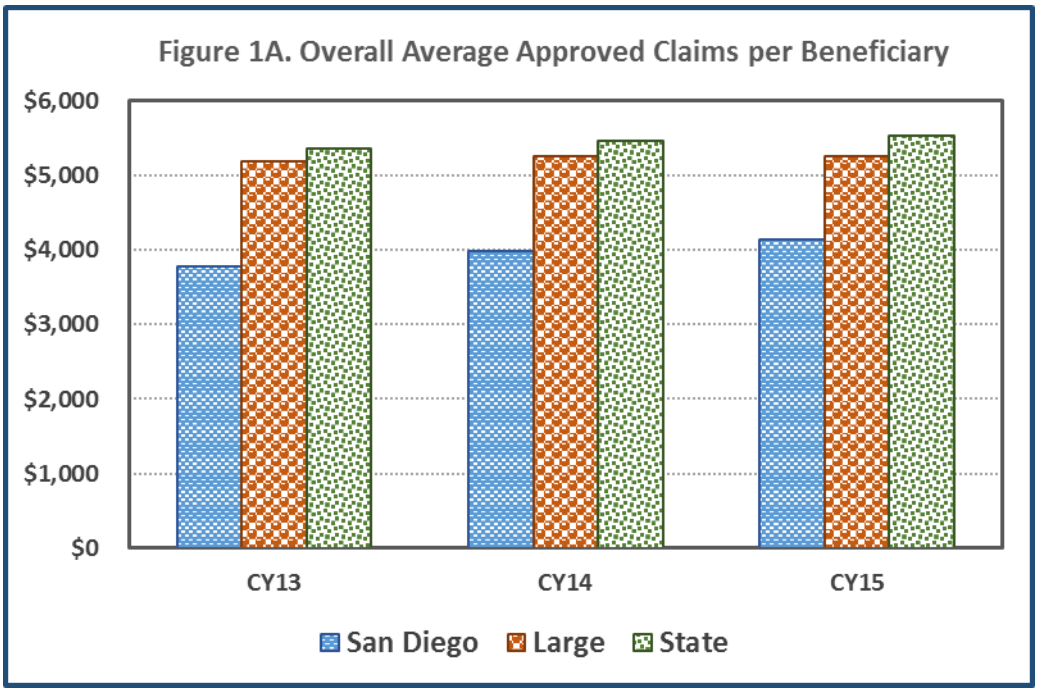
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

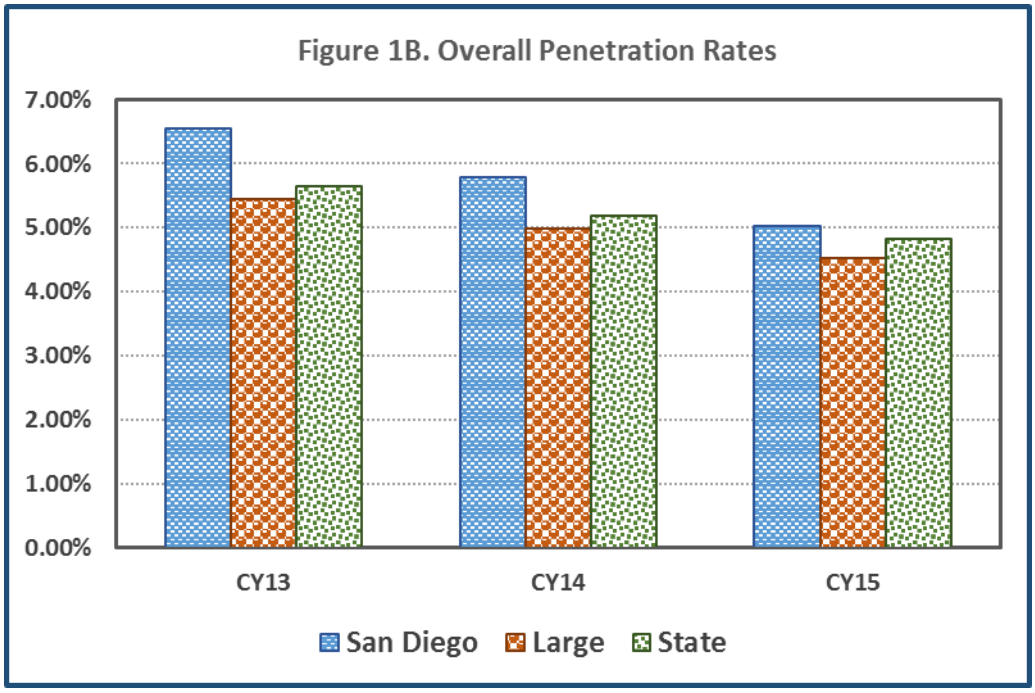
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

Regarding calculation of penetration rates, the San Diego MHP:

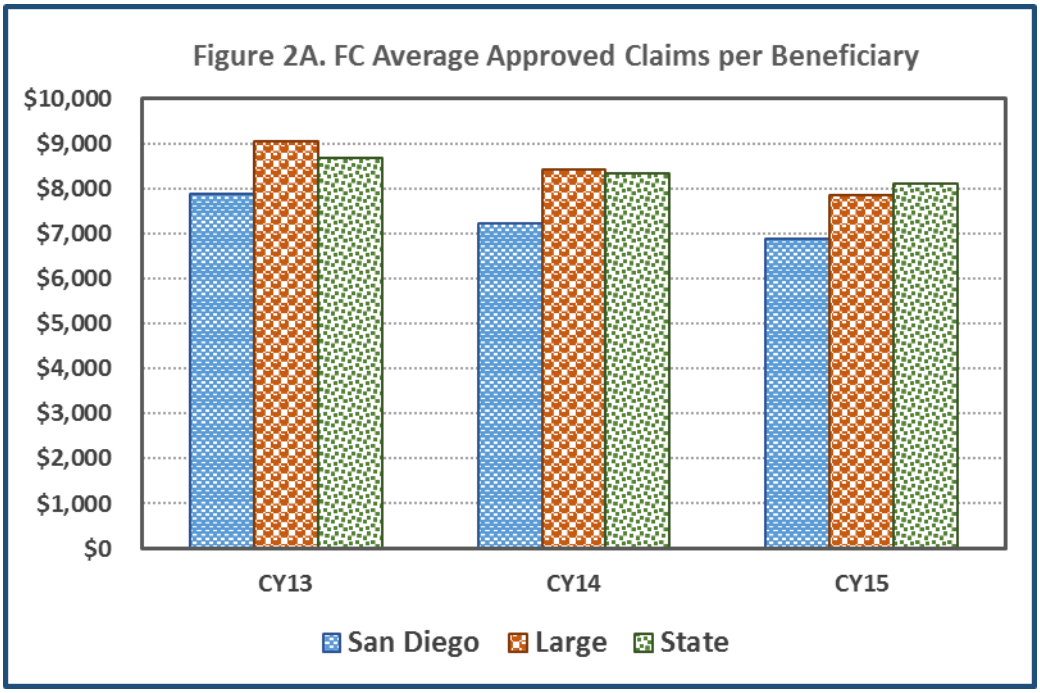
☒ Uses a different method: Every three years the MHP calculates its penetration rate data by using actual numbers of consumers served from its management information system (numerator) divided by the target population data as estimated in the California Health Interview Survey estimates (denominator).

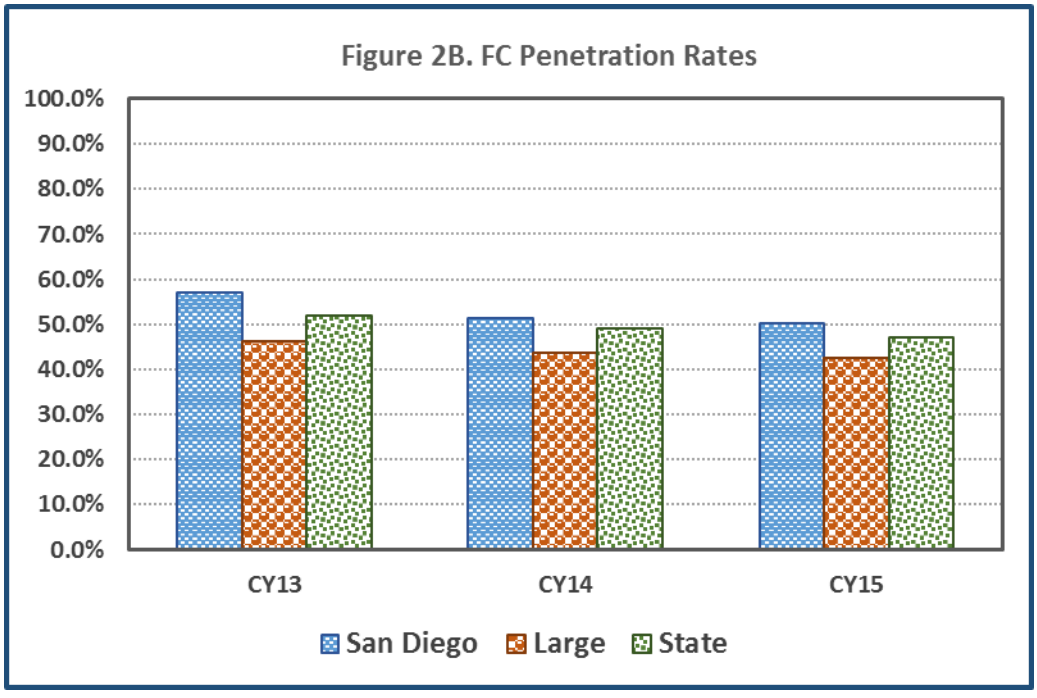
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



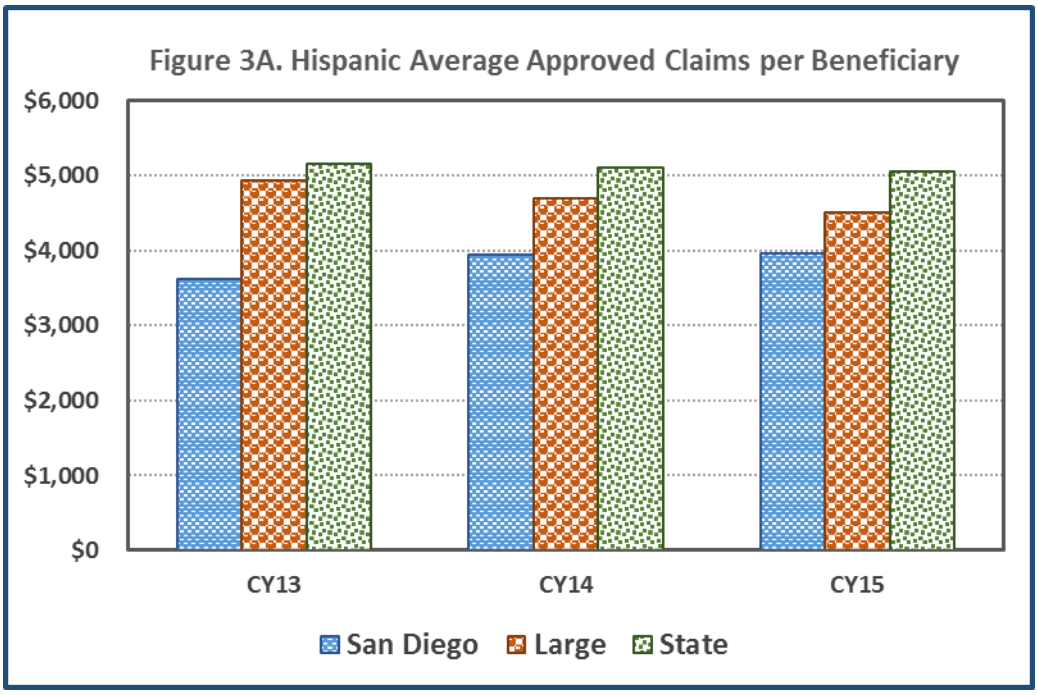


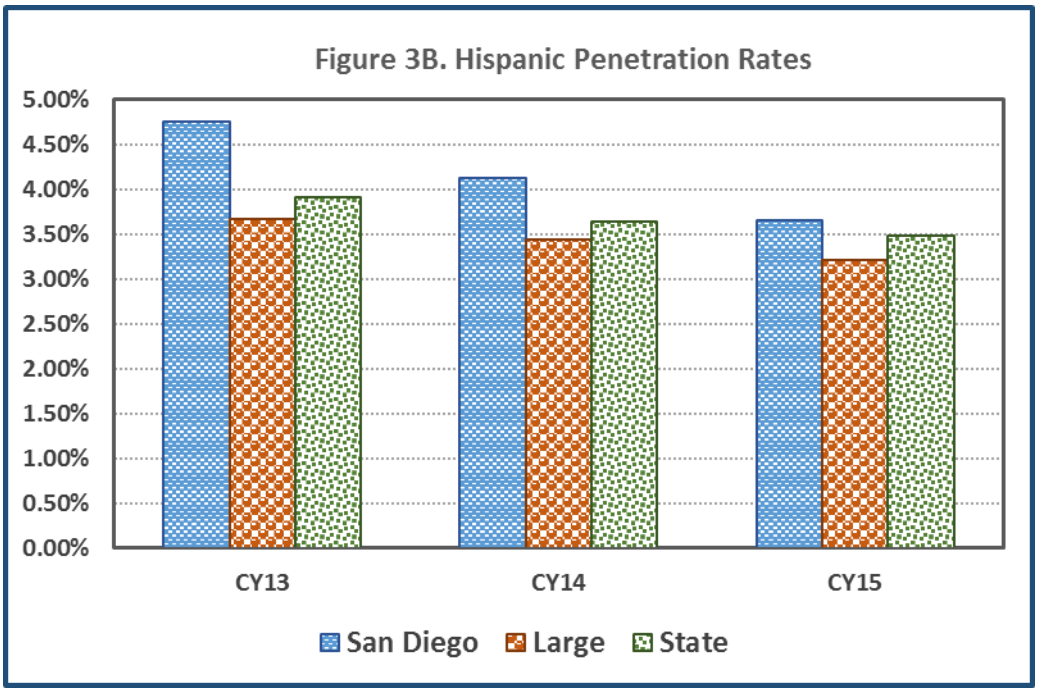
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





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





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

HIGH-COST BENEFICIARIES

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

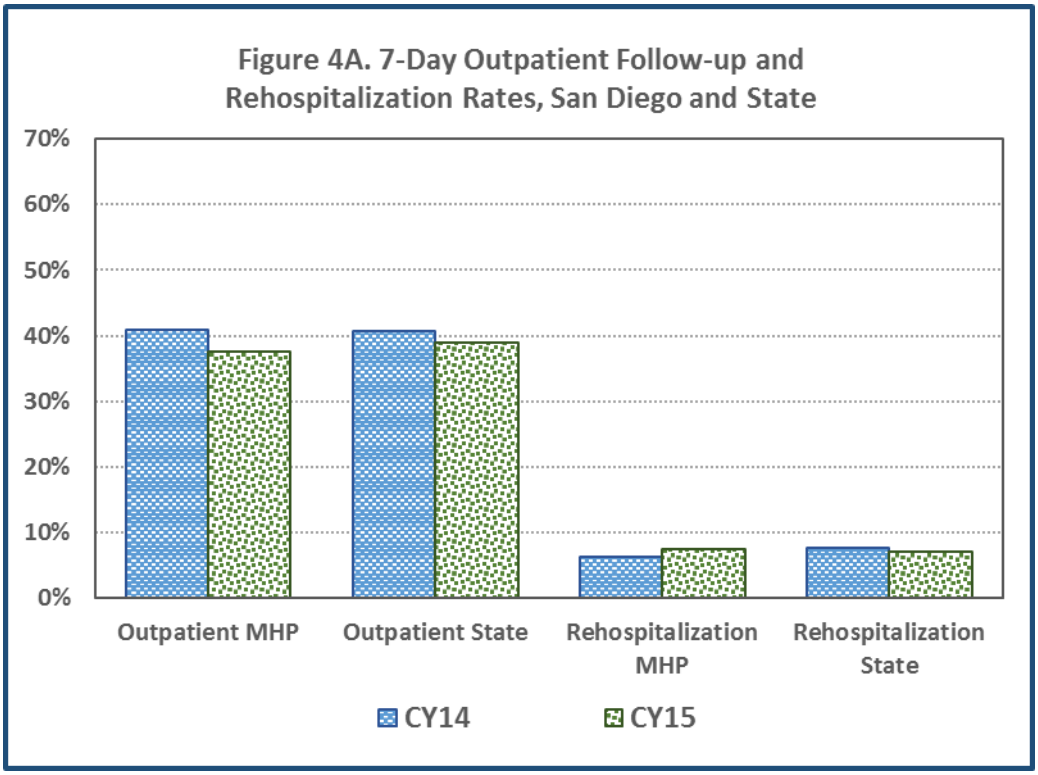
Table 2—High-Cost Beneficiaries

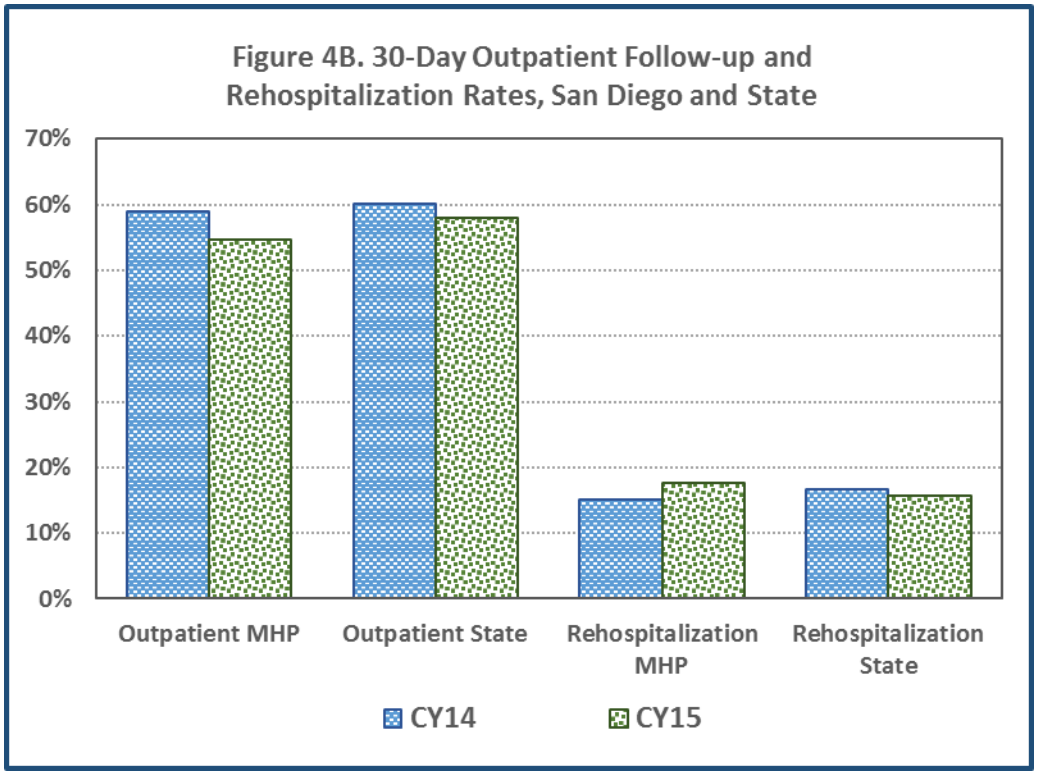
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
San Diego	CY15	721	32,923	2.19%	$45,642	$32,908,197	24.17%
	CY14	517	34,410	1.50%	$42,172	$21,802,775	18.12%
	CY13	635	34,248	1.85%	$44,301	$28,131,393	21.75%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.



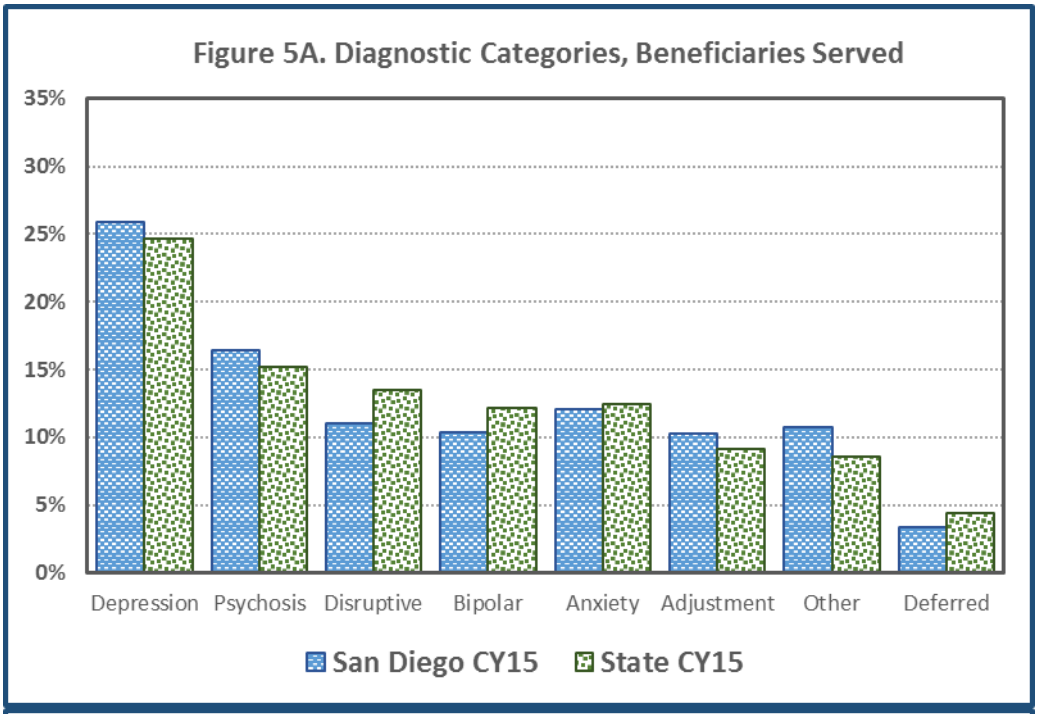


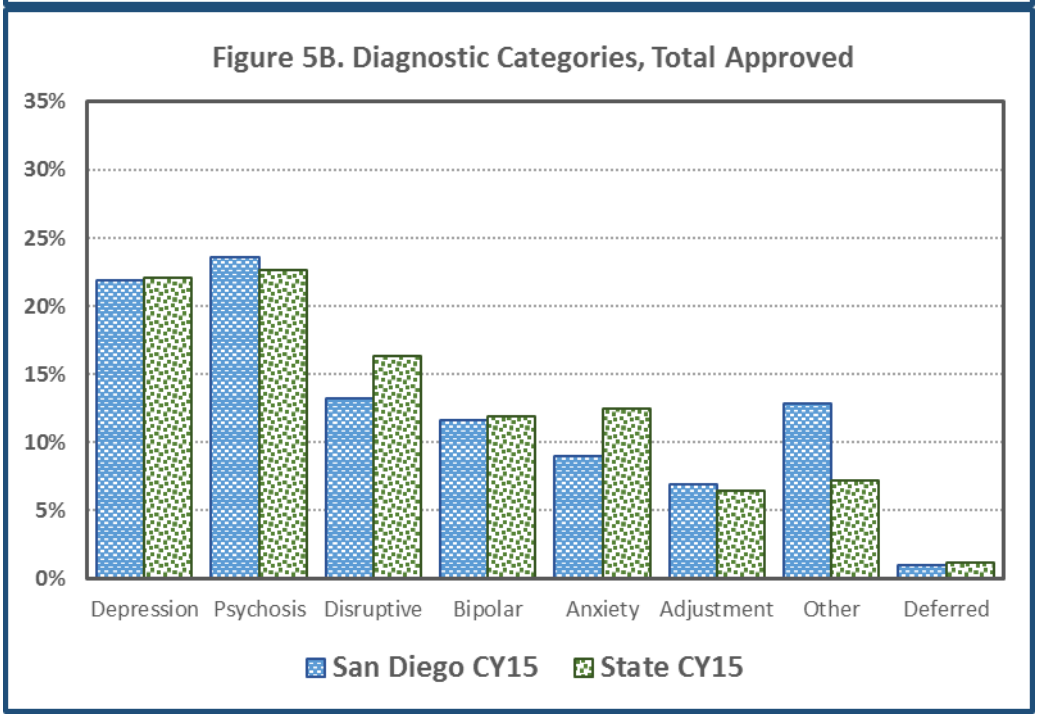
DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY15.

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

Children 5%
Adults 45%
Total 34%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - While the MHP's number of Medi-Cal eligibles rose from 599,543 in CY14 to 655,505 in CY15, beneficiaries dropped from 34,712 to 32,923 during this same period. This correlates to a drop in the penetration rate from 5.79% in CY14 to 5.02% in CY15. The MHP's CY15 penetration rate remains more than both the Large County (4.52%) and statewide (4.82%) averages.
    - The MHP's number of Affordable Care Act (ACA) eligibles for CY15 total was 132,182 and the beneficiaries served was 11,228, for a penetration rate of 8.49% for this sub-group (see Table C1 in Appendix C).
    - Combining the Medi-Cal and ACA data, the MHP's CY15 total eligibles was 787,687 while beneficiaries served total was 44,151 giving the MHP a CY15 overall combined penetration rate of 5.61%.
    - The MHP's penetration rates for foster care continue to be higher than other Large MHPs and the State average. Foster Care PR for all three cohorts appears to be declining at similar rates.
    - The MHP's penetration rates for Hispanic beneficiaries continue to trend above both Large MHP and statewide averages. As with the other PR categories a declining penetration rate also appears for Hispanic beneficiaries at rates consistent with statewide trends.
- Timeliness of Services
    - The MHP's 7- and 30-day outpatient follow-up rates are similar to the statewide averages.
- Quality of Care
    - The MHP's percentage (2.19%) of HCBs was lower than statewide averages (2.86%) in CY15, but had risen sharply from CY14 (1.50%). The Average Approved Claim per HCB was also significantly less than the statewide average but it had also risen from last year's low. (See Table 2)
    - While the MHP's Average Approved Claim per Beneficiary Served is trending slightly higher, it continues as lower than both the Large MHP and statewide averages.
    - The MHP's distribution of diagnoses is similar to that of the State, although it seems to use deferred diagnoses less often than statewide. The MHP's total approved claims in the Psychosis category is slightly above the statewide average and lower in the Disruptive and Anxiety Disorder groups.

- Consumer Outcomes
    - The MHP's 7- and 30-day rehospitalization rates were similar to that seen statewide during CY14-15.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

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—PIPs Submitted

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

Table 4—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating* Clinical PIP	Item Rating* Non-Clinical PIP
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	PM	PM
		1.4	All enrolled populations	UTD	M
2	Study Question	2.1	Clearly stated	PM	M

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	UDT	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	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	PM	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	PM	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	PM	PM
		8.2	PIP results and findings presented clearly and accurately	NA	PM
		8.3	Threats to comparability, internal and external validity	NA	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA

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

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

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

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	9	14
Number Partially Met	6	4
Number Not Met/UDT	2	0
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	17	18
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	70.58%	88.8%

CLINICAL PIP—THERAPEUTIC HOMEWORK

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

- "Will providing training on therapeutic homework result in a 10% increase in the use of therapeutic homework? Will the increased use of therapeutic homework result in improved client outcomes as measured by the Child and Adolescent Measurement System (behavioral/emotional symptoms) and length of time in treatment?"
- Date PIP began: April, 2016
- Status of PIP:

☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

The MHP identified that the treatment results for Children, Youth, & Families (CYF) consumers after six months of treatment with evidence-based treatments were small to moderate in FY11-12, and in FY14-15 remained moderate, not as high as would be expected. The MHP based its conclusion on studies that frequently reflect a moderate to large effect in some meta-analyses of Triple P.

The MHP determined that therapeutic homework (HW) is a common element of evidence-based practices (EBPs), and was not consistently utilized in San Diego. In the spring of 2016, the MHP conducted an analysis of the relationship between HW and outcomes. This study resulted in information that indicated better emotional and behavioral outcomes occurred with HW; caregivers also rated results of treatment higher with this additional intervention.

The MHP determined that it would initiate a Clinical PIP to improve the use of HW and also determine if outcomes improved in the local environment. This activity is initially limited to a pilot program in FY15-16 that impacted 600 unique individuals or 6% of total CYF served. This first element included (Phase I) system-wide education on the use of HW; in addition, adding an indicator to the progress note for tracking HW, and an element to aid the documentation review process. Supervisors were trained on HW (Phase II, starting January 2017) training of supervisors and then clinicians (Phase III, July 2017). The implementation is to expand with system-wide trainings on HW in Phase IV.

The MHP plans to report performance indicators of process: assignment of HW, all or most of time; outcome: caregiver report of disruptive behavior (reduction anticipated); outcome: caregiver report of depression or anxiety (reduction anticipated); outcome: length of treatment (reduction anticipated).

The interventions reflected preparations necessary to monitor if HW was occurring, the training of staff regarding HW, reinforcement with staff of the benefits and use of HW, and the training and tracking involved in supporting this activity.

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 and review of PIP feedback onsite. The MHP opted to submit an updated PIP following the review to reflect the input provided. The MHP did not set an outcome improvement goal in the study question, which needs to be corrected, but stated/included was a goal for the increase of the intervention, HW; however, it

did include the amount of disruptive behavior reduction and reported anxiety depression goals in with the performance indicator.

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 newly opened consumers or consumers who are not currently active with the SDCBHS – which includes an aftercare appointment within three days of discharge, a reminder call and other interventions as identified – improve outpatient engagement by 25% to 30% and reduce 60-day readmissions by 15% to 30%."
- Date PIP began: April, 2016
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year *(Not Rated)*

  ☐ Concept only, not yet active *(Not Rated)*

  ☐ Submission determined not to be a PIP *(Not Rated)*

  ☐ No PIP submitted *(Not Rated)*

The MHP is aware of a low engagement rate for post-hospital discharge consumers who were not open to outpatient services at the time of admission, compared to individuals who are open. Additional information comes to this topic from the review of incident reports and both successful and unsuccessful suicide attempts, and also in hospital readmissions. Only 11% of individuals who were open to outpatient services at the time of hospital admission were readmitted within 30 days of discharge, while 26% of those not open were readmitted.

The MHP reviewed historic studies and literature on the topic, and some of the outreach programs also interviewed relevant consumers. The transition from inpatient back to the community and the mechanism of follow-up was determined to have a key impact on this issue.

The MHP has identified the following interventions: An appointment within three days is given at discharge with a specific provider. This appointment is followed up by a telephone call to begin the engagement process. The MHP plans for this PIP to experience revisions and changes as information emerges from the process and other relevant issues and interventions are identified.

The tracked indicators include: the number of consumers who connect with outpatient follow-up within 7-, 30- and 90-days of discharge; the number of consumers who attend the scheduled 3-day

appointment following discharge; and lastly, the number of clients who are readmitted within 7-, 30- and 90-days.

The MHP initiated the interventions on August 1, 2016 and remeasured the data on December 1, 2016. Baseline data had shown that 28% followed-up with outpatient services within 90 days, and at remeasurement the results improved to 38%, a 10-percentage point improvement. The MHP did not provide the 7- and 30-day statistics yet, but has reported out the demographics of these individuals.

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 onsite discussion of the PIP with input from the EQRO review team. Since aftercare subsequent to discharge is a complex matter, the MHP would be advised to consider additional interventions beyond the basic elements of a specific appointment and follow-up call. This PIP is intended to be a multi-year, iterative process.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Efforts to assure that inpatient discharged consumers are linked with an appointment, and provided follow-up post-hospitalization are likely to reflect improved access to care, improve outcomes and reduce repeat hospitalizations.
- Timeliness of Services
    - Setting a goal of follow-up appointments within three days of discharge and providing follow-up calls are likely to improve engagement and timeliness of aftercare.
- Quality of Care
    - Therapeutic homework shows promise for improving the outcomes and effectiveness of treatment in the Children, Youth and Family services area. Caregivers report improved results, and the length of treatment may be reduced by making treatment a more involving process.
- Consumer Outcomes
    - Improved engagement in services as created by therapeutic homework has promise for improving consumer treatment outcomes and reducing the duration of treatment.
    - Consumer stability in the community and likelihood of rehospitalization are both improved by early post-hospital aftercare.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below.

Access to Care

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

Table 6—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP's CY15 approved claims penetration rate data indicates that it exceeds other large MHP and statewide data for all tracked ethnicities, with the exception of African-American, which is lower than the statewide average. The MHP also exceeds large and statewide penetration rates for all eligibility categories with the exception of "other child," which slightly lags the statewide numbers. The MHP's service delivery system is comprised of 13% directly operated programs, 12.9% network providers, and 74.1% contracted organizational providers. Providers have been identified to meet specific service area needs, including ethnic and linguistic issues, and as well meeting the needs of other sub-populations. The MHP operates with a Cultural Competence Plan (dated 2016) of 149 pages. The Cultural Competence Resource Committee meets monthly and consistently considers the disparity reports in their discussions. The committee includes MHP leadership and other diverse membership. The MHP's assessment document and process target cultural and linguistic needs, and most recently added spiritual needs. The MHP plans to adopt the Georgetown University cultural competence tools, and is using the Youth Satisfaction Survey (YSS) Consumer Perception Survey data that targets perception of cultural competence in service delivery. Annually, each program must perform a Cultural and Linguistically Appropriate Services (CLAS) survey, in order to identify current status and training needs. While the MHP's threshold languages are Spanish, Arabic

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			Vietnamese, and Tagalog, service needs in many other languages arise and are addressed. Recently, the needs of East African immigrants emerged as an area of need, with consideration of the development of a wellness center specific for this population. The MHP engages in reviewing the needs of regions through stakeholder meetings and other venues for providing input. It also tracks satisfaction with services as related to provision in preferred language, broken out by Children, Youth & Family (CYF) and Adults/Older Adults (AOA). The MHP Access Log (Optum operated) track the language and ethnicity of ACL calls and services; the MHP's programs track initial access to services at program sites. The MHP reports this and related information in the Annual QI Workplan Evaluation. The MHP runs a Special Population Report, for gathering other related data outside of race and ethnicity – such as sex/gender identity, trauma, and veteran status. The MHP is also examining a report on disparities, focusing on engagement and retention as reflective of cultural competence. Faith-based service outreach has recently been adopted by the MHP and has seen particular success in reaching forensically involved consumers. As part of the review, adding the language in which a service is delivered was discussed as a potential enhancement of the progress note, which would yield real-time linguistic information.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	Adjustments to capacity are a regular event for this MHP. During the current review period, the MHP established adult crisis stabilization services (CSU) in the North Inland and North Coastal regions of the county. This effort resulted in a contract with Palomar Health, for a six recliner (CSUs are not 24 hour/residential certified facilities and thereby recliners are the option most compatible with their certification type) CSU in the North Inland area; and a contract with Tri-City Medical Center for an eight recliner CSU serving the North Coastal region. In addition, PERT service expansion occurred, improving the number of mobile law enforcement paired with mental health worker teams, with 40 now in operation countywide. Numerous other modifications of the service delivery system occurred in order to assure access.
1C	Integration and/or collaboration with community based services to improve	FC	Collaboration is an inherent strong suit of this MHP, with 74.1% of services delivered by contract providers. The list of community partners is lengthy, and includes recent efforts to operationalize the contribution of faith-

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
	access		based organizations, law enforcement and housing agencies, and health delivery systems. There are numerous other examples of collaborations. Contractors include statewide entities such as Telecare Corporation and numerous local or regional providers.

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

Timeliness of Services

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

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP utilizes an 8-day standard for initial access to Adults and Older Adult Services (AOA), averaging 8 days (89% meet standard); and a 5-day standard for CYS, averaging 9.8 days (66% meet standard). This metric reflects the first clinical face-to-face contact, and is derived from an Excel based Request For Service log that is sent monthly by each provider to the MHP. Both values reflect slightly increased wait times over the prior review. The MHP has engaged in a variety of interventions to improve initial access, including the development of walk-in clinics and a prioritization process for those who have a high level of acuity, including post-hospital follow-up consumers, and those released from jail. The MHP is aware that their tracking in this area may have some inconsistencies and would benefit from an automated process. The MHP is working with Cerner to develop a "Services Journal," which will provide a platform for greater service data analysis, including time to second appointment, and capture of language, race and ethnicity. The MHP has considered the issue of establishing an initial time of contact for CYF beneficiaries, considering that referrals are often made by someone other than a caregiver who has the legal authority to consent. The MHP has evolved this tracking to use caregiver request as the anchor point, instead of outside referring person

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			who lacks authority to consent to treatment. Optum manages the Access Line for the MHP, and offers an innovative chat process during key working hours. This is an asset for reaching those with hearing impairments, TAY, and others who may be more comfortable keyboarding a request for service rather than speaking.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP utilizes a 30-day standard for initial psychiatry contact, with adults averaging 7.2 days (93% meet standard) and children & youth averaging 22.9 days (68% meet standard). It is noteworthy that consumer focus group participants' feedback corresponded to the timeliness data reported by the MHP. These numbers reflect an increase in wait time for initial prescriber contact for both AOA and CYF populations. The MHP is aware of the challenges that occur in this area, and have created walk-in clinics to offer those with an immediate need the chance to have both a clinician and psychiatrist appointment in close proximity to the initial contact. However, the walk-in solution is not available to those who present with a routine service need. Broad review feedback indicated that timeliness of initial psychiatric access is challenging, and merits further improvement efforts. Many of the issues require actions to improve prescriber recruitment and retention, perhaps including greater focus on positions for physician assistants and psychiatric nurse practitioners, and perhaps expansion of the walk-in clinic function to more regions.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP's urgent care standard is three days. AOA services average 1.2 days (100% meet standard) and CYF 2.0 days (95% meet standard). Children in crisis have a response standard of within one hour. Both metrics show an improvement over the prior review. The MHP has a prioritization process which identifies individuals who were discharged from inpatient, crisis stabilization or residential, high-risk presentation individuals such as suicidal/homicidal, severe psychotic symptoms, as "must see/urgent" within 72 hours of initial contact.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	Acute care follow-up is a very complex matter for this MHP. There exist 10 fee-for-service hospitals with acute psychiatric inpatient units, and one county unit, presenting complex coordination and follow-up issues. Furthermore, concurrent inpatient review is performed

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			by Optum, an MCO. Communication between inpatient and access/outpatient is complex and inconsistent with the private hospitals. The efforts to create health information sharing infrastructure may improve this communication over time. The MHP has made extensive efforts to improve the engagement and follow-up after hospital discharges. This includes Next Steps, incorporating peers who go into the county hospital and initiate contact prior to discharge. Challenges have also been uncovered with oversight reviews setting the medical necessity bar so high for children and youth acute care as to result in what is seen as premature discharge and undue subsequent readmissions. There are monthly meetings with hospital representatives to examine systemic issues. Within AOA programs, there are meetings with adult unit discharge planners. The MHP reports an experience of 10,712 total admissions to which a 3-day follow-up standard is applied. AOA services meet standard 50.5% of the time, CYF at 56.3%. These numbers reflect a decrease in 3-day follow-up percentages for both AOA and CYF consumers. This issue has become the target of a current Non-Clinical PIP. The MHP further analyzes this data by tracking and reporting 0-3 day and 4-7 day results to support a deeper understanding of the findings.
2E	Tracks and trends data on rehospitalizations	PC	The MHP's 30-day readmission rates are 20.63% for AOA services, and 13.28% for CYF. This is also an area the MHP has targeted for improvement with a PIP, which is focused on the engagement and follow-up of adults who are not open to outpatient services at the time of hospitalization. Total AOA and CYF admissions reflect a dramatic increase between the FY15-16 review and current data. This amounts to a 332% admission increase for adults and a 182% increase for CYF.
2F	Tracks and trends no-shows	FC	The MHP tracks no-shows for both psychiatry and non-medical clinicians. Within AOA non-psychiatry no-shows are 5.4% and 3.4% within CYF. For psychiatry services, AOA experiences a 15.9% and CYF 8.3% no-show rate. Non-psychiatry clinician no-shows were similar for both AOA and CYF this year compared to the prior review. Psychiatry no-shows increased slightly year over year for both AOA and CYF populations.

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

Quality of Care

As shown in Table 8, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8—Quality of Care

Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP operates with a very detailed and comprehensive Quality Improvement Work Plan. Analysis of the FY15-16 Work Plan results is an informative and easily understood document. Most of the MHP's quality metrics are posted online and available to interested constituents. The QI process is firmly integrated with contract monitoring and compliance activities. The use and examination of data is extensive, as is the very positive partnership with UCSD staff for data analysis. Examples of improving quality include the implementation of collaborative documentation, a process seen to improve engagement of consumers with treatment and integrate documentation with service delivery.
3B	Data are used to inform management and guide decisions	FC	Woven throughout all of the MHP's activities is extensive and often innovative approaches to data analysis. An example is the goal to track engagement and retention, going beyond the parameter of simple initial access timeliness that is awaiting the completion of a Cerner enhancement. Each provider contract has a unique set of data reporting requirements, contract compliance requirements and operational requirements such as the YSS, CANS, and MORS instruments.
3C	Evidence of effective communication from MHP administration	FC	Effective communication has inherent challenges in a system that contracts out 74% of services and possesses the MHP's scale of operation. As related to agencies, the Contracting Officer Representative (COR) is a key participant in this process. Each COR may utilize a unique approach and has latitude in interpreting the changing compliance requirements. An example identified was that of the

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			Tobacco Cessation priority of the county, which has various status levels imbedded in the contract monitoring tool. Many providers understood this review was not started yet, but some have been given corrective feedback on these items by their CORs in advance of the rollout timeline. Positive changes have occurred, including the recent addition of feedback option when receiving emails from the MHP. Not all are clear how this tool was intended to be used, but are appreciative of the option to provide feedback. It merits noting that the MHP did engage in activities to improve communications during this last year, which were acknowledged by contract providers. The MHP also provided evidence of extensive advisory groups, staff feedback meetings, with peers meeting together every two months in six service regions. The Optum website is used to post information for public consumption. Contract providers have a subgroup for discussion of QI related issues. The Clinical/Medical director has created a new process to make the clinical standards committee a revitalized format, which involves contract providers co-chairing the meetings. The MHP's mechanism for bidirectional communication with staff not at the leadership level seems reliant on program directors. While it is a common practice to use this conduit to pass information on regarding procedural changes, the MHP might benefit from periodic direct and anonymous surveys of line staff in all contracted and directly operated programs in order to assure there is an awareness of all issues.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	The MHP has both a process for and produced evidence of system-wide stakeholder input sessions during the review period. However, many of the line staff and consumer and family members interviewed during this review had not experienced a sense of involvement or opportunity to provide input on potential system changes. The review sessions indicated that supervisors, mid-level managers and community groups have regular meetings to provide input on system operations and needs. Contract providers have also had specific sessions to provide input on changes, although many of these are individual sessions to review specific contracts.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			There do not seem to be regular processes that obtain input, such as through an annual survey of all direct and contract staff, and then present the data back at a regional level. Perhaps the established meetings would be enhanced by developing a co-presentation process including the participation of regional line staff.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	The MHP's service delivery system heavily emphasizes partnering with existing mental health providers and other agencies, including the faith-based community. Other partners include Telecare and its Recovery, Transitions, Props and Pathways programs; Fred Finch; UCSD psychiatry; Exodus Recovery; Palomar Family Counseling, and the YMCA Tides program. The PERT services involve work with local law enforcement agencies. The new CSUs involves partnerships with private hospitals in the Northern county regions. Optum provides the Access Line service, utilization review of acute hospital stays, manages the provider network, and provides electronic health record training, among other activities. The programs funded by MHSA dollars that are not Medi-Cal reimbursed services comprise an exhaustive additional list of additional partners. Other public agencies have key relationships as well, including the court system, law enforcement and social services.
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP demonstrates continued focus upon levels of care and service needs throughout the continuum of care. An example of this process is found in the addition of crisis stabilization units, intended to augment and where possible divert individuals from acute care. The MHP largely provides evidence-informed practices, finding challenges in sustaining the training, certification and fidelity requirements of dedicated evidence-based (EBP) approaches. The MHP believes that gains from the key aspects of EBPs can be realized without full fidelity. However, some programs such as Assertive Community Treatment (ACT) programs and others do follow the models and randomly perform fidelity tests. The MHP performs medication monitoring reviews of all programs that utilize prescribers, in many instances contract providers perform this function. Issues identified are brought to the attention of the relevant prescribers.
3G	Evidence of individualized, client-driven treatment	FC	The MHP utilizes wellness and recovery principles, including a significant and increasing use of peer

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
	and recovery		employees in various roles, numbering at least 140. Contract agencies hire peer support specialists to fulfill a multitude of roles, such as crisis and post-hospital follow-up.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	Within the contract agencies, and particularly at Clubhouse and Wellness programs, consumer and family members have specifically designated positions, with some occupying supervisory positions. These individuals acknowledge that support exists for them to advance in their positions. Furthermore, the system also provides supported employment for those who seek work outside of the mental health system or wish to develop their own business. Designated consumer/family member positions are part of the executive or management team through liaison contracted positions. A defined career ladder is not formally present system-wide, but may exist in some but not all providers. Within the MHP's contractors Peer Support Specialists receive 75 hours of classroom and an internship. This MHP, like some other ones, has concerns over the creation of positions with the formal label of consumer and requiring individuals to self-disclose, feeling that this could be stigmatizing.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The MHP contracts for one comprehensive clubhouse called the Meeting Place, which operates a kitchen, provides education and employment programming, diet and fitness activities, among other options. There are 14 total clubhouse programs, the others which focus on employment, education and socialization activities.
3J	Measures clinical and/or functional outcomes of consumers served	FC	The MHP performs extensive tracking and analysis of level of care indicators that are rolled up once a year and presented in separate reports for Children, Youth and Families (CYF), Adults and Older Adults, and MHSA indicators. The instruments include the Milestones of Recovery Scales (MORS), administered every six months or more often when indicated; Recovery Markers Questionnaire; and for older adults the Illness Management and Recovery (IMR), which is also periodically summarized by provider. The CYF indicators are numerous and may relate to specific funding streams and EBPs. The summary documents are available on the web and are clear and easily understood by stakeholders.
3K	Utilizes information from	FC	The MHP provided results of the May 16-20, 2016

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
	Consumer Satisfaction Surveys		adult and older adult as well as youth & caregiver consumer perception survey. The adult surveys indicated 89% of consumers agreed or strongly agreed with the general satisfaction domain. The MHP notes that scores are slight lower in the Spring 2016 survey across all domains when compared to the Fall 2015 survey, except for the perception of functioning. Native Americans had higher mean scores and were highest of all racial/ethnic groups. Older adults comprised the most satisfied age group surveyed. The survey capture rate was impressive, with 83% of individuals receiving a service during the survey period completing a response. This information is broken out by provider and furnished to each program. The Youth Satisfaction Survey (YSS) was also analyzed in a similar manner, and indicated improvements. Parent/caregiver scores were at 80% for all survey items. It is important to note that the MHP creates standalone documents for each of the surveys, and provides analysis of completion and actual item results percentages.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Penetration rates, for most parameters, exceed other Large MHP and statewide averages.
    - Continued efforts to improve access in underserved regions are reflected in many different initiatives, ranging from addition of crisis stabilization programs in the North Inland and North Coastal regions, and expansion of PERT units for crisis response.
    - Monitoring of cultural and linguistic needs is an ongoing process, supported by annual evaluation of each program. Extensive tracking of interpreter use is part of this process.
    - The Optum-operated Access Line offers access to information about services via chat during peak call hours.

  - The continual turnover of licensed clinicians and prescribers, who are seasoned and experienced staff, directly impacts service quality and continuity for beneficiaries.
  - Collaboration with community agencies is a core practice of the MHP, with 74.1% of services delivered by contact providers, and includes a recent focus on faith-based initiatives.

- Timeliness of Services
  - Initial access standard for Adults and Older Adults is 8 days and is met 89% of the time; the Child, Youth and Families standard is 5 days with 66% meeting standard, and an average of 9.8 days. This metric tracks actual time to clinical face-to-face. Both metrics reflect a slightly increased wait time over the prior review.
  - Initial psychiatry contact standard is 30 days, with AOA averaging 7.2 days and CYF 22.9 days. These numbers reflect a slight increase in wait times; however, the adult access average time remains short.
  - Post-hospital follow-up remains a challenging matter for the MHP, complicated by the ten private hospitals that furnish acute care in addition to the directly operated inpatient unit. This area has been targeted with a PIP for improvement.

- Quality of Care
  - The MHP initiated numerous regional and targeted focus groups for input during the last year, providing needed information about service needs.
  - The MHP partners with UC San Diego for data reporting activities, which results in an impressive array of system reports that are routinely run and posted online in the public view.
  - The development of complex and ongoing communication strategies is a significant issue for an organization that has more than 74% of services delivered by contract agencies. It is evident that this MHP has made efforts over the past review cycles to improve communication, which current feedback confirms and identifies improvement. More effort in this area seems to be indicated, particularly efforts to obtain input directly from line staff of all programs, and provide analysis and feedback to participants.
  - Monitoring and evaluation of programming is one of the key responsibilities of the MHP, which oversees significant contracted services. The COR is a key link between the MHP and the contracted provider. This individual must translate and interpret changes in contractor expectation and requirements. In some areas, such as medication monitoring, the delegation of review functions is delegated to the contractors and the MCO Optum. Because this process is not supported by a ubiquitous health information exchange process, MHP medication monitoring surveillance can become incident-based rather than proactive review.

  - Consumer employment is significantly utilized in an expanding role, with the expansion largely at the contract provider level, and with the development of career ladder elements spearheaded by Telecare Corporation.
  - Outcomes and other summary data related to service delivery are aggregated and posted to the web through collaborative efforts of the MHPs, its providers and UC San Diego. The posted material is extremely visual and easily understood.

- Consumer Outcomes
  - The MHP incorporates Mental Health Services Act reporting requirements, the MORS and many other either EBP related or locally identified measures to produce information about outcomes. The resultant data is incorporated into annual reports for CYF and AOA services. This information provides in-depth and very complete analysis.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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 first focus group consisted of adult Hispanic consumers with the intent of the majority initially accessing services within the prior 12 months. This session was conducted at the MHP's main offices, 3255 Camino Del Rio South, San Diego California, in the Del Mar Room. Six participants were involved in this session, which also involved the assistance of an interpreter.

Number of participants – Six

For the six (all) participants *who entered services within the past year*, they described their experience as the following:

- All participants experienced almost immediate assessment, with the first therapy session occurring within one to two weeks. Access to psychiatry also occurred within one to two weeks.
- For most of the focus group participants, the initial access was positive and easy, and felt comfortable throughout the process. A small segment was assigned a therapist of the opposite gender and were not comfortable with that arrangement.
- The sources of information about treatment was varied for these participants, with some having been referred by a medical doctor, others referred by family and friends.
- No barriers to access were noted by these individuals, other than their own personal reluctance to seek treatment.

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

- The frequency of treatment varied among participants, with some seen every two weeks, group once a week, and intensity of services varying during the course of treatment.
- Most were offered group therapy. One had declined the offered group therapy.

- Psychiatry services occur on average every two to three weeks.
- Case management services were a very individual experience, with some participants receiving help with referrals or transportation. Case management tends to be an as-needed service, available for specific issues.
- Participation in recovery groups also varied among these participants. Some receiving services from Recovery International, others receiving Wellness and Recovery Action Plan (WRAP) or National Alliance on Mental Illness (NAMI) involvement.
- When service needs arise outside of regular appointments, the awareness of numbers and who to call varied. Some would contact 211, others the 911 emergency response number; some were unsure. Some would go to an emergency department. It should be noted that none of the participants had experienced a crisis.
- All participants have been involved in the decisions related to their treatment plan, with some stating that they helped create the plan. All participants have taken WRAP classes.
- Regarding results of treatment, most were positive with few negatives about services and changes in the last year. Many felt improvement has occurred.
- All participants are aware of the process to change psychiatrist, and a small component had done so satisfactorily.
- Most of the participants were aware of the wellness center(s) and attended. Awareness of this program occurred through therapist referral, a friend, or a flier. For those attending, there was a desire for more activities, concern about lack of funds for arts and crafts, and comments about very old transportation vehicles.
- The MHP does supply transportation for consumers; however, consumers report it is limited to exceptional situations and is not routinely available.
- When cultural and linguistic competence was discussed, none of these participants had any difficulties obtaining services in Spanish.
- While none of these participants accessed online information, they had been informed of changes, as recently as two weeks prior, circulated through written bulletins.
- Consumer input on services is sought by the clubhouse through a meeting to solicit programming suggestions. There have been no formal efforts to obtain input on psychiatry services. However, they were aware of, but did not participate in, focus groups run by the MHP.
- Participants noted that the clubhouse has a resource book that lists various services and activities available.

Recommendations for improving care included the following:

- Other than resources for the clubhouse, no suggestions about services were offered. The first words that came to mind related to "Woke up, light at the end of the tunnel." These individuals commented about participating in life, feeling less depressed, not as lonely and more outgoing.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The second consumer/family member focus group consisted of a culturally diverse group of parents/caregivers of children and youth receiving Katie A. services, the majority initially accessing services within the prior 12 months. This session was conducted at the MHP's main offices at 3255 Camino Del Rio South, San Diego, CA, in the Del Mar Room.

Number of participants – Five

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

- Initial access was described as "immediate," with none experiencing a delay.
- The time to the first psychotherapy appointment was two weeks at most; however, there was an example of a service step-down, which involved six weeks to make the treatment arrangements.
- Prescriber access apparently varied between the agencies providing care, with some experiencing a two-month wait for medications, and an example cited of experiencing a gap in medication continuity.
- Feedback regarding the initial experience varied widely, with some feeling it was good and others expressing frustration. The original information provided about services was provided by Child Welfare Services or other agencies.
- Challenges were identified with provider wait lists because of demand exceeding capacity. Also, there were pharmacy issues when a child has moved from another area, requiring a new treatment authorization request (TAR) to be initiated and approved.

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

- Once treatment has initiated services are considered adequate, and may involve three months of intensive services. Social worker involvement and visits vary.
- Case management is provided to all as needed, and generally once a week.
- Support groups for families are provided at the county, with a once monthly potluck.

- All participants know the phone number to call if additional services are needed. Immediate response is forthcoming. Extra help from workers on the phone or in the home is available. Participants are aware of the 911 response system and PERT teams.
- Caregivers provide input to clinical staff and case managers regarding what needs to be addressed in treatment. They identify the child and family team (CFT) process as a mechanism for directing care. There was some concern expressed about the Continuing Care Reform and the potential impacts.
- Changes in psychiatrist are implemented seamlessly, according to participants.

Recommendations for improving care included the following:

- Participants would like greater availability of support groups for families, and at times more convenient for the caregivers.
- Families that have multiple children need a collaborative session at least once quarterly for the entire family.
- More client focused treatment, addressing the child's needs.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The third focus group consisted of a culturally diverse group of parents/caregivers of children and youth in treatment the majority of whom have initially accessed services within the last 12 months. This session was conducted at the MHP's main offices at 3255 Camino Del Rio South, San Diego, CA, in the Del Mar Room.

Number of participants – five

None of the participants initially accessed services within the past year, thus initial access timeliness information could not be assessed.

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

- Urgent needs are met by calling 211, the PERT line, urgent care, or by calling an ambulance.
- This group felt they have strong input on the treatment plan.
- Less than half of the participants have received wraparound services, with for some TBS also provided.
- Some caregivers report changes involving cuts or changes in programs during the last year. Some of the changes required switching to another provider, an initial inconvenience that has since worked out well.

- Information is not routinely provided about other services to these caregivers. Occasionally, the clinician will provide information, but this is not typical.
- Participants were unaware that the MHP has a website that provides information.

Recommendations for improving care included the following:

- These participants felt that more information needs to be provided about the full scope of available services.
- This caregiver group report feeling judged by Child Welfare social workers, and not provided with information and support. They perceive a lack of caring in the social workers' approach.
- They feel more groups are needed that place children and multiple families together in treatment.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Generally, participants reportedly experienced more than adequate service capacity to quickly meet treatment needs in all modalities and with a frequency sufficient to provide improvement.
    - Individual, group and family therapy offered as relevant, as well as psychiatry. The psychiatry frequency was considered sufficient, often every two to three weeks.
    - Access to services in Spanish was available to relevant consumers.
    - Continuity of medication can be difficult when a child/youth has moved into the MHP's area from another county and is on medication, requiring a new TAR to be issued and approved.
    - Greater access to family therapy after usual business hours is a need frequently identified by caregivers of children and youth.
- Timeliness of Services
    - Consumers and caregivers of children and youth reported almost immediate access to care.
    - Initial psychiatry access occurred within several weeks for adults, with a great deal more variation for children and youth – for some up to several months.

- Quality of Care
    - Caregivers reported recent availability of family support groups; however, they would like to see more such groups and offered at more convenient times.
    - The wellness center is a resource utilized by most of the adult consumers interviewed during this review.
    - Caregivers with multiple children in treatment feel that a quarterly global check-in meeting should routinely occur.
    - Greater resource availability for the wellness center, including improved transportation, funding for activities and arts and crafts supplies, was considered needed by participants.
    - Both adult consumers and caregivers of children and youth consistently reported having a strong voice in the development of their plan of care.
    - The CWS social workers are experienced as critical monitors, and would benefit from presenting a more supportive and helpful approach to the caregivers.
- Consumer Outcomes
    - Most adult consumers interviewed reported use of clubhouse programs and find the program beneficial to improving their life circumstances, including education and employment preparation.
    - Consumers and family members report significant results from services, presenting inspiring testimonials as to the positive impact services have had on their lives.

INFORMATION SYSTEMS REVIEW

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	13.0%
Contract providers	74.1%
Network providers	12.9%
Total	100%

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

3.3%

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

☐ Yes ☐ In Testing/Pilot Phase ☒ No

MHP plans to implement the Cerner InteliChart product by the end of Fiscal Year 16-17

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

☒ Yes ☐ In Testing/Pilot Phase ☐ No

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

52

- Direct services through telepsychiatry practitioners are available in the following languages (does not include the use of additional translators): English, Spanish, Tagalog, Farsi, Hindi, Telugu
- The MHP provided data analysis of use patterns for telepsychiatry within the system of care. Of special interest was the marked use of telepsychiatry at its walk-in Access providers to provide timely service to this sub-group.

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE): no internal technology staff changes were noted during the past year.

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
5	0	0	0

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE): no internal data analytical staff changes were noted during the past year.

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
8	3	1	0

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

- Table 11 does not include MHP analytics staff beyond the QI team. The MHP expects it will be able to better quantify this data for the entire MHP next year.

CURRENT OPERATIONS

- The MHP continues to utilize the Cerner Community Behavioral Health (CCBH) EHR suite of products to meet its ongoing practice management, clinical and medical needs. It also uses the Cerner Millennium EHR for its inpatient consumers. Outcomes data is

collected independently through the UCSD Health Outcomes Data Management system. Both systems are remotely hosted for the MHP and its service partners.

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
CCBH Client Data	Practice Management & Managed Care	Cerner	8	Vendor
CCBH Scheduler	Scheduling	Cerner	7	Vendor
CCBH ATP	Assessments, Treatment Plans, Progress Notes	Cerner	6	Vendor
CCBH Doctor's Homepage	Medical & eRx	Cerner	4	Vendor

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has its new system firmly in place and has no immediate plans for change.
- While the MHP has no immediate plans for system change, it is aware that its vendor, Cerner, has been verbalizing sunset dates for the CCBH product. It has already begun the process of organizing a logical transition from the current product to Cerner's Millennium product, which will be tailored to the MHP's unique service paradigm. IT support reports having experience with the Millennium suite of products and should be able to make appropriate choices on how to ease the transition, which appears to be currently targeted for CY 2020.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	CBH Cerner	x			
Assessments	CBH Cerner	x			
Document imaging/storage	CBH Cerner	x			
Electronic signature—consumer	CBH Cerner		x		
Laboratory results (eLab)				x	
Level of Care/Level of Service	CBH Cerner	x			
Outcomes	CBH Cerner	x			
Prescriptions (eRx)	CBH Cerner		x		
Progress notes	CBH Cerner	x			
Treatment plans	CBH Cerner	x			
Summary Totals for EHR Functionality		7	2	1	0

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

- The MHP is currently deploying eSignature pads to internal staff and contractors.
- While parts of the eRx tools and the Doctor's Homepage have been implemented in the EHR the medical staff indicated that it is not in ubiquitous use across the system of care. The staff expect to implement the balance of functionality, including controlled substance prescribing, very soon so that broad adoption can be implemented.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- 90% completion of Phase I referral management of ConnectWellSD for CCBH
- Signature pad testing and approval
- Decreased new user account setup from 3 weeks to 24 hours
- Increased access to user trainings

- Decreased unplanned system down time from 2 times per month to 2 times per fiscal year

PRIORITIES FOR THE COMING YEAR

- Complete project management plan 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
- Complete monitoring plan for distribution of signature pads
- Implement DSM 5
- Progress Note Re-Write

OTHER SIGNIFICANT ISSUES

- Most of the data in the MHP's scope of operations is stored in siloed databases complicating system of care reporting. Fortunately, the MHP made significant progress this year in rectifying this issue by collaborating with technical staff and stakeholders to select ConnectWellSD as its future direction for data exchange. Fast tracking data exchange in a very practical sense would alleviate many internal stressors in MHP system of care operations. The MHP is in discussions to collaborate with IBM to forge a data exchange architecture and solution.
- The data silos have also prevented IS/IT from implementing broad medication surveillance tools across the system of care. The MHP makes a good effort at the monitoring of all its prescribers but the breadth of providers makes this effort a significant challenge. It is expected that the MHP's efforts to expand data exchange will create the possibilities of automating broader medication monitoring surveillance, and improved prescribing oversight.
- The MHP is not currently tracking the language in which service is provided. Considering the numerous threshold and non-threshold language needs that exist, it would be very useful for the MHP's planning process to have data on the match of consumer preferred language with that of service delivery. This is relatively easy

addition to the EHR and the large number of languages that the MHP has to cope with it may be an opportunity for them to improve system monitoring to have this enhancement built into the system.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☐ Monthly ☒ More than 1x month ☐ Weekly ☐ More than 1x weekly

- MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

The MHP receives a series of custom reports for program and fiscal use which is then managed with Microsoft Excel by fiscal staff. These reports are generated by Optum, the Administrative Service Organization (ASO), who provides substantial reporting resources to the MHP as a part of its scope of duties.

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 14—Summary of CY15 Processed SDMC Claims—San Diego

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
623,822	$114,233,671	$847,343	0.74%	4,456	$113,386,328	$401,122	$112,985,206

Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP makes good use of telepsychiatry for the redistribution of psychiatric resources around the county but has not, as yet, begun utilizing

this mechanism for improving availability of providers competent in threshold and other languages in need.

- Timeliness of Services
    - The MHP continues to struggle with long wait times for psychiatric services, particularly for youth, and has yet to strongly utilize telepsychiatry to supply additional FTEs to fill this need.
    - The MHP has made good progress and established a plan for working with Cerner to develop a "Service Journal," that creates an offline repository of data that can be manipulated and reported on for various analytic purposes, including timeliness.
- Quality of Care
    - The MHP has made good first steps toward resolving the siloed data repositories within its system of care. It needs to continue and expedite this work to gain control of its diverse data repositories so that system-wide data analyses, such as prescription drug surveillance and HEDIS measures can be broadly implemented.
- Consumer Outcomes
    - No IS/IT issue changes were noted in this review that materially impacted consumer outcomes.

SITE REVIEW PROCESS BARRIERS

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

- The review process would benefit from the MHP's increased efforts to obtain focus group participation of individuals who have initiated services within the prior year, and improved work in recruiting participants in advance and in sufficient numbers to meet the focus group specifications.

CONCLUSIONS

During the FY16-17 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
    - The MHP has expanded Assertive Community Treatment / Full Service Partnership services targeting underserved regions, the homeless, co-occurring disorders, and forensic involved individuals. Crisis residential and crisis stabilization program expansions have also occurred, improving alternatives to acute care and assuring stabilization resources are available.
    - The MHP provides targeted use of telepsychiatry at its walk-in sites and CSUs to improve access.
    - Consumer input was overall quite positive regarding the ability to access care in a timely fashion, and the capacity to provide services at a level sufficient to achieve improve.
    - Penetration rates are higher than statewide and other Large MHP values in almost all categories.
    - The MHP manages to achieve lower average approved claims per beneficiary than the statewide and other Large MHP averages (CY15).
    - The availability of chat on the Optum operated Access Line improves access for those who have hearing impairment and those who prefer non-verbal communication.
- Opportunities:
    - While the MHP provides extensive interpreter services and tracks this use, consumers who need psychotropic medications would likely be better served by enhanced capacity of linguistically appropriate professionals through external telepsychiatry resources.
    - The MHP may benefit from implementing enhancements to the electronic health record that captures information on the language in which services are provided.

- The graduates of local Psychiatric Nurse Practitioner (PNP) training programs tend to be locally underutilized due to a practice culture, which prefers psychiatrists, and perhaps added to by the fairly large psychiatry presence in this region.

Timeliness of Services

- Strengths:
  - Adult consumers and parents/caregivers of children both reported very quick initial access to assessment, which also tracks with the data provided by the MHP's self-report.
  - The experience of adult consumers indicated very quick psychiatry access, most within one week of initial contact, which was also consistent with MHP data.
- Opportunities:
  - Psychiatry wait time data reflects extended access for children and youth. Caregivers of children and youth participating in focus groups also reported long wait times for initial psychiatry access. Beneficiaries would be aided by an exploration of the issues related to enhancing capacity in this area, which may include expansion of telepsychiatry.

Quality of Care

- Strengths:
  - The MHP engaged in extensive focus group sessions to obtain input on services needs and targeting specific populations.
  - The MHP made practical progress by engaging contract providers and other stakeholders for a targeted re-evaluation of treatment plan and progress note requirements within the EHR, which has resulted in streamlining of the documentation.
  - The MHP engages in significant use of data and in-depth analysis for the purpose of decision support. The reports furnished by Optum provide dashboards for tracking, and UC San Diego assists in the production of extensive system outcome and other data analysis reports.
  - The MHP's contract language includes the requirements for the inclusion of individuals with lived experience, resulting in numerous consumer-employee/peer support specialist positions.
  - Optum manages admissions and claims with 11 contracted inpatient psychiatric units, and a provider network that provides a training site for UC San Diego psychiatry residents, and partnering with two Psychiatric Nurse Practitioner programs to provide training and employment opportunities.

  - The collaborative documentation process, in use on a pilot basis, uses a dual-screen to enable consumer participation and real-time viewing of the treatment documentation. This is seen to have the benefit of improved engagement in the treatment process, and as well improve the timeliness of documentation.
  - Optum performs nightly data transfers for analytic purposes from the EHR and creates inpatient and CSU dashboard, as well as examining readmissions within and between acute facilities.

- Opportunities:
  - The MHP should consider the application of tracking psychiatry HEDIS measures and tracking this information for its internal psychiatrists.
  - The MHP would benefit from greater psychiatry use of the medically oriented portions of its EHR.
  - Given the breadth of its system of care, the MHP may wish to expedite as many pieces of ubiquitous Health Information Exchange as possible to allow for better and less staff intensive monitoring of treatment.
  - The roles for peers are varied; however, there is inconsistency in the presence of a career ladder and formal opportunities for advancement.
  - Despite continued efforts of the MHP to improve the consistency and function of the CORs, which includes an imbedded process for providing feedback on their communications, providers continue to identify this area as one with unique and individual interpretation of standards and requirements and benefitting from continued attention.
  - Consumers, as in prior reviews, identify lack of information about services as a concern.
  - The MHP's medication monitoring actions are chiefly focused on directly operated programs and prescribers (MD/PNP), with organizational contractors delegated this responsibility for their internal prescribers. Other medication review actions are predicated upon incidents, coroner's reports and pharmacy identified issues. Because most prescriptions are filled by widely dispersed pharmacies, there are no currently available surveillance tools to identify potential prescribing issues proactively.

Consumer Outcomes

- Strengths:
  - The MHP has partnered on the development of housing for the mentally ill in programs such as the Hotel Churchill in downtown San Diego. Other housing related actions have included Project One For All and incentives for landlords, with close coordination with housing and community development entities.

  - Interwoven throughout the MHP's service delivery are a panoply of programs that focus on the achievement of positive outcomes through services that target complex and inter-related issues such as homelessness, forensic involvement, foster care, and co-occurring disorders. The programs weave MHSA funding with SB82 and other funds to enhance the system of care to improve outcomes.
  - The MHP continues to have a robust system of outcomes tools, which it uses to tailor treatment to consumer need.
  - Optum performs nightly data transfers for analytic purposes from the EHR, outputs 120 reports that provide decision support, and creates inpatient and CSU dashboards, as well as examining readmissions within and between acute facilities.
  - The MHP's Performance Improvement Projects target improving clinical outcomes for children and youth and post-hospitalization follow-up for individuals not open to outpatient services at the time of discharge.
- Opportunities:
  - The existence of a career ladder for consumer-employees is individually determined by contract programs and is not consistently present.

RECOMMENDATIONS

- 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.
- The MHP's non-English speaking beneficiaries would benefit from efforts to increase the numbers of multi-language capable telepsychiatry providers.
- The use of collaborative documentation would benefit from study to determine if local experience demonstrates improvement of consumer outcomes and improves timeliness of documentation.
- 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.
- 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.

- 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.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

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
Crisis & Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Prescriber Staff Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s) / Parent/Caregiver Focus Group
Contract Provider Group Interview – Administration and Operations & Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
Access Call Center Site Visit
Wellness Center Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, RN, MPA, Quality Reviewer
Lynda Hutchens, MFT, Quality Reviewer
Duane Henderson, IS Reviewer
Nosente Uhuti, Consumer-Family Member

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

Sites of MHP Review

MHP SITES

San Diego County Behavioral Health
3255 Camino Del Rio South
San Diego, CA 92108

CONTRACT PROVIDER SITES

Optum, San Diego, 3111 Camino Del Rio North, Suite 500, San Diego, CA 92108
The Meeting Place Clubhouse, 2553 State Street, San Diego, CA 92101

Participants Representing the MHP

Name	Position	Agency
Adrienne Yancey	MHSA Coordinator	BHS
Alfredo Aguirre	Behavioral Health Director	BHS
Amanda Lance-Sexton	BH Program Manager	BHS
Amy Chadwick	Project Coordinator	CSRC
Amy Panczakiewicz	Program Evaluation Specialist	HSRC
Ana Briones-Espinosa	Director of Finance & Business	Optum
Andy Sarkin	Director of Evaluation Research	HSRC
Angela Chen	NH Director	UPAC
Anna Paid	Chief Agency Ops	BHS

Name	Position	Agency
AnnLouse Conlow	Sr MIS Manager	BHS
Becky Lanier	Protective Services Supervisor	Child Welfare Services
Ben Lenker	Recovery Coach	RI International
Betsy Knight		BHS
Bill Penfold	Sr MIS Manager	Optum
Brandon Carlisle	Sr MH Researcher	CASRC
Brittany Vetter	Therapist	YMCA
Bruce Wexler	Senior Director	Fred Finch Youth Center
Cara Evans Murray	BHPC-AOA	BHS
Carlos Gutierrez	Research Analyst	BHS
Carol Neidenberg	Program Manager	CCHEA
Caryn Sumek	HPPS-CAO	BHS
Cecily Thornton-Stearns	BHPC-AOA	BHS
Charity White-Voth	AOA-BH Program Coordinator	BHS
Chona Penalba	Principal Accountant	BHS
Chris Strows	Admin Analyst III	BHS
Christine Davies	PERT Asst. Director	Community Research Foundation
Christopher Guevara	AHZ-BHS	BHS
Cinthya Luis	Peer Recovery Programs Coordinator	NAMI SD
Dan Maccia	VP of Residential Services	CRF
Dane Gapuz	Admin Analyst	BHS
Danyte Mockus-Valenzuela	Manager for the Prevention and Planning Unit	BHS
Dasha Dahdouh	Analyst to QI PIT	BHS
Dave Post	Analyst QI PIT	BHS
David Mullen	Program Coordinator	BHS
Dawn Gruss	Training	Optum
Debbie MacDougall	UR/QI Supervisor QM	BHS
Diane Haishman	Project Payee	NAMI SD
Diane Panton	Associate Medical Director	Optum
Edith Mohler	Administrative Analyst III	BHS-CYF
Eileen Quinn-O'Malley	Program Coordinator CYF	BHS
Emily Trask	Psychologist	CASRC

Name	Position	Agency
Eric Camerino	Administrative Analyst II	BHS
Fran Cooper	BH Program Coordinator	BHS
George Scolari	Healthy SD	Healthy San Diego
Heather Aston	Crisis Line	Optum
Heather Parson	Quality Improvement Team	BHS
Holly Salazar	Assistant Director Departmental Operations	BHS
James Rogers	Senior VP of Clinical Services	CRF
Jamie Mancera	Senior OA	BHS
Jane Maldonado	Support Desk Manager	Optum
Janet Cacho	QM Supervisor	BHS
Jeff Rowe	Supervising Psychiatrist	BHS
Jimmy Gomez	MH Rehab Spec.	CRFDTI
Joanna Hamilton	LMFT/Clinician	BHS
John Laidlaw	Org Provider	Org Provider
Joyce Thompson	Utilization Management Supervisor	Optum
Judi Holder		RII
Judith Yates	Regional Supervisor	Hospital Association of San Diego and Imperial Counties
June Archer	Peer Support Specialist	NAMI SD-PeerLinks
Junida Bersabe	Analyst	BHS
Justin Terrell	Training	Optum
Katie Rule	QI Analyst	BHS
Kristie Preston	Clinical Director	Optum
Krystle Umanzor	Admin Analyst III	BHS
Lara Duff	Therapist/IMF	Wrapworks
Lavonne Lucas	Medicare Claims Manager	BHS
Leo Pizarro	Education Coordinator	NAMI San Diego
Liane Sullivan	Analyst	BHS
Linda Bridgeman Smith	PV & DUI Manager	BHS
Lisa Irving	Peer Liaison	RII
Lisa Sawin	Division Chief	Probation
Lisa Turner	PFSO, ED	Palomar Families Counseling Svs

Name	Position	Agency
Liz Locano	Principal Admin Analyst	BHS
Liz Miles	Principal Admin Analyst	BHS
Lucyna Klinicka		HSRC
Mandy Kaufman	PWB Program Manager	BHS
Maria Morgan	AOA County	BHS
Marjan Loghman		HHSA Pharmacy
Mary Ellen Baraceros	Program Director	Pathways-Cornerstone
Mary Woods	Regional Director of Operations	Telecare
Melinda Nickelberry	Deputy Director, Admin Services	BHS
Mercedes Webber	Peer Liaison	RII
Michael Krelstein	Clinical/ Medical Director	Optum
Michelle Golvon	Executive Director	Optum
Michelle Raby	Program Manager	BHS East County Clinic
Mike Phillips	Director Patient Advocacy Program	Jewish Family Services
Minola Clark Manson	Program Director	BHS
Nancy F. Garcia	Licensed Mental Health Clinician	SDUSD/SDOP
Nancy Nguyen		SDCPH-MHCMC
Nathally Carrillo	Peer Support Specialist	RI International
Nathan Aish	MH Rehab Specialist	CRF-DTI
Nicole Esposito-Montazen	Asst Medical Director	BHS
Nilsa Rubenstein	System Maintenance Manager	Optum
Paulina Martinez	Admin Services Manager	BHS
Phuong Quach	Program Coordinator	BHS
Piedad Garcia	Deputy Director, AOA	BHS
Raul Loyo-Rodriguez	Budget Manager	BHS
Rebecca Raymond	Program Coordinator	BHS
Renee Cookson	Community Development Director	NAMI San Diego
Rose Woods	Training and Curriculum Coordinator	BHETA
Sabrina Shammas	Clinician	KickStart
Sarah Breding	PM	North Inland Mental Health
Sarah Tysseland-McMinn	MH Clinician	County of SD
Shannon Jackson	Program Coordinator	BHS

Name	Position	Agency
Skylar Hayes	Manager of Reporting	BHS
Stephanie Hansen		BHS
Steve Jones		BHS
Steve Tally	Research Director	HSRC
Steven Wells	Protective Services Supervisor	CWS
Sun Wook Kimbang	Therapist	UPAC
Tabatha Lang	Chief QI Unit	BHS
Talia Morrison	LMFC Coach/Trainer	FFYC
Tim Tormey	Program Coordinator	BHS
Tonya Jenkins	IMF/Clinician	Pathways
Valerie Brew	Deputy Director	South Bay Community Services
Valesha Bullock	Deputy Director	CWS
Veronica Alzaga	Lead Clinician	NIMHC-MHS
Wendy Maramba	Chief CYF	BHS
Yael Koenig	Dep Director	BHS

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

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

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

Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary
San Diego

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Large	950,222	63,298	6.66%	$263,166,307	$4,158
San Diego	132,182	11,228	8.49%	$39,887,628	$3,553

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

Table C2—MHP CY15 Distribution of Beneficiaries by ACB Range
San Diego

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	31,480	95.62%	94.46%	$85,499,050	$2,716	$3,553	62.79%	61.20%
>$20K - $30K	722	2.19%	2.67%	$17,749,688	$24,584	$24,306	13.04%	11.85%
>$30K	721	2.19%	2.86%	$32,908,197	$45,642	$51,635	24.17%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 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): 24

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): January 10-12, 2017

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):

This problem came to the MHP's attention during another SDCBHS project which had the goal of quantifying the average change in behavioral and emotional outcomes at the end of therapy. The results of this project uncovered a smaller benefit to therapy than was expected. Further, a recent research study that was completed with clients in this MHP found that caregivers rated treatment as more effective when clinicians utilized therapeutic homework in sessions with their children (Haine-Schlagel et al., 2015). Given that homework is a fundamental skill building component of the majority of evidence-based treatments (Garland et al., 2008) and is associated with the perceived effectiveness of treatment in San Diego (Haine-Schlagel, Fettes, Garcia, Brookman-Frazee, & Garland, 2014) as

well as therapy outcomes nationwide (Kazantzis, Whittington, & Dattilio, 2010), this MHP realized that increasing therapeutic homework (THW)use could improve client outcomes.

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	PIP team includes research staff, community services staff, performance improvement/QI staff, San Diego State University and UC San Diego research staff. Consumer input was included through the participation of the Youth Advocate. Caregivers of children and youth have contributed to this PIP via their feedback that therapeutic homework provided better outcomes.
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 became aware that Child/Youth consumers were not demonstrating the amount of improvement usually anticipated with the EBPs in use.
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	While it seems from the write-up that all consumers will be included the description of the consumer population impacted significantly lacks any reference to numbers of consumers. This should be remedied. Also, Phase III as described sounds like Phase I. If it is an expansion programs should be identified, and numbers stated, both of programs and consumers.
Totals		**2** Met **1** Partially Met **0** Not Met **1** 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 providing training on therapeutic homework result in a 10% increase in the use of therapeutic homework? Will the increased use of therapeutic homework result in improved client outcomes as measured by the Child and Adolescent Measurement System (behavioral/emotional symptoms) and length of time in treatment?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While training staff in use of therapeutic homework is an essential component, it is the actual use of therapeutic HW, the breadth and depth of application that are going to produce the results. Furthermore, while the MHP has stated a quantifiable goal for the intervention, homework, there is not improvement amount identified for the results of treatment. The MHP must establish a goal for clinical improvement.
	Totals	**0** Met **1** 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 consumers of ages 1-20, from the reported data. Note: The MHP also references children and youth over 12 years.
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: Those who receive homework assignment.	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	As currently written, the emphasis seems to be upon the training of staff and their assignment of therapeutic homework. The MHP did not define what use of THW "most of the time" means. While it is clear what general population will be targeted with THW, it is not clear how the consumers who receive THW will be individually tracked. The MHP acknowledges this issue. If the MHP does not know each individual who receives THW, how will it track the CAMS results related to consumers receiving THW?
	Totals	**1** Met **0** Partially Met **0** Not Met **1** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Clinicians assigned HW *all* or *most of the time* Caregiver report disruptive behavior outcomes discharge score (PCAMS Externalizing Score) Caregiver report depression / anxiety outcomes discharge score (PCAMS Internalizing Score) Treatment Length (Close date – open date)	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP must have an indicator that tracks the number of consumers who receive therapeutic homework. The MHP currently cannot validate a clinician's assertion that THW is being utilized "all or most of the time."

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	Caregiver reports of disruptive behavior, depression/anxiety, and length of treatment are strongly associated with improved outcomes.
	Totals	**1** Met **1** 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	**#** Met **0** Partially Met **3** Not Applicable

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	HW assignments; CAMS data, Length of treatment. The CAMS data is located online in the DES system, and length of treatment is associated with the billing system. The HW assignment tracking process involves a clinician survey instrument. It is unclear to the extent that this has accuracy or indicates the scope – number and % of caseload – the intervention is used with.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☒ Provider ☒ Other: Outcome instruments, duration of treatment, and survey of clinical staff.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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	The answer is yes for most elements, however that which relates to clinicians using THW "all or most of the time" and the number/% of consumers receiving THW is also unclear.
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: Text if checked	☒ 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:* Name: Liz Miles, Ph.D, MPH, MSW Title: Principal Administrative Analyst Julie McPherson – Community Research Foundation Program Manager Rhaelynne Scherr – South Bay Community Services Program Manager Michelle Ly – Union of Pan Asian Communities Program Manager Dasha Dahdouh – Performance Improvement Team Research Analyst, Behavioral Health Services Amanda Lance-Sexton – Behavioral Health Program Coordinator, Behavioral Health Services Shane Padamada – Youth Advocate (CFM representative) Yael Koenig – Deputy Director, Children, Youth and Families, Behavioral Health Services Emily Trask, Ph.D – Child and Adolescent Services Research Center (CASRC), University of California San Diego Bill Ganger, M.A. – Child and Adolescent Services Research Center, San Diego State University Amy Chadwick – Child and Adolescent Services Research Center, University of California San Diego John Ferrand – Child and Adolescent Services Research Center, University of California San Diego	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals	**5** Met **1** 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:* *The MHP is in the process of revisiting the interventions and is going to provide more training.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	MHP has discerned the change goals not being met and believes more training by a THW advocate will improve results. But that is based on simple outcome tracking and there is no current data as to the scope/number of consumers receiving nor the #/% of staff providing THW, as measured on a concurrent basis. Clinician assertion is the only manner of validation.
	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 PIP is not completed yet and interim; Phase 1 analysis has been provided.
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: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
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:* Text *Conclusions regarding the success of the interpretation:* Text *Recommendations for follow-up:* Text	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **1** Partially Met **0** Not Met **#** 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	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **5** 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	NA

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: NA		
Recommendations: NA		
Check one: NA	☐ 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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 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): 24

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): Jan 10-12, 2016

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 observed that a low percentage (28%) of consumers whose initial mental health treatment contact is through an acute inpatient stay connect with aftercare services following discharge. This contrasts with 45% of individuals who were already receiving outpatient services. Readmission rates of 11% exist for those who had followed up within 20 days of discharge, versus 26% for those that did not receive follow-up aftercare.

Having access to this information, the MHP set about attempting to improve this follow-up with care for those not receiving/connected with outpatient services at the time of acute admission.

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.* o Clients: Clients were interviewed from a similar linkages program, "Next Steps." o Program staff: Program staff from SDCBHS programs. o Clinicians: Clinicians from both the SDCPH and participating outpatient clinics. o 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	It's not clear what the input of consumers was, and if that input was considered from the POV of using their ideas as part of the intervention process.

Select the category for each PIP:		
Clinical:		*Non-Clinical:*
☐ Prevention of an acute or chronic condition	☐ High volume services	☒ Process of accessing or delivering care
☐ Care for an acute or chronic condition	☐ High risk conditions	

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	The focus is on engagement of new consumers when their first MH contact is with an inpatient treatment stay. However, the intervention seems to be simply an appointment scheduled within three days of discharge, while there may be many other variables that pose barriers to follow-up and engagement with care. No mention was made of the consumer input from the survey and their ideas.
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	Includes all individuals who initially access care through an acute treatment stay.
Totals		**1** Met **1** 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 newly opened consumers or consumers who are not currently active with the SDCBHS – which includes an aftercare appointment within three days of discharge, a reminder call and other interventions as identified – improve outpatient engagement by 25% to 30% and reduce 60-day readmissions by 15% 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 discharged from the psychiatric hospital that were not open/existing consumers at the time of admission.
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	
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 Appointment attendance Readmission rates	☒ 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 **3** Not Applicable

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	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: Text if checked	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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: Text if checked	☒ 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: Liz Miles, Ph.D, MPH, MSW • Administrative personnel at SDCPH: Psychiatric Social Work 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.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The documentation is not clear what the input of surveyed consumers consisted of, or if this feedback was responded to.
	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 data analysis plan does not specify a reporting frequency, nor frequency of review and analysis by the PIP committee.

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	Remains early in the process.

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: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Preliminary report does not reflect significant improvement but this is the first data reporting. It is too early to draw definitive conclusions.
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:* Text *Conclusions regarding the success of the interpretation:* Text *Recommendations for follow-up:* Text	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **2** Partially Met **0** Not Met **2** 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	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **5** 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:

NA

Recommendations:

NA

Check one: NA

☐ 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