FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

MHP FINAL Report

Fresno

Conducted on

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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 (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Beneficiaries served in CY13—12,737
  - MHP Size—Large
  - MHP Region—Central
  - MHP Threshold Languages—Spanish, Hmong
  - MHP Location—Fresno

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Fresno mental health plan (MHP) by the California External Quality Review Organization (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 **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven 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

[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.

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark.
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Fresno County MHP submitted two PIP's for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) 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 (PM).

(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 one 90-minute focus group 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.

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[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.

- 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 serve 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.

PRIOR YEAR REVIEW FINDINGS, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that 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—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY13-14

- Recommendation #1: Consider the creation of an Office of Consumer and Family Member engagement or an in-house peer supervisory position that can be housed with MHP administration and serve the leadership team.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - Office of Consumer and Family Member engagement or in house peer supervisory position that can be housed with MHP administration and serve the leadership team has not been implemented.
  - The MHP continues to engage with community members through the "Review and Advisory Committee (RAC) with participation from in-house Peer Support staff members. These forums continue to involve the clients' or parents' voices to promote engagement, and to create another channel of communication embedded in to the MHP.

As the MHP continues with its Transformation Plan, the MHP will re-visit the effectiveness of this engagement and the recommendation.

- Recommendation #2: Consider the creation of an IT Manager position and prioritize the development of an IT Strategic Plan, within the existing planning process.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - Substantial organizational changes have been made to the Department of Behavioral Health.
  - A new Division Manager position has been created in the Business Operations Unit for Technology and Quality Management. This Division Manager was appointed as the Information Systems Decision Support (ISDS) Manager in July 2014.
  - The ISDS Senior Systems Support and Procedures Analyst reports directly to the Division Manager
  - A list of short-term and long-term IT initiatives has been developed and is being maintained.
  - Since the last CalEQRO review, the IT Manager position has been allocated and filed as of July 2014. In addition to prioritizing the development of an IT Strategic Plan, this position also oversees Quality Improvement, Medical Records, and Staff Development within the existing planning process.

- Recommendation #3: Proactively engage staff, especially within the CYS division, as decisions are made to contract out various programs/service streams and as staff reassignment decisions are made to ensure best clinical skill/experience fit.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP continues to conduct monthly All-Supervisors meetings and quarterly All Staff meetings for sharing of information. There are three (3) available sessions on the day of the meeting to encourage participation.
  - The MHP/Department of Behavioral Health (DBH) has worked closely with County Administration and Personnel to support the retention of positions in an effort to increase timely access, capacity and program needs. A process was developed through this plan to provide staff the opportunity to select programs of skills and interest followed by interview with respective Clinical Supervisors. The process appeared by response to be viewed favorable and it provided assurances to impacted staff of their future assignment upon closure of their program.
  - The MHP Administration and Management met with the staff members impacted by program closures to explain planned actions provided assurance that positions were secured through vacancies or provided options in the event of position elimination.

  - As programs closed, the staff members were recognized with certificates of appreciation signed by the Director, Deputy Director and Division Manager and potlucks were held to provide closure and to support staff morale.

- Recommendation #4: As PMs are developed within the MHP (with the roll-out of MyAvatar and various proposed dashboards), work with contract providers to incorporate similar quality indicators into their annual contracts (i.e., timeliness indicators, consumer flow).

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The Behavioral Health Department has established a unified Contracted Services Division which has been tasked with standardizing quality, timeliness, outcomes and other performance measures for all programs both County operated and contracted.
  - Monthly planning meetings are being held with Substance Abuse contractors and similar meetings with Mental Health contractors are planned for the coming year.

- Recommendation #5: Develop a mapping/signage project that includes all county-run programs as well as providers which results in current, clear, publishable directions and maps for consumers, family members, and the community to access services system wide.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - As part of an MHSA Capital Facility funds project of renovation and improvements, better signage is being installed in renovated facilities.
  - Client/Family suggestions and feedback was included in the process via the Adult Review and Advisory Committee (RAC).

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
  - The newly built youth sixteen (16) bed psychiatric facility (youth PHF), contracted to Central Stars Behavioral Health, opened the end of April 2015. This allows Fresno County youth to receive inpatient treatment without out of area placement.

- The expansion of adult Crisis Stabilization Unit (an additional 12 beds), operated by Exodus Recovery, Inc., allows for increase in access for adult clients as well as decreases possible inpatient hospitalizations.
- Opening of an 8-bed Youth Crisis Stabilization Facility (Youth CSU) adjacent to Youth PHF allows access to continuum of care as well as allowing for possible decrease in needed inpatient hospitalizations.

- Timeliness of Services
  - Initiated centralized scheduling with selected clinicians in the Children's Outpatient Program in a PDSA model to reduce wait times for clinical appointments with clinicians and/or psychiatrists.
  - The MHP launched the second Trauma Focused CBT Team to allow for more timely access to these services.
- Quality of Care
  - Allocated one Senior Staff Analyst and a second clinical position (Clinician) to the Quality Improvement unit. This will increase the MHP's ability to assess quality of service delivery.
  - Quality Improvement (QI) unit Coordinator position has been vacant since October 2014.
- Consumer Outcomes
  - The MHP sent representatives of the Quality Improvement Outcomes Subcommittee to the Mental Health Center, Denver, CO to be trained in Recovery 360 to implement within the MHP. Outcomes tools to measure Recovery from multiple perspectives, including the client, the practitioner, and overall agency assessment with a level of care component that correlates with services that are offered through the MHP, make this model a good fit for this MHP. The MHP is moving forward with contract development to use these tools and train all staff involved.
  - The MHP administers the state POQI on a yearly basis to assess client satisfaction and outcomes. Most recent survey administered November 17-21, 2014. This data not yet evaluated. November 2014 POQI Raw Data was received by the county in late June/July 2015.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2015.

TOTAL BENEFICIARIES SERVED

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

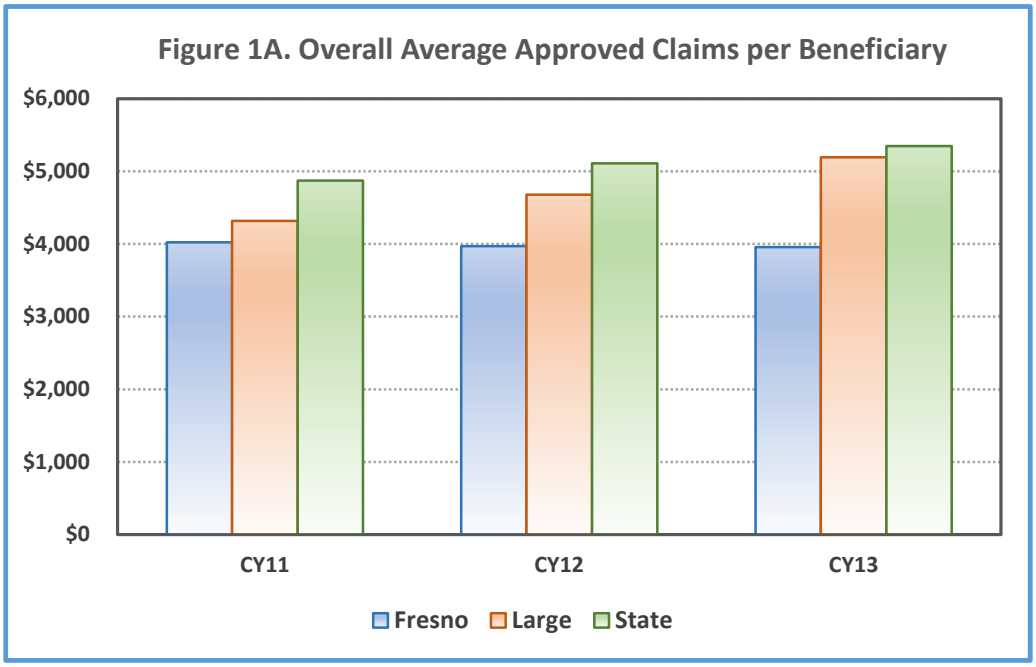
Table 1—Fresno MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

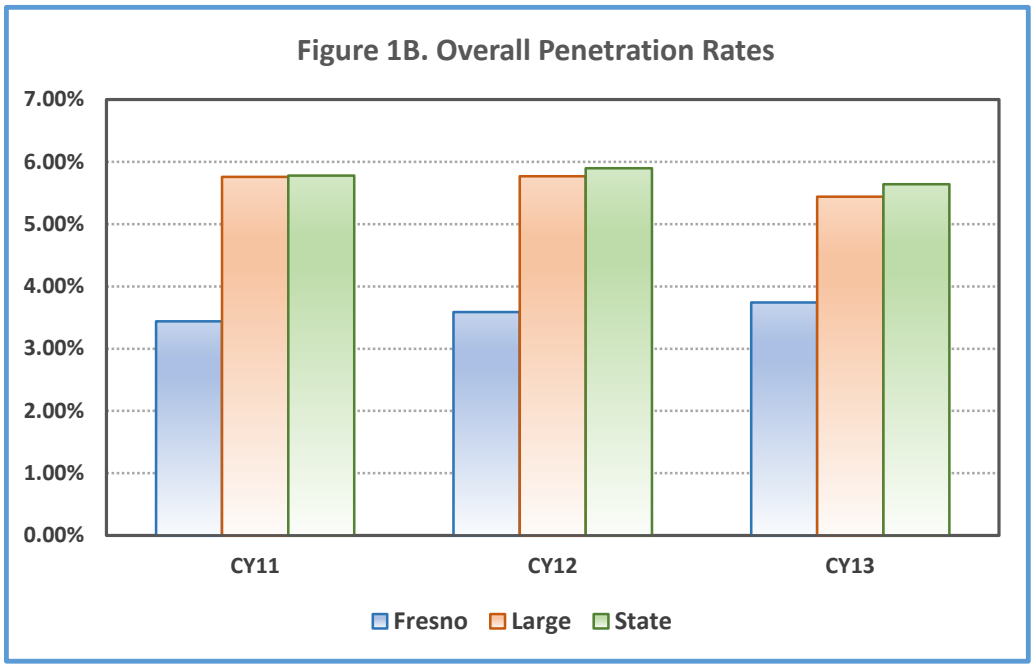
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	47,260	3,345
Hispanic	209,422	5,672
African-American	23,622	1,618
Asian/Pacific Islander	34,184	871
Native American	2,004	133
Other	23,629	1,098
Total	340,119	12,737

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

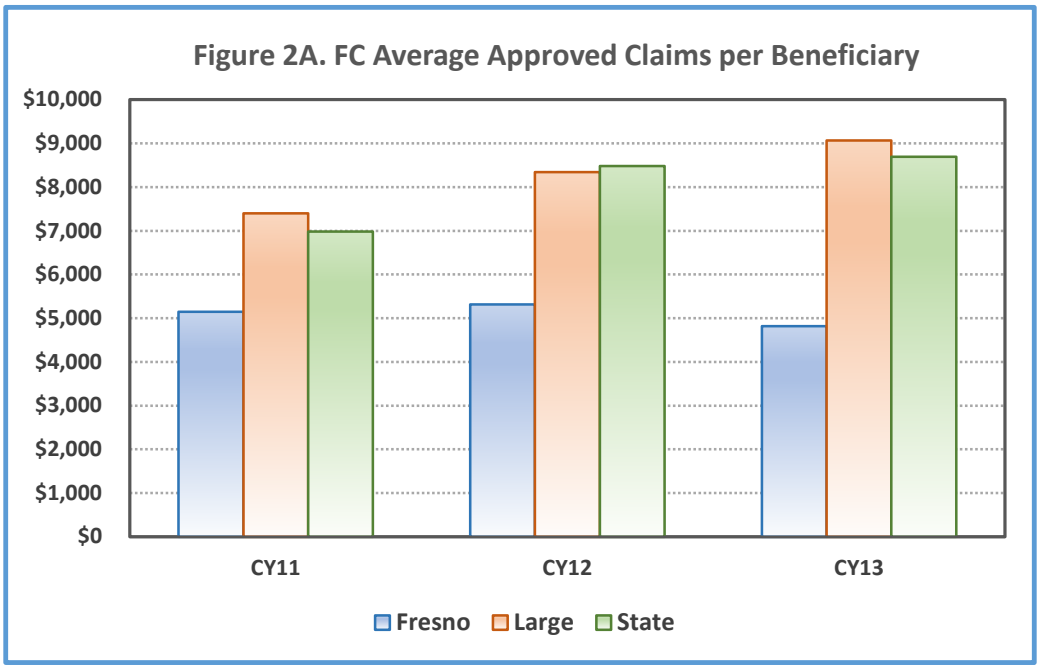
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

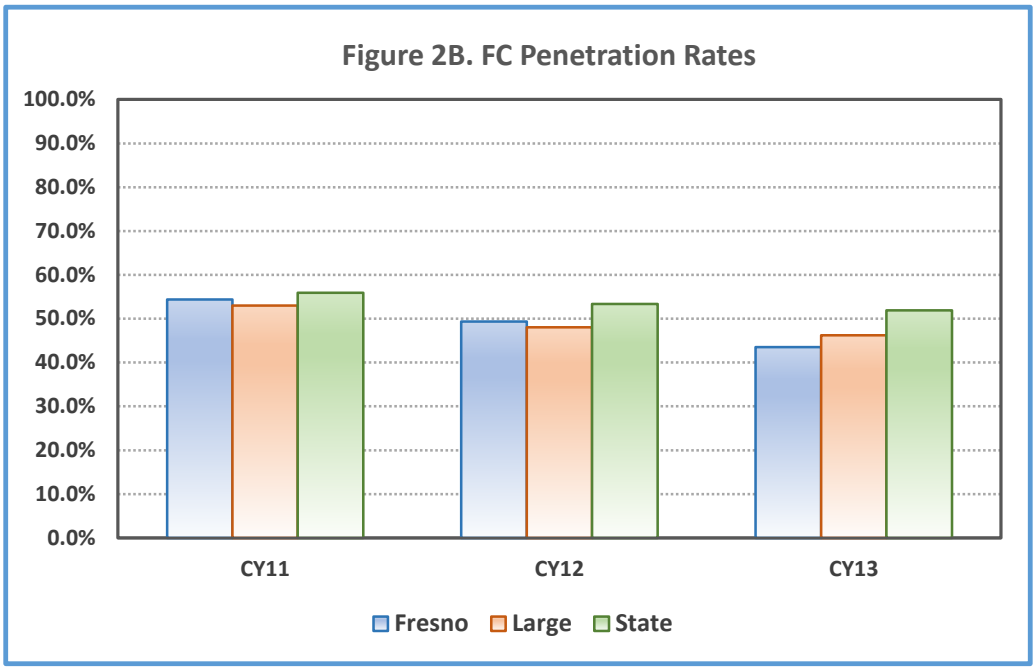
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



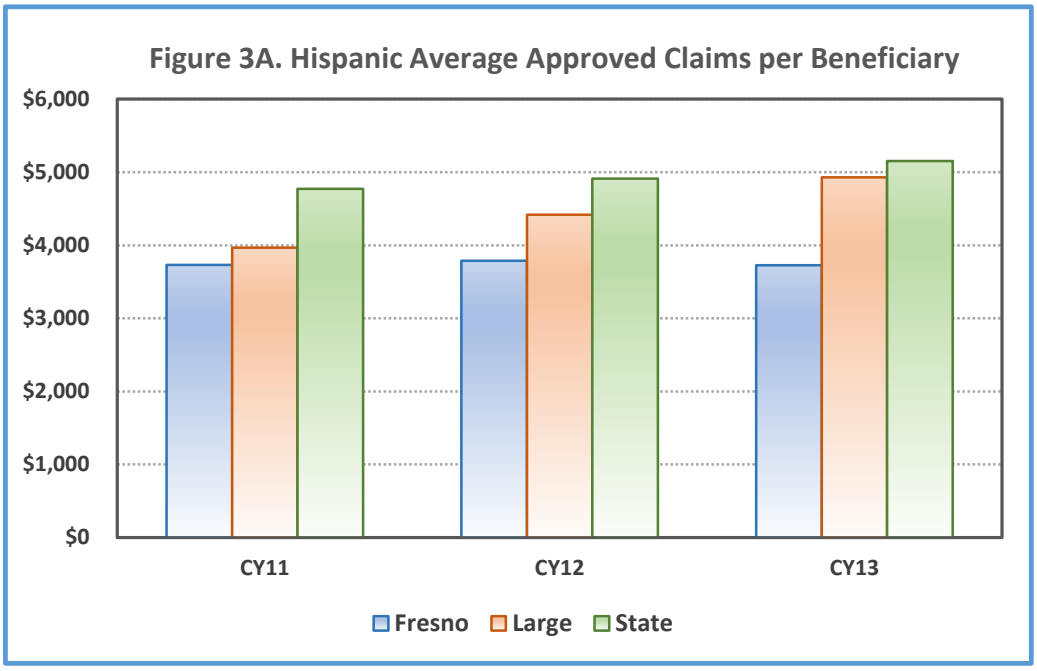


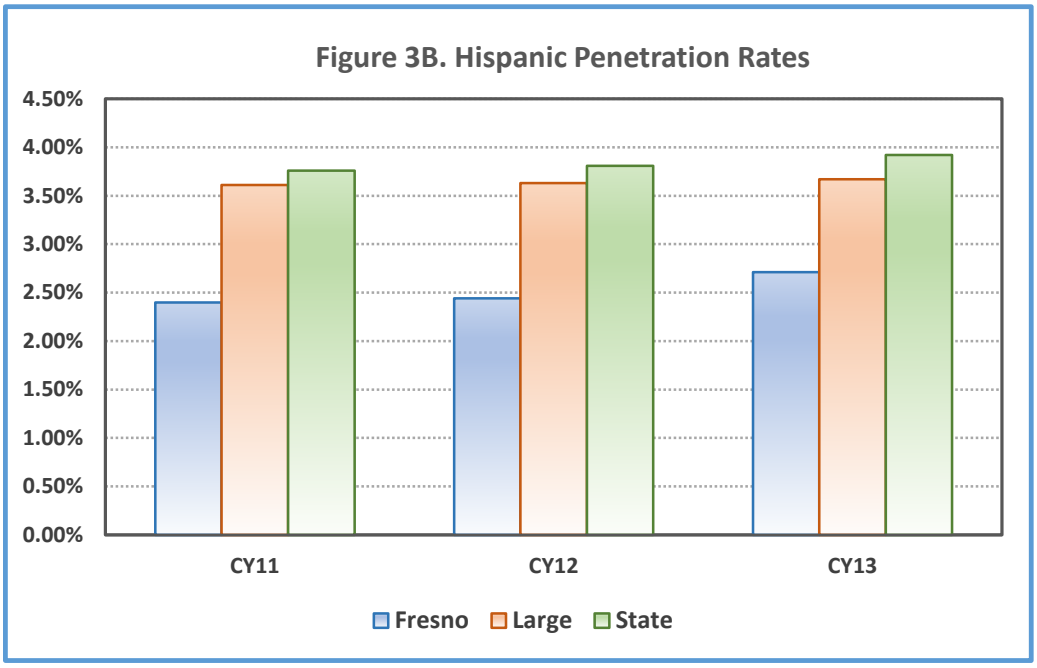
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





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.





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, as well as the prior 2 years. High-cost beneficiaries 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	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Fresno	CY13	216	12,737	1.70%	$46,804	$10,109,673	20.07%
	CY12	224	11,731	1.91%	$47,326	$10,601,024	22.76%
	CY11	221	11,083	1.99%	$46,829	$10,349,308	23.17%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

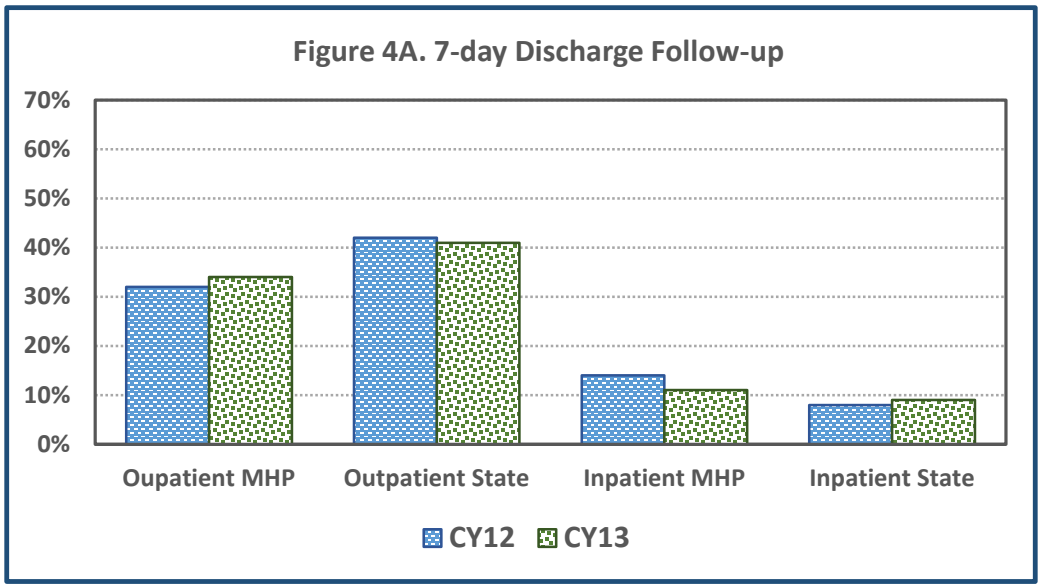
Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

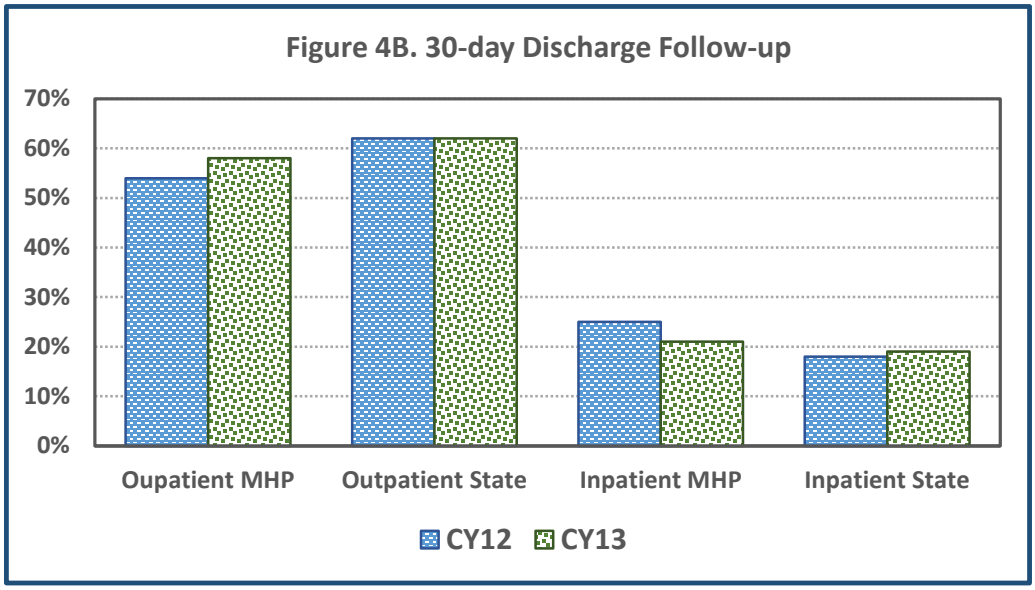
Table 3—TBS Beneficiary Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
Fresno	Yes	5,984	251	4.19%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

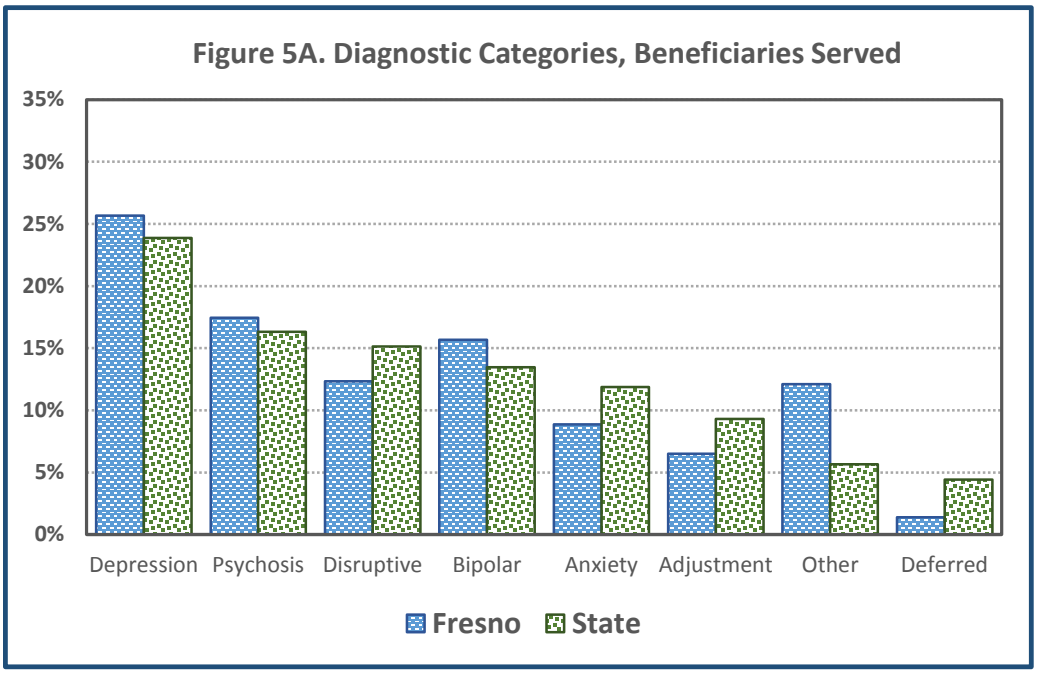
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

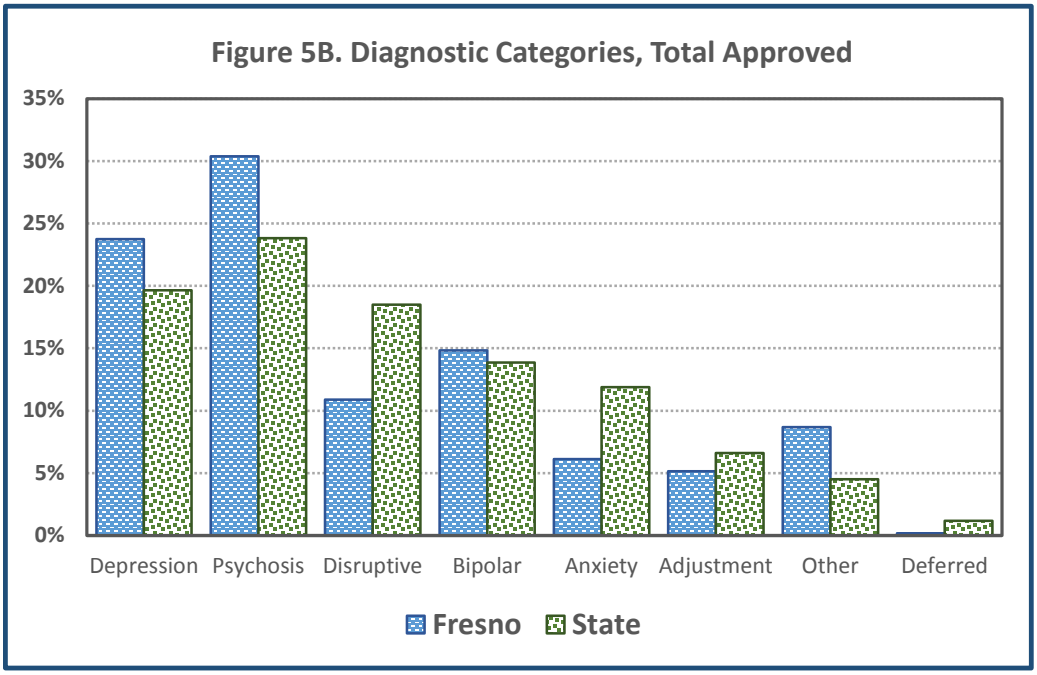




DIAGNOSTIC CATEGORIES

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 CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate is significantly lower than both the large MHP average and the statewide overall penetration rates.
  - The MHP's foster care penetration rate is similar to both the large MHP average and statewide foster care penetration rates.
  - The MHP's Hispanic penetration rate is significantly lower than both the large MHP average and the statewide Hispanic penetration rates.
  - The MHP's TBS Level II penetration rate is moderately higher than the statewide TBS Level II penetration rate.
- Timeliness of Services
  - The MHP's 7 day outpatient follow-up rate after psychiatric inpatient discharge is slightly lower than the statewide rate; the 30 day outpatient follow-up rate after psychiatric discharge is minimally lower than the statewide rate.
  - The MHP's 7 and 30 day inpatient recidivism rates are both very similar to the statewide recidivism rate.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are significantly lower than statewide.
  - The MHP's overall, foster care and Hispanic average approved claims per beneficiary are all lower than the corresponding averages for large MHPs and statewide.
  - The MHP's distribution of diagnostic categories is similar to statewide distribution. The MHP has a slightly higher incidence of depression, psychosis, bipolar disorder diagnoses, and a lower incidence of disruptive, anxiety, adjustment and deferred diagnoses compared to statewide.
  - The MHP has a significantly higher incidence of "Other" diagnoses compared to the state but corresponding very low total approved claims for "Other" diagnoses.
- Consumer Outcomes
  - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (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 2013.

FRESNO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Fresno MHP submitted two PIPs for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Care Coordination Collaborative (CCC). Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	Access Line. Onsite technical assistance was provided to identify future PIP topics.

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

[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 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	NM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	UTD	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	NM	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	M	PM
		7.2	Interim data triggering modifications as needed	M	NM
		7.3	Data presented in adherence to the plan	M	NM
		7.4	Initial and repeat measurements, statistical significance, threats to validity	M	NM
		7.5	Interpretation of results and follow-up	M	NM

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	M	PM
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	M	NM
		8.3	Threats to comparability, internal and external validity	PM	UTD
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	UTD
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	UTD
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	NM
		9.3	Improvement in performance linked to the PIP	UTD	NM
		9.4	Statistical evidence of true improvement	NM	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NM	UTD

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	22	15
Number Partially Met	3	2
Number Not Met	3	9
Number Unable to Determine	2	4
Number Applicable	30	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	75%	53.33%

CLINICAL PIP—CARE COORDINATION COLLABORATIVE (CCC).

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

- "Will coordination of mental and physical health care for adult clients on the Clozaril caseload through the development of a bi-directional referral process, sharing of treatment information, and conducting regular clinical case review consultations, improve over health and client satisfaction?"
- Date PIP began: November 2013
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

The PIP is a Care Coordination Collaboration. The Fresno County CCC included Fresno County Mental Health Plan (convener of collaborative); Community Regional Medical Center – Ambulatory Care Center; Clinica Sierra Vista Medical Centers; CalViva Health (Medi-Cal Managed Care Program). The PIP endeavored to measure improvement of overall health of study population (adult clients on the Clozaril caseload) through bi-directional referral process, sharing of treatment information, and conducting regular clinical case review consultations improve overall health and client satisfaction.

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: The PIP is complete. CalEQRO offered technical assistance in selecting new PIP to study.

NON-CLINICAL PIP—ACCESS LINE

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

- "Will development of an intuitive database that provides step by step instructions on how to handle mental health calls improve access to services for Fresno County beneficiaries?"
- Date PIP began: October 2012

- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☒ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

The PIP attempted to measure accuracy of logging mental health requests by vendor PESC received on Access Line after hours. The MHP hypothesized that an intuitive data that provided step by step instructions would improve access to services for Fresno County beneficiaries. Test Calls were implemented in English, Spanish and Hmong. This PIP is inactive as it has been dormant for one year.

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 recommendation that the MHP complete the analysis of the data and complete this 3 years old PIP.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The Non Clinical PIP attempts to measure increase in access to services, but has been dormant one year. There is no outcome that can be measured at this time.
  - The Clinical PIP attempts to increase coordination of care for clients in study population. This coordination increases access to medical care.
- Timeliness of Services
  - The Non Clinical PIP has potential to affect timeliness in appropriate referral when initial call comes to Access Line.
  - Clinical Pip has a goal of timely referral to medical care.
- Quality of Care
  - The Non Clinical Pip speaks to positive interaction as perceived by client who is making initial call to Access line. This is measured by appropriate handling and referrals of call.

- The Clinical PIP presupposes that quality of care will be improved through collaboration of multidisciplinary teams.

- Consumer Outcomes
  - The Non Clinical PIP measures appropriate outcome of initial call to Access Line as a consumer outcome measure.
  - The Clinical PIP evaluates referrals to medical health providers and resulting improvement in health monitors (BP, BMI), as well as collaboration of multidisciplinary teams as evidence of positive consumer outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management—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—are discussed below.

Access to Care

As shown in Table 5, 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 5—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	Trained 776 (County & Contract) in Cultural Competency 2014. New Cultural Competence Committee creating future goals.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	MHP working to fill clinical positions that were vacant during economic downturn. Increased investment in staff development and strategic 3 years plan.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP continues to engage with community members through the "Review and Advisory Committee (RAC) with participation from in-house Peer Support staff members. Multi agency access program – near a homeless shelter. Multiple agencies coming together. Promoting "linkages" to services.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 6, 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 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	MHP standard 30 days; average length of time 35.11 days
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	MHP standard 14 days; average 91.74 days
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	MHP standard 3 days; average .82 days – consistently exceeds standard
2D	Tracks and trends timely access to follow up appointments after hospitalization	NC	The MHP does not routinely monitor wait time to post discharge appointment. Notification of discharge date by hospitals is not always timely.
2E	Tracks and trends data on rehospitalizations	NC	The MHP does not monitor rehospitalization rates. See recommendation #1 in SORs.
2F	Tracks and trends No Shows	FC	4% No Shows for non-psychiatry MD and 5% for psychiatrist. No standard is set for either of these measures.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 7, 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, 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 7—Quality of Care

Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has an active QI team with regular meetings, but the QI Coordinator position has been vacant for more than 7 months.
3B	Data are used to inform management and guide decisions	FC	Consumer outcomes are not monitored. Data was used to guide restructuring of Urgent Care services and planning of Crisis Residential program.
3C	Evidence of effective communication from MHP administration	FC	Regular all staff to communicate all the various and complex changes. Regular meeting to disseminate information on 360 Wellness elements.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Quarterly RAC meeting notes indicate Adult, Children's and within past year TAY RACs are active and involved with administration in system planning and implementation of programs.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	Ongoing integration with Recovery 360 model promotes collaboration with community, clients and MHP as partners in wellness and recovery.
3F	Measures clinical and/or functional outcomes of beneficiaries served	NC	The MHP does not collect or assess data on beneficiary outcomes.
3G	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP has not reviewed the results of the most recent POQI survey.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	No consumers nor family members have been identified in supervisory or management positions.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	Blue Sky Wellness Center Consumer run and driven programs with wellness and recovery model.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Access to psychiatrists continues to be difficult due to issues of recruitment and retention. The MHP is developing plan to increase number of psychiatrists available. The MHP acquired a new Chief Child Psychiatrist (start date July 2015) and six (6) new psychiatrists of whom 3-4 will be FTE.
  - The MHP has a Cultural Diversity Committee with CY 2015 Work Plan in place. No data available at this time to assess effectiveness.
- Timeliness of Services
  - The MHP does not routinely monitor wait time to post discharge appointment. Notification of discharge date by hospitals is not always timely. New EHR tools will help address this issue.
  - The MHP does not routinely monitor readmission within 30 days. This data along with the time to first post discharge appointment would be useful in assessing outcomes of treatment.
- Quality of Care
  - The MHP has an active QI team with regular meetings, but the QI Coordinator position has been vacant for more than 7 months.
  - The MHP has a comprehensive Quality Improvement Work Plan for Fiscal year 2014-2015.
- Consumer Outcomes

- The MHP utilizes the Child and Adolescent Needs and Strengths (CANS) tool (Life Domain Functioning) to measure outcomes for youth within Avatar and PHQ-9 Patient depression Questionnaire in some adult programs. The data is presented as program outcomes to the Behavioral Health Board.
- Claims data are utilized to guide restructuring of Urgent Care services and planning of Crisis Residential program.
- The MHP implemented a QI Recovery-360 committee to review Recovery 360 model in Denver. The MHP is in process of contract development to be able to utilize the outcomes assessment tools for clients, practitioners and overall agency assessment.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted 3 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 3 focus groups, which included the following participant demographics or criteria:

- Focus Group 1: 8-10 English speaking, culturally diverse group of adult beneficiaries, including both high and low utilizers of MHP services, and includes at least 3 beneficiaries who have initiated services within the last year.
- Focus Group 2: 8-10 Spanish speaking, culturally diverse group of adult beneficiaries, including both high and low utilizers of MHP services, and includes at least 3 beneficiaries who have initiated services within the last year. Translator provided.
- Focus Group 3: 8-10 Parents/family and caregivers of child/youth beneficiaries receiving services, including both high and low utilizers of services, including at least 3 beneficiaries who have initiated services within the last year. English speaking

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

The Focus Group consisted of twelve (12) adult consumer/family members, culturally diverse and English speaking, who were currently receiving services from Fresno County MHP. Participants reported varying lengths of time that they had received services from the MHP. This group was held at the Blue Sky Wellness Center, 1617 E. Saginaw Way #108, Fresno, CA 93726.

For participants who entered services within the past year, the experience was described as

- One participant reported that she had to wait 3 months to be seen. One participant stated that when her family member requested services, it only took a couple of weeks to be seen.
- The majority of participants report they were given information on how to access services in an urgent or emergency situation – 24 access telephone line, calling case manager, 9-1-1, go to emergency room at hospital.
- Participants agreed that once receiving services they perceived treatment as easy to access and providers as responsive and caring about their wellbeing.

Recommendations arising from this group include:

- Participants agreed that wait time to see psychiatrist (in person or virtual) needs to be shortened.
- All participants agreed that transportation assistance to come to appointments would be useful to them.
- Majority of participants would like more activities and groups available at the Wellness Centers.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	5 2 5
Ages of Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 7 5
Preferred Languages	English Spanish Bilingual Other	12
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	6 6
Gender	Male Female Transgender	3 9 1

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The Focus Group consisted of seven (7) adult consumer/family members, culturally diverse and Spanish speaking, who were currently receiving services from Fresno County MHP. Participants reported varying lengths of time that they had received services from the MHP. This group was held

at the Heritage Center, Children's Outpatient, Room #264, 3133 N. Millbrook Ave, Fresno, CA 93703. A translator was provided.

For participants who entered services within the past year, the experience was described as

- Initial accessing of services was through differing referrals, with varying response times – all where within timely limits of 30 days or less.
- All participants endorsed that they were able to receive services in their preferred language. All agreed that having an interpreter was good, but it was better if they had the option to speak directly to the provider.
- One participant has been active as a volunteer within the MHP. All others said they were never ask to participate in any committees, activities, or meetings.

Recommendations arising from this group include:

- Majority would like Wellness Centers to have more Spanish speaking services, to include groups and activities.
- All participants would like to have better communication between their various providers.
- All participants mentioned the need for more availability of psychiatrist with less wait time.

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only	5
	Consumer and Family Member	1
	Family Member	1
Ages of Participants	Under 18	
	Young Adult (18-24)	
	Adult (25–59)	4
	Older Adult (60+)	3
Preferred Languages	English	
	Spanish	7
	Bilingual	
	Other	

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	7
Gender	Male Female	1 6

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The Focus Group consisted of five (5) parents/family and caregivers of child/youth beneficiaries receiving services, including both high and low utilizers of services, from Fresno County MHP. Participants reported varying lengths of time that they had received services from the MHP. This group was held at the Heritage Center Children's Outpatient, Room #66, 3133 N. Millbrook Ave, Fresno, CA 93704

For participants who entered services within the past year, the experience was described as

- All participants reported that access to services was somewhat difficult and took a long time – two or more months – and finding "the right door".
- All participants have a primary care physician and report communication with psychiatrist happens on a regular basis.
- All participants state that communication with treatment providers is adequate and mostly with therapist.

Recommendations arising from this group include:

- Parking at site where service is delivered is a problem. Participants all agree that they would like better parking options.
- All participants would like a support group for parents to be offered by the MHP.
- A majority of participants would like 12 Step Programs offered for teens and day programs where needed.
- All participants stated that they would like MHP to offer literature to families on their child's diagnosis and treatment.

- Several participants said that they would like to see culturally diverse programs for children/youth.
- Several parents said that there was a need for inpatient substance abuse treatment for teens.

Table 8C displays demographic information for the participants in group 3:

Table 8C—Consumer/Family Member Focus Group 3		
Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	 5
Ages of Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 3 2
Preferred Languages	English Spanish Bilingual Other	5
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	5
Gender	Male Female	 5

Interpreter used for focus group 3: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Issues were presented regarding access and difficulty finding the right door – especially where children/youth are concerned.
  - Shortage of psychiatrist appointments and change in provider are both issues that consumers/family members feel are barriers to wellness and recovery.

  - All focus groups participants endorsed feeling that their services were delivered in a culturally competent environment. However, several mentioned they would like more bilingual providers in Spanish.

- Timeliness of Services
  - Time between appointments is often longer than the consumer is comfortable with, and this is especially true for medication management.
  - The majority of focus groups participants are satisfied with response of MHP when contacted by telephone.
- Quality of Care
  - Most Focus Groups participants are aware of Wellness and Recovery (WRAP) model and talk about their providers using this and it giving them a hopeful perspective.
  - The majority of Focus Groups participants point out that consumers are not completely clear on how to access information about services offered, wellness center activities, NAMI, etc.
- Consumer Outcomes
  - The large majority of Focus Groups participants expressed feeling more hopeful and having more wellness than before they began receiving services.

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	64.12%
Contract providers	32.57%
Network providers	3.31%
Total	100%

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

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

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

40%

- MHP self-reported average monthly percent of missed appointments:

8.43%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- Medi-Cal penetration rate reports are produced quarterly.
- The MHP reported a 50% rate of co-occurring diagnoses last year versus 40% this year, but was unable to identify the cause of the drop.

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar Suite from Netsmart Technologies as a remotely hosted IS managed by the vendor under an Application Service Provider (ASP) contract.
- Internally developed databases are used to track initial contacts and integrate the information with the EHR in order to calculate timeliness data.
- Implementation of the EHR is largely complete.
- The MHP continues to utilize the Avatar Suite from Netsmart Technologies as a remotely hosted IS managed by the vendor under an Application Service Provider (ASP) contract.
- Internally developed databases are used to track initial contacts and integrate the information with the EHR in order to calculate timeliness data.
- Implementation of the EHR is largely complete.

MAJOR CHANGES SINCE LAST YEAR

- The user interface was upgraded to MyAvatar in 2014.
- Assessments were implemented in the EHR in March 2015.

PRIORITIES FOR THE COMING YEAR

- Implementation of CareConnect lab order outbound and inbound interface.
- Integration with SureScripts Electronic Prescribing Network

- Implementation of medication inventory management in Avatar
- Establishment of MyHealthPointe consumer portal kiosks in clinics.
- Implementation of Reaching Recovery adult level of care needs assessment and outcome instruments in Avatar
- Conversion of diagnoses codes to ICD-10 & DSM-V
- Implementation of ScriptLink RADplus in Avatar for the development of additional custom programing functionality and data mining
- Implementation of the MHP's EHR by 1 contract provider.

OTHER SIGNIFICANT ISSUES

- Although the MHP is planning a broad range of IT initiatives, they do not have an IT strategic plan or timeline for implementation of their goals.
- Contact providers have limited access to Avatar primarily for lookup only.
- Little activity or planning was reported towards establishment of electronic health information exchange with hospitals or primary care.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (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 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar PM	Practice Management	Netsmart Technologies	5	Netsmart
Avatar CWS	EHR	Netsmart Technologies	5	Netsmart
Avatar Infoscriber	e-prescribing	Netsmart Technologies	3	Netsmart

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plan for IS change other than the implementation of additional EHR components described above.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Avatar	X			
Clinical decision support				X	
Document imaging				X	
Electronic signature—client	Avatar	X			
Electronic signature—provider	Avatar	X			
Laboratory results (eLab)				X	
Outcomes	Avatar	X			
Prescriptions (eRx)	Infoscriber	X			
Progress notes	Avatar	X			
Treatment plans	Avatar	X			
Summary Totals for EHR Functionality		7		3	

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

- Contractors have access to Avatar for EHR lookup and service entry only.
- LOCUS and CANS instruments are integrated into Avatar.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP has been reporting penetration data on a quarterly basis

- Timeliness of Services
  - The MHP has the capability to track post hospitalization follow-up appointments and rehospitalization data, but does not monitor these elements.
- Quality of Care
  - ISDS produces reports for the QI and management teams on a routine basis and as requested.
- Consumer Outcomes
  - No outcome reporting is available from the LOCUS and CANS data entered in Avatar.
  - The MHP intends to produce outcome reports from the Reaching Recovery Instruments once they are implemented in Avatar.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers affecting the CalEQRO's ability to prepare for and/or conduct a comprehensive review.

CONCLUSIONS

During the FY14-15 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 new child/youth 16 bed PHF offers opportunity for Fresno County child and youth to receive inpatient treatment locally in lieu of out of area. This offers access to family support and treatment continuity upon discharge.
  - The Access committee is working with IT to track the data on wait times from initial request for service. These are compared to the MHP standards in order to note areas where there are timeliness issues.
- Opportunities:
  - The MHP's penetration rate based on Medi-Cal claims data for specialty mental health service (Short-Doyle Medi-Cal) is 3.59%. This is lower than comparison to State wide and other large MHP's.
  - The MHP trends "on-time" services at the end of the fiscal year for purpose of assessing how well they are doing meeting service accessibility goals. This would be more useful information increasing access to services if it were produced on a not more than quarterly basis.

Timeliness of Services

- Strengths:
  - The recent capability of Avatar system (as of March 2015) to automatically notify providers that their patients are entering the hospital and when they are being discharged offers the opportunity to decrease follow up after discharge time.

  - The MHP is aware of issue of wait time for psychiatrist appointment. A psychiatrist via tele-psychiatry currently has office hours for "walk ins" in an effort to help reduce this wait time for those in need of early appointments.

- Opportunities:
  - The MHP does not have a standard for percentage of readmission within 30 days following discharge from hospitalization.
  - The MHP does not have a reasonable standard or goal (currently 30 days) for timely access to follow-up appointments with a clinician after hospitalization. The HEDIS measure goal is 7 days. The MHP does not consistently track this measure.
  - The MHP has a standard of 3 days for appointment for urgent conditions. In reality they are generally achieving one day. It would be a more realistic goal to set it at one day as three days is not a reasonable time frame for an urgent condition to wait.

Quality of Care

- Strengths:
  - Recovery 360 is in process of training and implementation across MHP. This measures recovery from multiple perspectives, to include clients, practitioners and the overall agency.
  - Currently the MHP has one program (Supportive Employment Education Services Program) accredited by CARF and continues to judiciously explore other possible accreditations.
  - Evidence of strong collaboration with community organizations serve to increase quality of service delivery and enhance wellness and recovery model.
- Opportunities:
  - The MHP has a higher percentage of those receiving four (4) services or less during the year compared to State and other large counties.
  - Expenditures for Fresno MHP (average approved claim per consumer served) is $3,970, which is lower than State average and other large counties.

Consumer Outcomes

- Strengths:

- The MHP Law Enforcement Field Clinician (LEFC) program is working to assist county law enforcement officers with training on mental health and writing of 5150 holds and the 5150 process. This program goals include diversion from jail and increased access and engagement with mental health services for the client, as well as increased community and law enforcement officer safety. 2014 reports show increase in 5150's written and decrease in incarceration.

- The MHP utilizes LOCUS (Level of Care Utilization System) and CANS (Child and Adolescent Needs and Strengths) to measure outcomes. They are considering adding the Denver Recovery 360 assessment for outcomes into their practice.

- Opportunities:

  - The MHP has not developed any regular, ongoing client satisfaction surveys to utilize for the assessment of programs and services.

  - The Non Clinical Pip regarding telephone call to Access Line has not been surveyed with actual live consumers reaching out for services. Also, the website does not have any outcome measures that are being tracked and utilized to improve access and engagement in services.

RECOMMENDATIONS

- The current Fresno Behavioral Health website (http://www.co.fresno.co.us/Departments.aspx?id=120) is confusing and difficult to navigate. Website could benefit from reorganization so as to be more accessible to consumers.

- The MHP does not track data regarding rehospitalizations. This is an important measure of timeliness and quality of care. The MHP needs to have a reasonable standard for time from hospital discharge to first appointment. This needs to be tracked as to relationship to rehospitalizations, including frequency and time from first discharge.

- The MHP is growing its consumer/family member employee and volunteer program. A delineated career ladder, a designated in-house supervisory position for a CFM employee to report to leadership is needed to assure lived experience continues to play a vital role in the wellness and recovery model.

ATTACHMENTS

Attachment A: Review Agenda

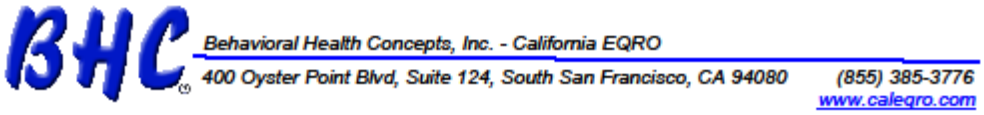
Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the Fresno County MHP On-Site Review Agenda:



Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

Fresno County
MHP CalEQRO Agenda

Day 1 **Wednesday, April 15, 2015**

Time	Activity Unless otherwise noted, all sessions will be held at Department of Behavioral Health Heritage Center Children's Outpatient 3133 N. Millbrook Ave 93703
8:30 am – 9:00 am	Opening Session • Introduction to BHC • MHP Team Introductions Participants: MHP Leadership, Quality Management Staff, Key Stakeholders Location: UC Merced Center, Fresno 550 E. Shaw Avenue Fresno, CA 93710 LH, JM, GB, TdW
9:00 am- 10:30am	Review of Past Year • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • Use of Data in the Past Year Participants: MHP Leadership, Quality Management Staff, Key Stakeholders Location: UC Merced Center, Fresno 550 E. Shaw Avenue Fresno, CA 93710 **** Same participants as opening session *** (15 minutes break to allow for change in participants)
10:45 am- 12:00pm	Performance Improvement Projects • Clinical PIP • Non-Clinical PIP • Technical Assistance Participants: Quality Management Staff, Key PIP

fresno mhp eqro review final agenda fy14-15 lh v2

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT, Lead Quality Reviewer
Gale Berkowitz, DrPH, Quality Reviewer
Jerry Mark, Information Systems Reviewer
Tilda De Wolfe, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP SITES

Heritage Center Children's Outpatient
3133 N. Millbrook Ave
Fresno, CA 93703

Blue Sky Wellness Center
1617 E Saginaw Way #108
Fresno, CA 93726

Participants Representing the MHP

Name	Position	Agency
Alexandra Moy	QI Clinician	DBH
Alicia Austin-Townsend	Program Supervisor	MHS Fresno IMPACT
Angel Maanriquez	Biller/Bookkeeper	TPOCC/ICSS
Arnold Christensen	Peer Support Specialist	TAY Turning Point
Ashely Gartin	Peer Support Specialist	TAY Turning Point
Bai Houngviengkham	Senior Staff Analyst	DBH
Betty Brown	Division Manager	DBH Managed Care

Billie Hughes	Peer Support Specialist II Advanced Level Facilitator	DBH –Metro
Brenda Kent	Regional MH Director	Kings View
Brian McKeenan	Clinical Supervisor	DBH
Brian Wagner	Administrator	Central Star Behavioral Health
Chao Xiong	Senior Staff Analyst	DBH
Chris Schreiber	Utilization Review Specialist	DBH
Chris Weatherby	Clinical Supervisor	DBH
Connie Chun	DSC	DBH
Cornell Archie	Senior SPA	DBH DSS – IT
Dawan Utecht	Director	DBH
Delores Bernal	OA-CAAT	DBH
Diana Yee	Managed Care Coordinator	DBH
Doug Cox	Senior SPA	DBH
Elizabeth Vasquez	Compliance Officer	DBH
Francisco Escobedo	Senior Staff Analyst	DBH
Freddie Zavala	Senior AI	DBH – UCWC
Gabriel Gomez	QI Clinician	DBH
Heather Mann	Peer Support Specialist	DBH Metro Housing MHSA
Irene Takahashi	Division Manager	DBH Children's MH
Iris Badillo	Accountant	Fresno County
James A. Ritchie	MHSA WET Coordinator	DBH Business operations
Jeanie Cox	Clinical Supervisor	DBH
Jeannie Hurtado	Business Manager	DBH Business Office
Jeff Avery	Clinical Supervisor	DBH
Jeffery Robinson	Clinical Supervisor	DBH

Joan Keenen	Clinical Supervisor	DBH
Joseph Rangel	Division Manager	DBH
Kannika Toonachat	Division Manger	DBH
Karen Cowdrey	SAC Supervising Account Clerk	DBH
Karen Markland	Division Manager	DBH
Karla Boyd	Licensed Mental Health Clinician	DBH Children's MH
Katherine Martindale	DSS PM	DBH DSS
Kathy Anderson	Senior Analyst	DBH SUD Services
Kristi Williams	Family Advocate	Family Advocates
Lesby Flores	Clinical Supervisor	DBH
Laura Lambright	Peer Support Specialist II	DBH
Laura Spera	Senior Licensed Mental Health Clinician	OAT
Les C. Lucas	Clinical Supervisor	DBH
Loren Wiens	Senior Licensed MH Clinician	DBH Adult
Lynn Kliewes	Senior Licensed MH Clinician – First Onset	DBH Adult
Manny Joaquin	Housing Coordinator	Turning Point
Margaret Villavazo	Peer Support Specialist	TAY Turning Point
Mark Winslow	SPA	DBH - ISDS
Maryann Le	Deputy Director – Business Operations	DBH
Mathieu Gee	Program Tech	DBH - ISDS
Melanie Cerrion	Program Manager	MHS – Fresno IMPACT
Michael Miller	SPA	DBH
Michell Owhadi	Administrative Director	CPI
Michelle LeValley	Senior Licensed Psychologist	DBH Children's MH
Natasha Hagaman	Principal Analyst	DBH SUD Services

Natasha Pettengill	Biller/Bookkeeper	Turning Point, RMH
Noelle James	Clinical Director	EMQ Families First
Paulette Murray	Clinical Supervisor	DBH
Preet Sanghera	Principal Analyst	DBH
Ricardo Ochoa	Supervising Accounting Clerk	Fresno County Business Office
Richard Brown	SPA	BHS
Rita R. Mehia	Clinical Supervisor	DBH
Robbin Scida	SPA	DBH
Robert Johnson	Senior Substance Abuse Specialist	DBH
Roger Hager	SPA	DBH – ISDS
Rohina Fazil	Program Manager	Mental Health Systems
Ruth Chavez	Medical Records Coordinator	DBH
Ryan Banks	Program Director	Turning Point
Sandra Medina	Clinical Supervisor	DBH
Scott Hollander	C.O.O.	Turning Point
Sean Patterson	Senior Staff Analyst	DBH
Shari Shintaku	BO Supervisor Accountant	DBH
Sharon Ross	Reg. Director	TPOCC
Stacy VanBruggen	Division Manager – Adult	DBH
Sue Ann Nguyen	Program Technician	DBH
Susan Holt	Deputy Director – Clinical	DBH
Tina Garcia Hindman	SOA III	DBH – ASOC
Tracie Emmerson	Supervising Accountant	DBH Business Office
Trever Birkholz	Clinical Supervisor	DBH – Older Adult /DBT Team
Tyler Etceverry	Unlicensed Mental Health Clinician	DBH Children's MH

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP separately in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Fresno	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Care Coordination Collaborative (CCC)		
Dates in Study Period: November 2013 – January 2015		
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 ☐ Not Applicable ☐ Unable to Determine	Consumer stakeholders missing from participants; no mention them.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***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	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	How is this a problem for Fresno specifically and how do you kn Clients who have been prescribed atypical antipsychotic drug C (Clozapine), who are generally an extremely high needs popula who have a treatment resistant diagnosis (i.e. schizophrenia or psychotic disorder).

CalEQRO PIP Validation Tool V1.3 Pag

Non-Clinical PIP:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Fresno	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Access Line		
Dates in Study Period: October 2012 to present		
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 ☐ Not Applicable ☐ Unable to Determine	All involved DBH employees; no consumers or other stakehold
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Test calls were conducted, collected and reviewed. There were issues with calls being logged appropriately.