FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP DRAFT 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 CY14—14,161
  - MHP Size—Large
  - MHP Region—Central
  - MHP Threshold Languages—Spanish, Hmong
  - MHP Location—Fresno

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Fresno 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

[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.

- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- 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 MHP submitted two PIPs 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 three 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:

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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.

- 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 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, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 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 FY14-15

- Recommendation #1: The current Fresno Behavioral Health website (http://www.co.fresno.ca.us/Departments.aspx?id=120) is confusing and difficult to navigate. The website could benefit from reorganization so as to be more accessible to consumers.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - In October 2015, the Internal Services Department (County IT) began its RFP process for a complete redesign of the entire county website (in use over past 15 years with no upgrade of user end functionalities) with the estimated rollout of Summer 2016.
  - The RFP bidding document was released February 2016. The Fresno MHP projects beginning to reorganize and redesign its website to be more accessible

to clients and the public in the next five months. This is expected to resolve the issue of user friendliness and access to information.

- The MHP has added to the website the ability for users to access it in Spanish or Hmong languages.
- A "Community Resource Card" three-fold was designed to provide multi-agency access information during the time needed for developing a more user friendly website.

- Recommendation #2: The MHP does not track data regarding re-hospitalizations. 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 re-hospitalizations, including frequency and time from first discharge.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has taken steps that demonstrate the understanding of the importance of re-hospitalizations tracking and measuring of timeliness and quality of care; this includes the need for tracking re-hospitalizations to include frequency and time from first discharge. These steps include:
    - Hospital Alert: In March 2015 the MHP developed the Hospital Alert process in its EHR (Avatar) and hospitalizations tracking.
    - Following the Hospital Alert roll out, the MHP began tracking re-hospitalization to include frequency and time from first discharge.
    - The MHP receives hospital census daily from the Psychiatric Hospital Facilities (PHFs) and hospitals. A designated staff reviews the census, identifies current DBH clients, and provides a Hospital Notification alert into client's EHR. The provider receives the alert and has three days to respond.
    - The MHP set a standard for time from hospital discharge to first appointment as 30 days.
    - The Hospital Alert provides a prompt if a client is admitted more than once in a 30 days period.
  - The Hospital Alert system has increased the MHP's ability to accurately track timeliness.
  - The MHP tracks data on re-hospitalizations within 30 days with a percentage of 20% readmission rate (21% for adults and 13% for children). The MHP does not have a goal rate for readmissions within 30 days at this time.

- Recommendation #3: 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.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The Fresno MHP explicitly decided not to adopt this recommendation. However, they assert that they understand the importance that lived experience plays in the wellness and recovery model.
- Some staff members in Fresno MHP who started as Peer Support Specialists (PSS) have been promoted into other classifications. A PSS pursuing a career in clinical services would advance through the Community Mental Health Specialist (CMHS) to Unlicensed Mental Health Counselor (UMHC) career pathway.
- The MHP is currently increasing training across all classifications to include PSS. These trainings include Workforce Integration, Support and Education (WISE), Wellness Recovery Action Plan (WRAP) facilitation and other useful trainings.
- There are a number of personnel throughout all classifications in the department who have lived experience either as a person receiving services or a family member. The MHP maintains the view that this is a better system in that it does not promote stigma.
- Fresno MHP Clinical Operations will continue reviewing and discussing how Fresno MHP clinical care is organized and delivered, and should the supervisory structure of Peer Support be changed in the future then this recommendation/option will continue to be explored.

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 MHP currently has 26 FTE clinician positions which are unfilled that impacts clients access to timely care. They contracted with local contract provider organizations to provide additional services throughout their system of care.
  - The MHP is in the process of executing a contract with Exodus for provision of the Access Line. This will replace the current system now in place which was the subject of last year's administrative PIP.

        - ▷ The MHP expects to deliver the scope of work to the Board of Supervisors (BOS) in June 2016.
        - ▷ The Exodus Access Line will be available 24 hours a day, seven days a week.
        - ▷ It has the potential to be linked into the EHR system.
        - ▷ It would require staffing by a trained clinician.
        - ▷ Rollout is projected for later in 2016.
    - The MHP initiated same day access in their adult clinics in past year. This allows for a walk-in system that includes a screening and any urgent appointment needed that day and/or future appointments scheduled if not urgent.
    - The MHP opened the Crisis Stabilization Center for Youth and adults. Operated by Exodus Recovery, a contract provider in April 2015.
    - The MHP opened a 16 bed Psychiatric Health Facility for Youth in April 2015. Fresno County funds 12 beds, it is operated by Central Star Behavioral Health, a contractor provider.
- Timeliness of Services
    - The MHP increased tracking and monitoring of key performance indicators to include establishment of performance goals in timeliness assessment.
    - The Hospital Alert process developed by the MHP in its EHR (Avatar) and hospital tracking purpose is to notify staff through Avatar when their clients have been admitted inpatient in PHF/hospital and promotes the clinical staff member to follow up with their clients. Unlinked clients are given information on post discharge follow up options by the facility discharge planner.
- Quality of Care
    - The vacant Quality Improvement Coordinator position was filled in October 2015.
    - The MHP reinitiated the Quality Improvement Division in the past year. This will facilitate the need for more data utilization in program planning and implementation.
    - Reaching Recovery is a program the MHP began implementing over a year ago as the technology of choice for integrating wellness and recovery principles into their Adult Systems of Care (SOC). This is a result of incorporation of the Mental Health Center of Denver's Reaching Recovery, which the MHP has engaged for training and support. Complete roll out is projected by the end of 2016.
        - ▷ Reaching Recovery Tools are being implemented into the EHR in Avatar.

    - ▷ Roll out will be across all adult systems of care. The MHP is waiting for the development of children's tools by the vendor to include in children's services at a later date.
    - ▷ The MHP has defined levels of care and is defining caseloads to be more in line with Mental Health Center of Denver model and Reaching Recovery tools.

- Consumer Outcomes
    - The incorporation of the Advancing Recovery Model allows the MHP to measure client progress in recovery. This is useful for care coordination and creating more positive treatment outcomes.
    - The Intensive Analysis Committee was reconvened after a hiatus of over a year to identify/address critical incidents that occurred while a client is in MHP care. This committee focuses on clinical review of a case and what might have been done differently to facilitate a more positive outcome.

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 TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- 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 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, 2016.

TOTAL BENEFICIARIES SERVED

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

Table 1—Fresno MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

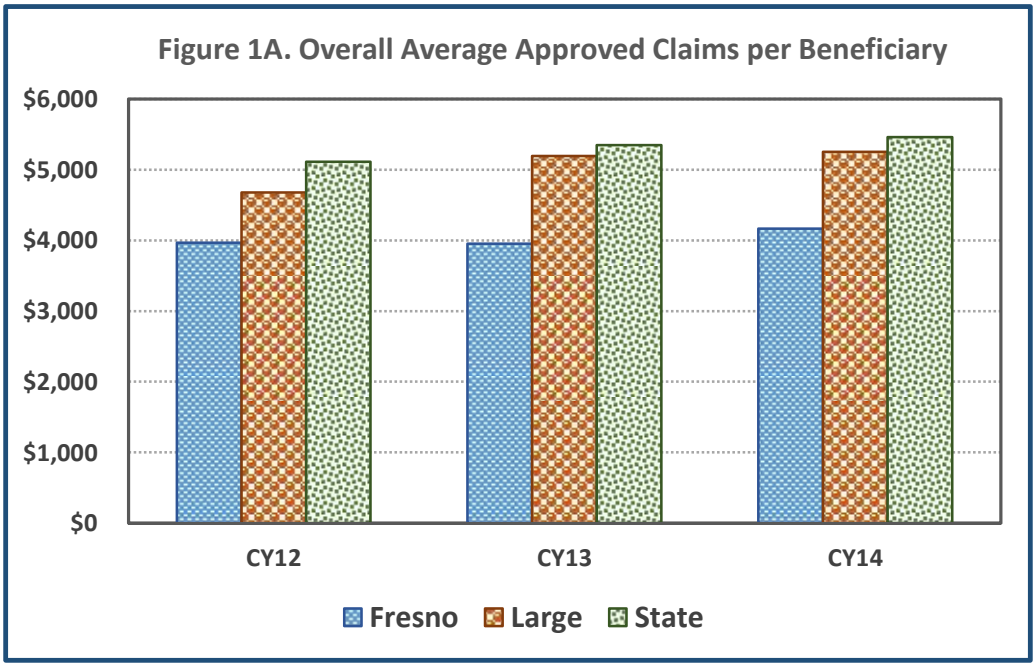
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	50,543	3,590
Hispanic	223,189	6,168
African-American	24,609	1,641
Asian/Pacific Islander	41,787	1,020
Native American	2,175	121
Other	27,598	1,621
Total	369,898	14,161

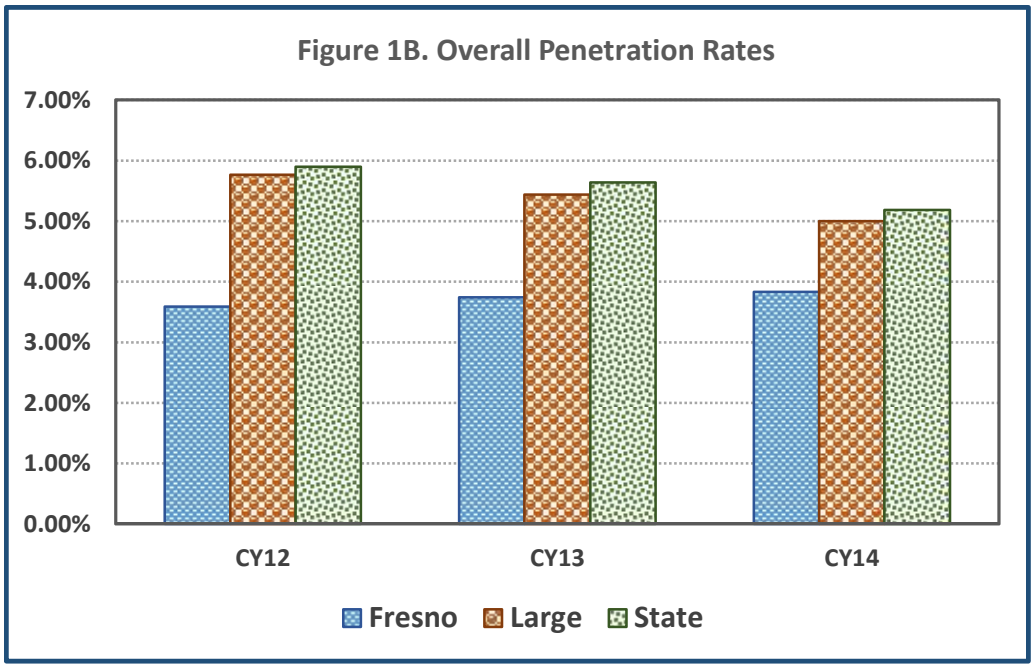
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

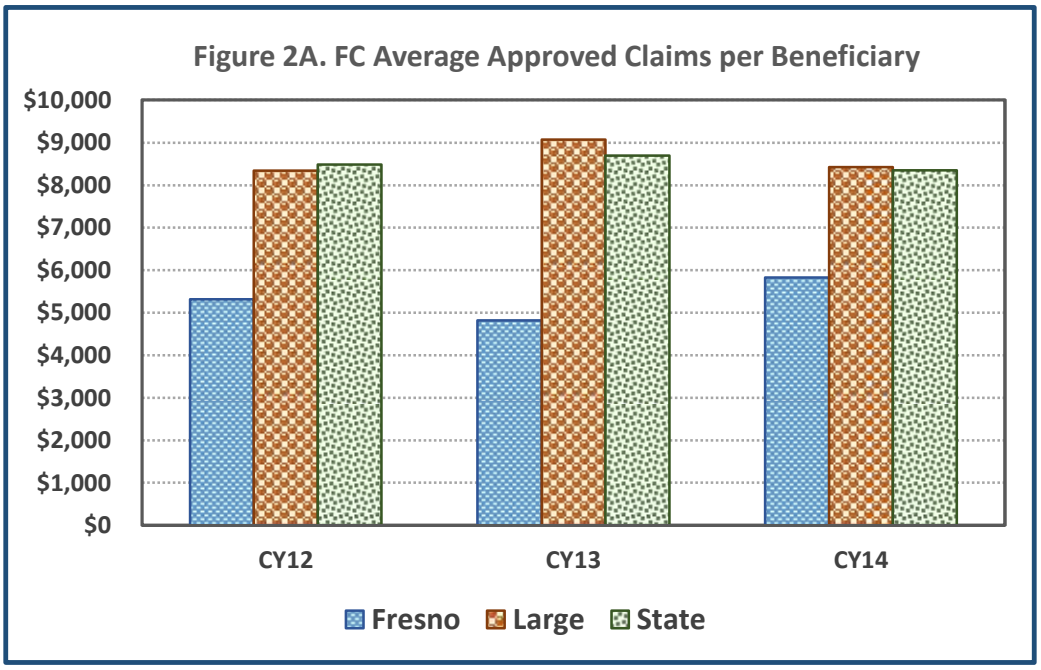
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

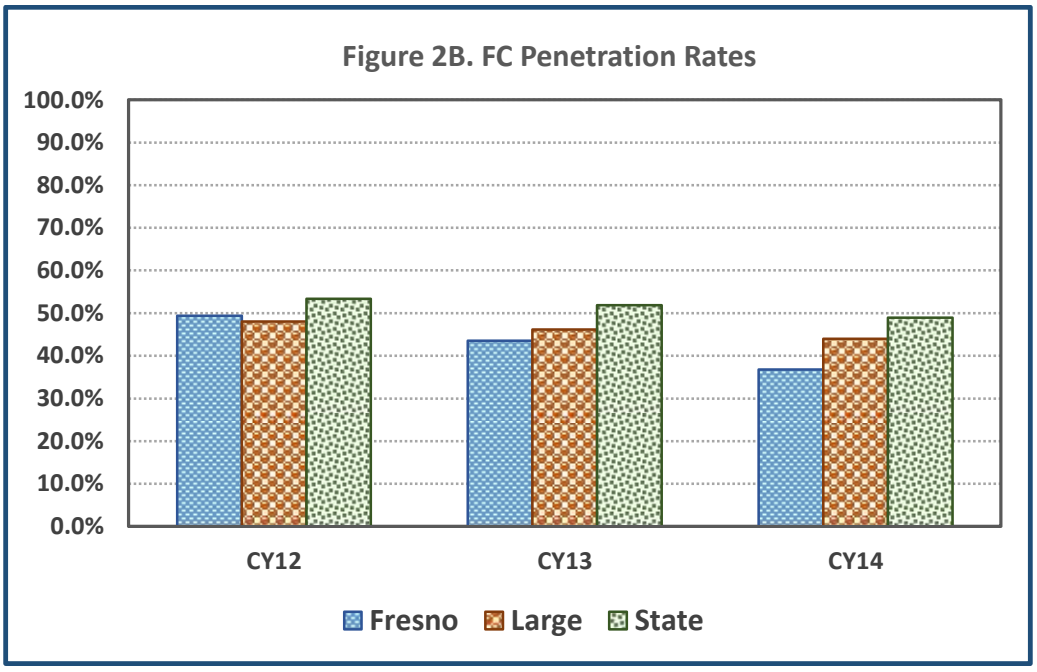
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



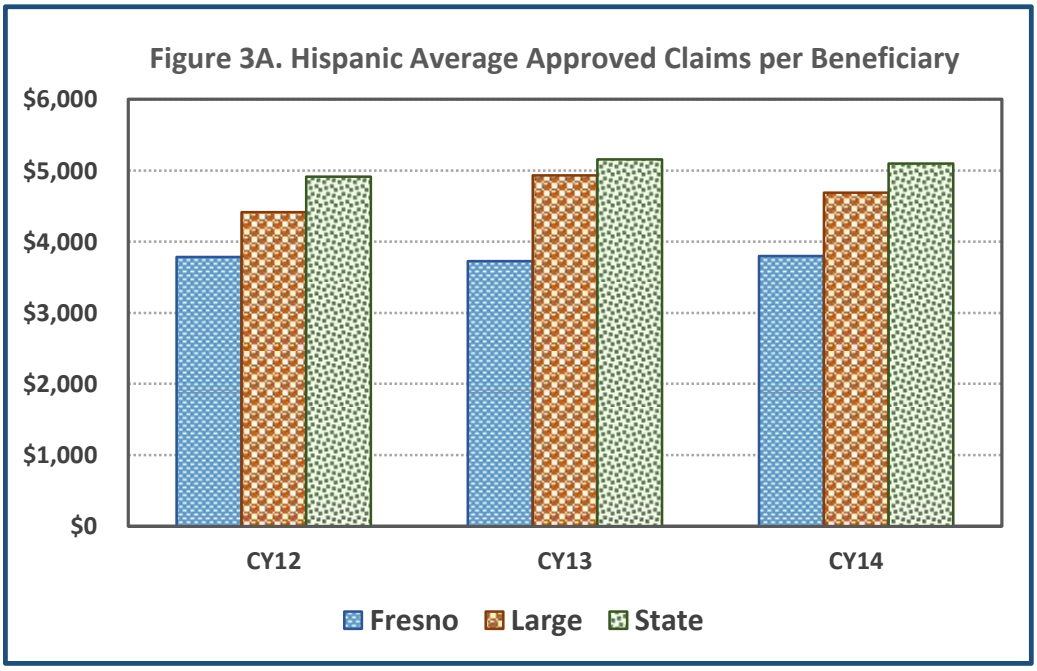


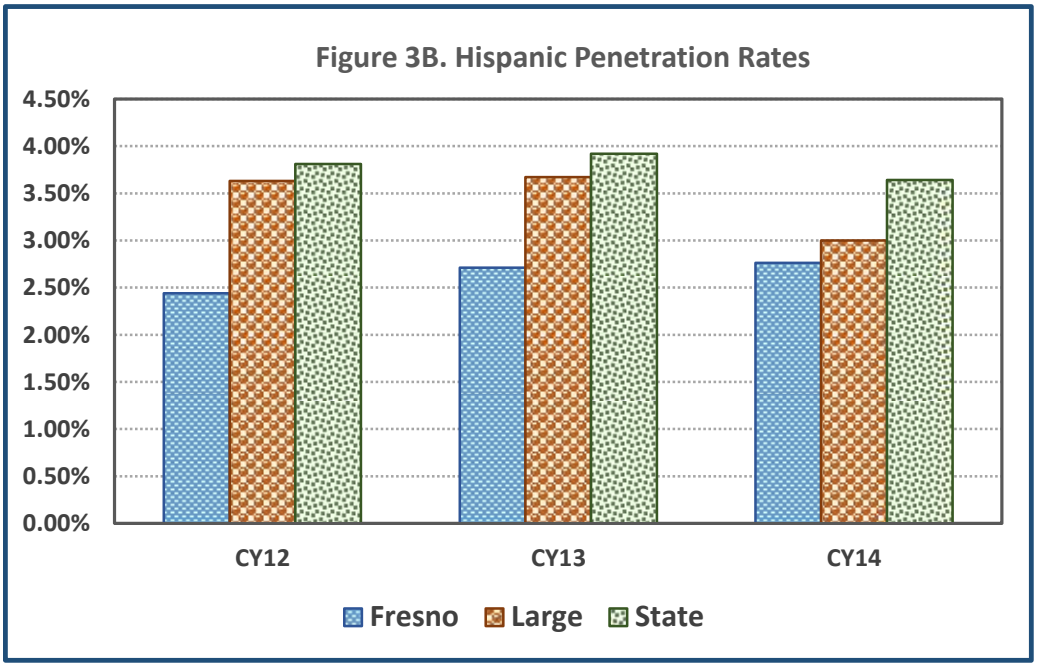
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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

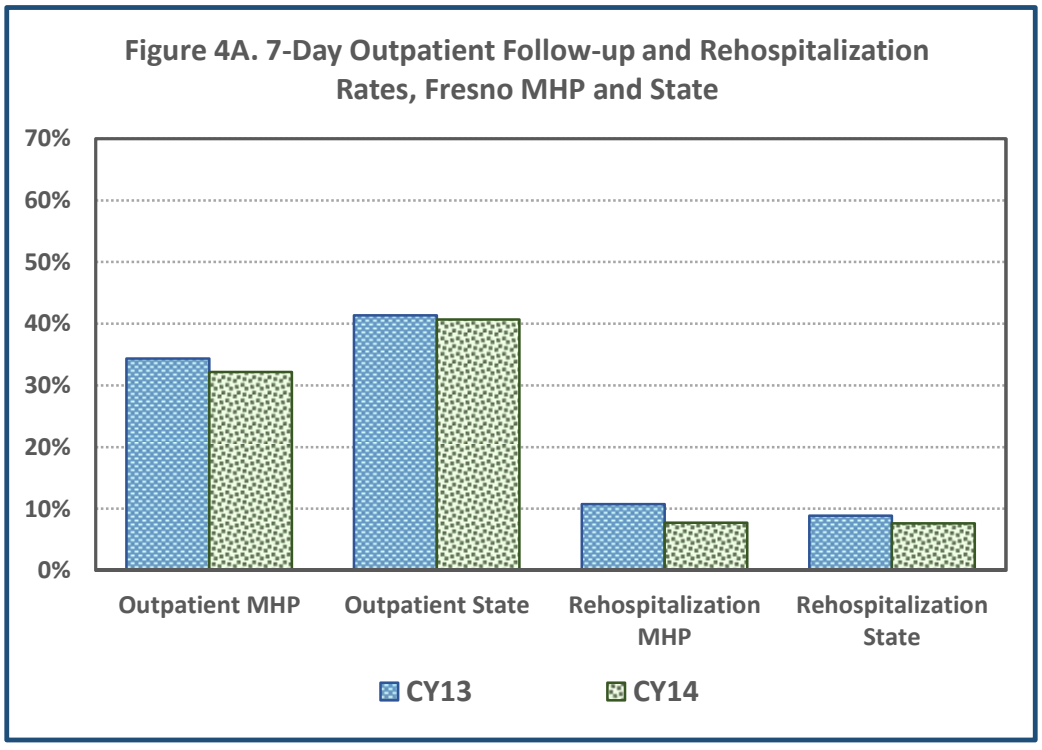
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

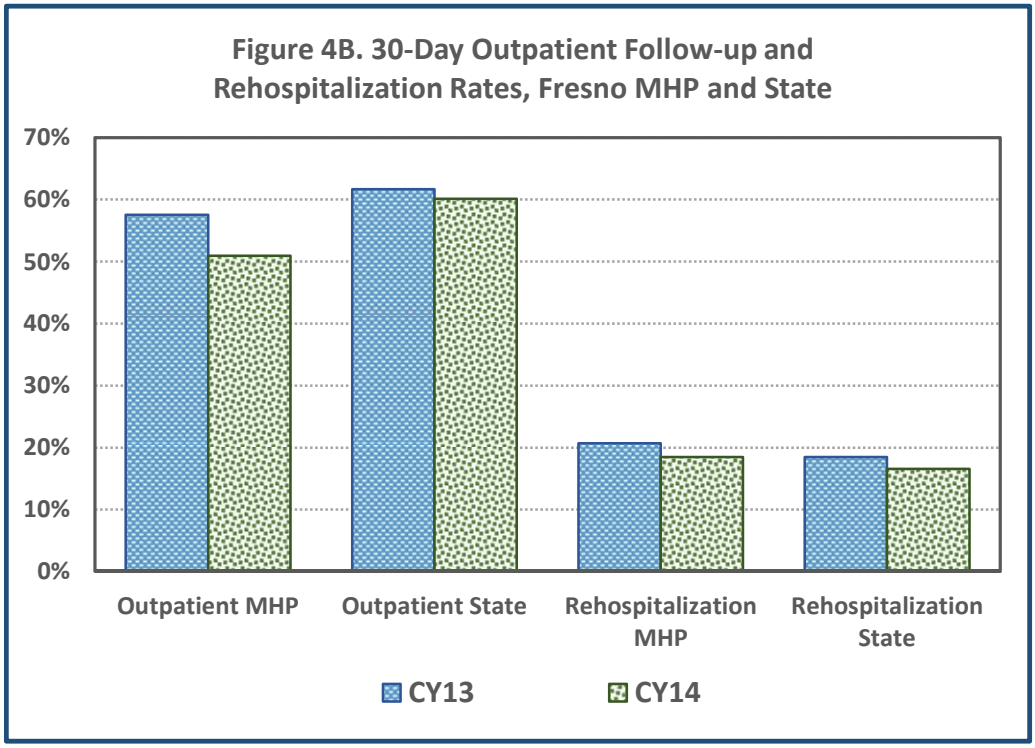
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Fresno	CY14	178	14,028	1.27%	$47,025	$8,370,499	17.29%
	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%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

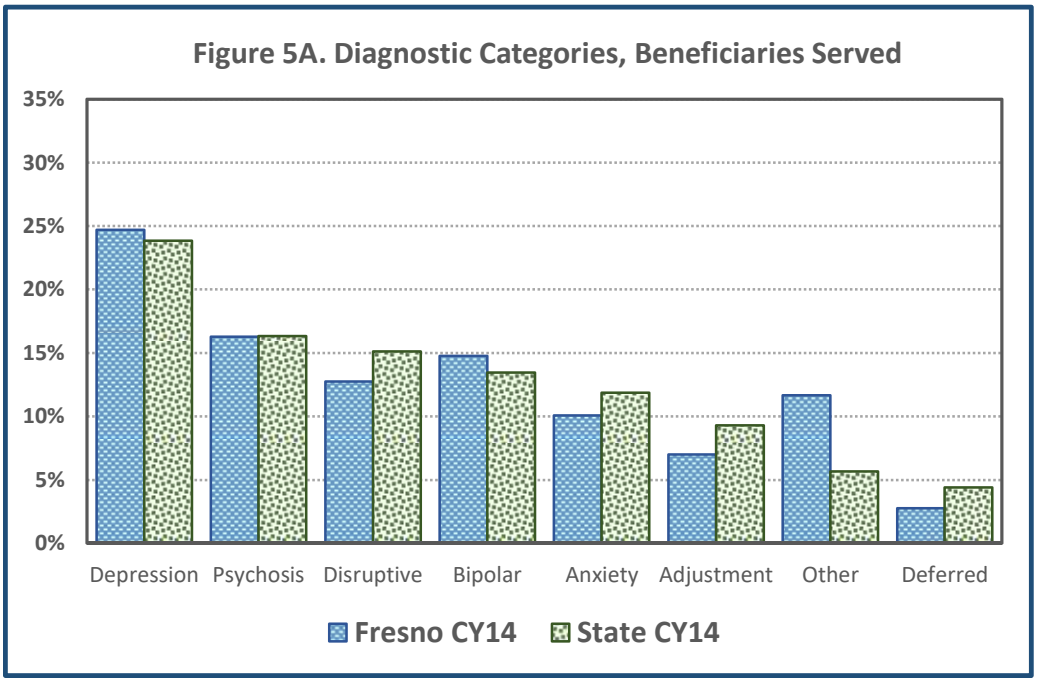
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and re-hospitalization rates for CY13 and CY14.

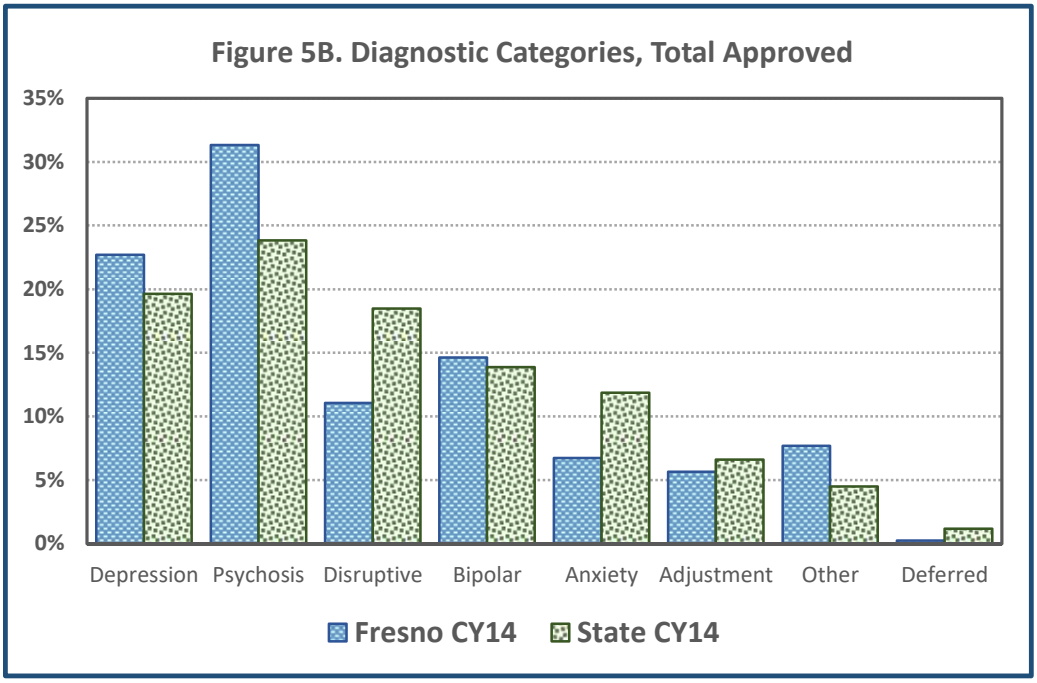




DIAGNOSTIC CATEGORIES

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 CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Although the MHP penetration rate slightly improved over the three-year period, their penetration rate was significantly lower than both large MHPs and statewide averages for the same period. (See Fig. 1B.)
  - The MHP Approved Claims per Beneficiary Served (ACBS) over the three-year period was lower than similar size MHPs and the statewide experience. (See Fig. 1A.)
  - Foster Care penetration rate declined during the three-year period and this trend was dissimilar to both large MHPs and statewide averages. (See Fig. 2B.)
  - The MHP Foster Care ACBS for CY14 improved over prior years. However ACBS was significantly lower than large MHPs and the statewide experience over the three year period. (See Fig. 2A.)
  - Hispanic beneficiary penetration rates continue to be significantly lower than the statewide experience, and the Hispanic ACBS was also lower than large MHPs and the statewide experience. (See Figs. 3A&B.)
- Timeliness of Services
  - The MHP's 7 day outpatient follow-up rate after psychiatric inpatient discharge is lower than the statewide rate; the 30 day outpatient follow-up rate after

psychiatric discharge is minimally lower than the statewide rate. (See Figs. 4A&B.)

- The MHP's 7 and 30 day inpatient re-hospitalization rates are both similar to the statewide re-hospitalization rates. (See Figs. 4A&B.)

- Quality of Care
  - The MHP percentage of HCBs for CY14 was 1.27%, which was significantly less the statewide experience at 2.48%. The MHP's total percentage of approved claims for HCBs in CY14 at 17.29% was seven points lower than the statewide figure at 24.41%. (See Table 2.)
  - Both the HCB number served and HCB total costs for CY14 were lower than CY13 and CY12 results. (See Table 2.)
  - The MHP use of "Other" diagnoses category was higher than statewide figures. Also, the claims dollars approved for Psychosis diagnoses was higher than the statewide average. (See Figs. 5A&5B.)

- Consumer Outcomes
  - The MHP 7-day and 30-day outpatient follow-up rates for CY14 are minimally lower than CY13 rates. (See Figs. 4A and 4B.)

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 2014.

FRESNO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two 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	Reduce Wait Times for Post Hospitalization Follow Up
Non-Clinical PIP	Consumer Grievances Process Assessment and Improvement

Table 3A 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 3A—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	N/A	N/A
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	N/A	N/A
		1.3	Broad spectrum of key aspects of enrollee care and services	N/A	N/A
		1.4	All enrolled populations	N/A	N/A
2	Study Question	2.1	Clearly stated	N/A	N/A

[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 3A—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	N/A	N/A
		3.2	Inclusion of the entire study population	N/A	N/A
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	N/A	N/A
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	N/A	N/A
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	N/A	N/A
6	Data Collection Procedures	6.1	Clear specification of data	N/A	N/A
		6.2	Clear specification of sources of data	N/A	N/A
		6.3	Systematic collection of reliable and valid data for the study population	N/A	N/A
		6.4	Plan for consistent and accurate data collection	N/A	N/A
		6.5	Prospective data analysis plan including contingencies	N/A	N/A
		6.6	Qualified data collection personnel	N/A	N/A
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	N/A	N/A
		7.2	Interim data triggering modifications as needed	N/A	N/A
		7.3	Data presented in adherence to the plan	N/A	N/A
		7.4	Initial and repeat measurements, statistical significance, threats to validity	N/A	N/A
		7.5	Interpretation of results and follow-up	N/A	N/A
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	N/A	N/A
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	N/A	N/A
		8.3	Threats to comparability, internal and external validity	N/A	N/A
		8.4	Interpretation of results indicating the success of the PIP and follow-up	N/A	N/A
		9.1	Consistent methodology throughout the study	N/A	N/A

Table 3A—PIP Validation Review					
				Item Rating*	
Step	PIP Section		Validation Item	Clinical PIP	Non-Clinical PIP
9	Validity of Improvement	9.2	Documented, quantitative improvement in processes or outcomes of care	N/A	N/A
		9.3	Improvement in performance linked to the PIP	N/A	N/A
		9.4	Statistical evidence of true improvement	N/A	N/A
		9.5	Sustained improvement demonstrated through repeated measures.	N/A	N/A

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

Table 3B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	N/A	N/A
Number Partially Met	N/A	N/A
Number Not Met	N/A	N/A
Number Applicable (AP) (Maximum = 30)	N/A	N/A
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	N/A %	N/A %

CLINICAL PIP—REDUCE WAIT TIMES FOR POST HOSPITALIZATION FOLLOW UP

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

- "Will implementing a notification tool in the Electronic Health Record for providers of hospitalized consumers of the Fresno MHP, 1) Increase the number of consumers that access in person follow up services within 30 days of hospitalization by 5%, and 2) Reduce by 5% the number of re-hospitalizations within 30 days of discharge."
- Date PIP began: August, 2014

- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☒ Submission determined not to be a PIP

  ☐ No PIP submitted

This PIP was not rated for validation due to being determined to not be a PIP as this time.

The PIP had a goal of increasing the number of people who engage in services post discharge from hospitalization and reduce by 5% the number who are re-hospitalized within 30 days. No clinical interventions or outcomes were noted. Although data was collected and correlated there was no intervention that pointed towards a clinical outcome.

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 discussions with the MHP to better understand the process for developing a PIP, as well as brainstorming ways to improve their current concept. Ongoing technical assistance was offered by the EQRO.

NON-CLINICAL PIP—CONSUMER GRIEVANCES PROCESS ASSESSMENT AND IMPROVEMENT

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

- "Will educating and training staff on the Fresno county MHP grievance process increase the number of Grievances captured?"
- Date PIP began: February 2016
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☒ Submission determined not to be a PIP

☐ No PIP submitted

This PIP was not rated for validation due to being determined to not be a PIP as this time.

The PIP goal was to find out if all grievances were being captured by the MHP and contractors. This question arose out of a DHCS audit where it was remarked the grievances were quite low for the size of the county. However, there were no stated consumer outcomes or consumer surveys to see if this was a problem.

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 discussions with the MHP to better understand the process for developing a PIP, as well as brainstorming potential other study questions. Ongoing technical assistance was offered by the EQRO.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Neither PIP was determined as viable for validation. No access to care can be measured via the PIPs.
- Timeliness of Services
    - Neither PIP was determined as viable for validation. No timeliness to care can be measured via the PIPs.
- Quality of Care
    - Neither PIP was determined as viable for validation. No quality of care can be measured via the PIPs.
- Consumer Outcomes
    - Neither PIP was determined as viable for validation. No consumer outcomes can be measured via the PIPs.

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 4, 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 4—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	Cultural Competency Plan; Cultural Competency Meeting includes multiple stakeholders.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP is recruiting staff to fill vacancies.
1C	Integration and/or collaboration with community based services to improve access	FC	MHP demonstrated evidence in multiple areas of engagement and collaboration with community based services.

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

Timeliness of Services

As shown in Table 5, 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 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	MHP tracks and has 30 days standard, with an overall average of 15 days, and meets the standard 82% of the time. For adult services, the MHP reports an average of 7.83 days meeting the standard 89% of the time. For children's services, the MHP reports an average of 21.05 days meeting the standard 71% of the time. The MHP presently does not regularly review timeliness to services throughout the year.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	MHP tracks and has 30 days standard which is met 45% of time with an average of 39 days. For adult services the average is 37 days meeting standard 52% of the time. For children's services the average is 30 days, and meets standard only 31% of the time. The MHP does not analyze this metric for improvement even though the standard is met less than ½ of the time.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	MHP tracks and has a 3 days standard for urgent condition, which it meets 92% of the time with an overall average of 2 days.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	MHP tracks and has a 30 days standard which is met 69% of time with an overall average of 18 days (standard met 66% of the time for adults and 75% for children).
2E	Tracks and trends data on re-hospitalizations	PC	MHP tracks but has no standard metric. Readmission rate within 30 days is 20% (21% for adults and 13% for children). The results reported covered a 9 months period – March – December 2015.
2F	Tracks and trends No Shows	FC	MHP tracks and trends no shows and has an average of 6% for clinicians and 17% for psychiatrists. The standard is 20% for both.

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

Quality of Care

As shown in Table 6, 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 6—Quality of Care

Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has a current QI Work Plan; reinitiated the QI Committee and filled QI Coordinator position this year.
3B	Data are used to inform management and guide decisions	PC	The MHP measures data elements which reflect quality, however it is lacking in establishing baselines and tracking progress.
3C	Evidence of effective communication from MHP administration	FC	Multiple demonstrations of effective communication from MHP administration were presented during this review.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Consumer employee staff and family members included as active participants in Cultural Competency Committee and Quality Improvement Committee.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	MHP validated strong collaborative relationships with many community based services.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The newly designed and utilized Hospital Alert system and soon to be activated Exodus Access call center both measure clinical and functional outcomes of access/engagement.
3G	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP administers the POQI 2X yearly. They compile and distribute results to MHP staff and Contractors due to usefulness of timely feedback.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	No consumers or family members have been identified in supervisory or management positions.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
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
  - The MHP is in process of completing a contract with Exodus for provision of the Access Line. This will replace the inadequate system now in place.
  - The MHP increased their telepsychiatry capacity this year to allow more access to psychiatric appointments.
- Timeliness of Services
  - Capacity issues effecting timeliness continue as the MHP engages in solving the staff recruitment issue.
  - The MHP initiated same day access in their adult clinics in past year. Consumers requesting treatment can now walk-in to MHP clinics and will receive a screening and any urgent assessment/medication prescriptions necessary that day, as well as appointments for future when client meets medical necessity.
  - As noted in 2B, the, MHP meets its standard of timeliness from initial contact to first psychiatric appointment less than half the time.
  - The MHP reports an average length of time (18 days) within its standard/goal metric of 30 days for follow up appointments post discharge from hospitalization. It meets this standard 69% of the time. HEDIS standard is 7 days.
- Quality of Care
  - The information from both supervisors and contract providers support effective two way communication with administration.
  - Collaboration with administration validated as demonstrated in Advisory Committee, MHSA meetings and Consumer Employees Staff meetings.
- Consumer Outcomes

- The MHP is engaged in ongoing dialog with NAMI in regards to consumer outcomes.
- Consumer and Family Member (CFM) employees suggest it would be useful to have an employee liaison on the Executive Management Team.
- The MHP is providing a variety of trainings for CFM employees to include WRAP and WISE within the past year.

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

- Focus Group 1: 8-10 Adult consumers and family members, culturally diverse group of beneficiaries, including both high and low utilizers of MHP services, of which at least three beneficiaries who have initiated services within the last year.
- Focus Group 2: 8 -10 Adult consumers and family members, culturally diverse group of beneficiaries, non-English speaking, including both high and low utilizers of MHP services, of which at least three beneficiaries who have initiated services within the last year.
- Focus Group 3: 8 – 10 Parents/caregivers of child/youth beneficiaries, culturally diverse group including both high and low utilizers of MHP services, of which at least three beneficiaries who have initiated services within the last year.

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

Focus Group 1 consisted of 11 adults, including 3 males and 8 females. They represented both high and low utilizers of services. All participants identified as consumers of services and/or family member of a consumer of services.

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

- Only one person began services within past year. This person had heard about services through the PCP and was involved with perinatal services. There were no issues in accessing care and consumer felt things were professional and timely.

Recommendations arising from this group include:

- Transportation is an issue for participants. They agree providing transportation for services would help them in engagement.
- The participants noted capacity issues in getting appointments. Due to lack of clinicians there is at times a longer wait between clinical appointments than they would like.
- Participants would like more information easily available on what services are available to them.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		11
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	8 3
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	0 0 4 7
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	6 5
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	3 7 1
Gender	Male Female Transgender Other Decline to state	3 8

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

Focus Group 2 consisted of 22 adults, including 3 males and 19 females. They represented both high and low utilizers of services. All were culturally homogenous first-generation Hmong immigrants. All participants identified as consumers of services and/or consumer and had family member who

was consumer of services. The large size of this group inhibited the ability to have a focus group type of exchange. Many questions were answered by a show of hands.

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

- Two participants began services in the past year.
- There were no perceived difficulties with accessing services.
- The participants felt that their culture was respected and that the services they received were culturally and linguistically competent.

Recommendations arising from this group include:

- The participants would like more extracurricular activities provided to help with their depression.
- Transportation was reported as a barrier to engaging in treatment. All agreed that having transportation to/from clinical appointments would facilitate engagement.
- The participants noted that they would like all staff to be aware of their lack of literacy in any language and the assistance they need in filling out forms, following written directions.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants*		27
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	13 9
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 12 10
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) ____Hmong_____	 22

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)____Hmong_____ _____	 22
Gender	Male Female Transgender Other Decline to state	3 19

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☐ No ☒ Yes Language(s): Hmong - Large group of 100% Hmong immigrants, majority with little or no English language skills.

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

Focus Group number 3 consisted of seven Parents/Caretakers of children/youth receiving services. There was one male and six females. They represented both high and low utilizers of services and were culturally diverse beneficiaries.

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

- The majority of parents reported that their child/children were referred by their PCP.
- The participants agreed that accessing services did not present difficult barriers insofar as getting an initial appointment. All agreed that after that there is sometimes a long wait of six to eight weeks for the next clinical appointment.
- The participants agreed that they felt respected by the people delivering services and that their children's mental health issues were improving.

Recommendations arising from this group include:

- MHP provides transportation to/from clinical services, as the participants stated that transportation is one of the largest barriers to receiving services.

- Provide classes for families to learn as a whole; multi-family educational groups to enhance family communication, parenting, understanding diagnosis, etc.

Table 7C displays demographic information for the participants in group 3:

Table 7C—Consumer/Family Member Focus Group 3		
Category		Number
Total Number of Participants*		7
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	 7
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 5 2
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	5 2
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	3 3 1
Gender	Male Female Transgender Other Decline to state	1 6

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 3: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - All CFM groups noted transportation as a barrier to access.

  - Capacity issues were a barrier to timely clinical appointments, which consumers note as a barrier to continued engagement.

- Timeliness of Services
  - Although initial access was normally not difficult, follow up appointments were difficult to get in a timely manner. This affects engagement of the client.
- Quality of Care
  - All participants reported being able to receive services in their preferred language.
  - The shortage of psychiatrists and need for more tele psychiatry was noted in all groups as a barrier to quality treatment.
- Consumer Outcomes
  - The majority of participants feel learning and engaging in the WRAP program had added value to their recovery.

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 8 shows the percentage of services provided by type of service provider:

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	66%
Contract providers	28%
Network providers	6%
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:

52%

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

9%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- The MHP calculates Medi-Cal beneficiary penetration rates quarterly. They periodically use Fresno County population and geographic data to measure unmet service needs by ethic, cultural and linguistic population, and by County Region (Metro, East, West, and Out of County).

CURRENT OPERATIONS

- The MHP continues to use the Avatar application from Netsmart Technologies for their EHR system, which is remotely-hosted by the vendor under an Application Service Provider (ASP) contract.
- Technology support is currently allocated seven full-time equivalent positions. Since the previous CalEQRO review the MHP has experienced no staff turnover.
- Avatar user trainings are available for hands-on experience in a test database. All courses are available for County and Turning Point (a contract provider) staffs. There are monthly Avatar training classes and a library of training videos. Individual Avatar support is provided by subject matter expert clinicians.
- The MHP provides telepsychiatry services at county-operated sites. Services are available in English and Spanish. During the past year they served about 2,300 clients.
- Three contract providers also provide telepsychiatry services. During the past year these providers served about 3,000 clients.

MAJOR CHANGES SINCE LAST YEAR

- ICD-10 implementation.
- Turning Point programs were added as full Avatar mental health record users.
- Expanded document scanning – Beyond Health Records – new forms are either electronic or scanned into clients EHR.
- Finalized Contractor Payment Module.
- Finalized Staff Productivity Report.
- Created Overall Outcome Tracking Tool.

PRIORITIES FOR THE COMING YEAR

- Decide whether to either release a Request for Proposal (RFP) for new IS system, or to renew current Avatar contract.
- Implement Reaching Recovery and Level of Care Assessment tools for Adult System of Care.
- Implement Managed Services Organization (MSO) authorization module.
- Implement Order Connect - eLab outbound and inbound interface.
- Implement Netsmart Technologies – Surescripts (pharmacy orders).
- Implement Netsmart Technologies – Script Link (Web Services Definition Language).
- Medication Inventory Management.
- MyHealthPoint Kiosks.
- Rollout the new DBH website for public information.
- Partner with Central Valley community health care providers on the Health Information Exchange project (CVHIE).

OTHER SIGNIFICANT ISSUES

- Permit additional contract providers programs full access to Avatar EHR to create a comprehensive electronic record for clients served system wide.
- Double data entry for those contract providers with a local EHR system remains a challenge as staff also does data entry into Avatar. This process is both time-consuming and prone to data entry errors.
- While network providers account for small percent (6%) of services provided. It's time to automate support for this group of providers by implementing Netsmart Technologies MSO and Provider Connect applications. Eliminate paper process and embrace and implement electronic transactions.

Table 9 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 9—Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar PM	Practice Management	Netsmart Technologies	6	MHP
Avatar CWS	EHR	Netsmart Technologies	6	MHP
Avatar Infoscriber	e-prescribing	Netsmart Technologies	6	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- As of March 2016, the MHP is at a decision point to negotiate and extend the Fresno County and Netsmart Technologies - Avatar contract or to develop an IS system Request for Proposal and seek other IS vendor responses to that solicitation.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	Avatar CWS	X			
Clinical decision support					X
Document imaging	Netsmart		X		
Electronic signature—client	Topaz	X			
Electronic signature—provider	Topaz	X			
Laboratory results (eLab)				X	
Outcomes	CANS/LOCUS	X			
Prescriptions (eRx)	Infoscriber	X			
Progress notes	Avatar CWS	X			
Treatment plans	Avatar CWS	X			
Summary Totals for EHR Functionality		7	1	1	1

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

- The MHP is incrementally implementing document imaging. New forms are entered directly into EHR or are scanned into same. The paper documents will be phased-out over time. End date is as yet unspecified.
- The MHP plans to implement laboratory orders and results – OrderConnect.
- The MHP relies on hybrid (electronic and paper) medical records system wide.
- County-operated programs have full access to Avatar EHR functions listed above.
- Turning Point programs, a contract provider, have full access to Avatar EHR functions listed above. Other contract providers have Avatar EHR lookup and service data entry only access.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Both county-operated sites and three contract providers currently provide telepsychiatry services which are used by nursing, psychiatrists, and clerical staffs.
  - The MHP continues to report penetration rate data on a quarterly basis. The analysis includes summary by age groups, primary language, race/ethnicity, and by County Region (Metro, East, West, out-of-county).
- Timeliness of Services
  - The quarterly Under-utilizer report identifies patients who did not have an outpatient visit within 30 days of hospital discharge. Summary reports include by County Region (Metro, East, West, out-of-County), primary language, gender, and client's first service. The client-level report identifies if client has a case manager or is on a caseload in the Systems of Care (SOC).
  - The MHP produces Wait Times Report for a 12 month period that measures quarterly results. The report measures "average number days to 1st service" for four cohorts – adult (urgent, non-urgent) and child (urgent, non-urgent).
- Quality of Care
  - The "Reaching Recovery Tools" are being embedded into the Avatar EHR system.
- Consumer Outcomes
  - CANS and LOCUS tools are embedded in Avatar EHR.

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 or conditions that significantly affected CalEQRO's ability to prepare for and/or conduct this review.

CONCLUSIONS

During the FY15-16 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:
    - Same day access in MHP adult outpatient clinics offer clients the opportunity to be screened when s/he walks in requesting services. If a client meets medical necessity and/or an urgent situation requires it, an assessment and medication evaluation can be done that same day.
    - Exodus call line will replace existing access lines. The Exodus Access line will operate 24/7 and has the potential to connect to the EHR system.
    - Both county-operated sites and three contract providers currently provide telepsychiatry services which are used by nursing, psychiatrists, and clerical staffs.
    - The MHP continues to report penetration rate data on a quarterly basis. Analysis includes summary by age groups, primary language, race/ethnicity, and by County Region (Metro, East, West, out-of-county).
- Opportunities:
    - Fresno continues to have low penetration rates in comparison with state wide and other large counties. There has been no significant research into the context, possible causes and ways to improve penetration.
    - The MHP currently experiences 26 FTE open clinical positions. This means they are over 20% understaffed.

Timeliness of Services

- Strengths:

- The Hospital Alert system, newly designed and utilized, gives to the client who has been admitted to the hospital timely contact and discharge planning from the clinician who is engaged with the client in an outpatient setting.
- The quarterly Under-utilizer report identifies patients who did not have an outpatient visit within 30 days of hospital discharge. Summary reports include by County Region (Metro, East, West, out-of-County), primary language, gender, and client's first service. The client-level report identifies if client has a case manager or is on a caseload in the SOC.
- The MHP produces a quarterly Wait Times Report. The report measures "average number days to first service" for four cohorts: adult (urgent, non-urgent) and child (urgent, non-urgent).

- Opportunities:
  - The MHP's Post hospital discharge timeliness standard at 30 days is considerably longer than the HEDIS standard of seven days.
  - The MHP meets its standards for timeliness from initial contact to first psychiatric appointment less than half the time for both adult and children's services. The MHP does not presently analyze this metric for improvements.
  - Stakeholders have voiced concern in being able to access required medications in a timely manner.

Quality of Care

- Strengths:
  - Input from consumers is gathered through the Review Advisory Committee (RAC). RAC is the mechanism to communicate with consumers. This is shared with the Quality Improvement Committee.
  - Outreach to minority cultural communities is robust. In the past year the MHP created focus groups for linguistic and cultural language for the growing Punjabis population. Information/documents were created in Punjabi language. These are now being distributed state wide.
  - Collaboration and integration of the Katie A. Pathways to Mental Health program in Fresno County is demonstrated throughout this system. DSS CWS uses the MHP Mental Health assessment for all children with an open CWS case.
  - DSS and DBH collaboratively created an information pamphlet to make available to family members and caretakers of foster children in the child welfare system entitled "Mental Health Services Children Involved in Child Welfare". This pamphlet describes services, gives contact numbers and explains the system in layperson terms.

  - Katie A. Dependency Court Brown Bag meetings, a monthly meeting to present to or hear feedback from Court personnel, are used as a forum on the mental health delivery system. At the most recent meeting (March 2016) changes in the JV 220 processes related to psychotropic medications were discussed. Present at this meeting are judges, DSS, DBH, attorneys and advocates.

- Opportunities:
  - The MHP currently tracks denied claims on an excel spreadsheet which may not be the most efficient and effective method.
  - The annual web-based (Survey Monkey) self-assessment of cultural competency completed by staff is not used, nor was it designed to identify needs for training or to denote exemplary knowledge. The survey does seek self-reporting of level of competency.
  - The "Mental Health Services for Children Involved in Child Welfare" pamphlet is currently printed only in English. There are plans to also translate it into Spanish and Hmong. This affects access for non-English speaking beneficiaries.

Consumer Outcomes

- Strengths:
  - The MHP analyzes the POQI data two times a year for internal use in order to make the results more useful and timely in program planning.
  - CANS and LOCUS outcome tools are embedded in Avatar EHR.
  - PSS report trainings in past year in WRAP, WISE and other useful psychoeducational systems.
- Opportunities:
  - The MHP does not currently support Level of Service/Level of Care active tracking coupled with recommended levels of services for consumers.
  - PSS continue to report lack of career ladder or understanding of how to advance within the MHP system.

RECOMMENDATIONS

- For the purpose of improving access, timeliness and better meeting demand for services (capacity), both County HR and the MHP needs to aggressively recruit for the 26 vacant clinical positions.

- The MHP is required to have two active PIPs. Create PIPs that address quality improvement of clinical outcomes and consumer outcomes respectively. Assure inclusion of the beneficiary voice in the PIP team selected.
- Fresno continues to have low penetration rates in comparison with state wide and other large counties, a trend that has been long-standing. Conduct a systematic analysis of service needs, demand, access and utilization in order to understand the conditions and factors affecting penetration rates to be better able to improve access to services.
- With Reaching Recovery, the MHP's new environment promotes a goal of wellness and recovery. This could be enhanced and facilitated by 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.
- Support integration of EHR with contract providers:
    - Develop plans and strategies to include additional contract provider programs with Avatar EHR full access.
    - Investigate the feasibility to improve Avatar EHR functionality to include viable solutions that address health information exchange initiatives for contract provider organizations who maintain their own EHR systems.
- Develop a project plan and timeline to implement Netsmart Technologies MSO and ProviderConnect applications as soon as practical to support electronic transactions for the network provider organizations.

ATTACHMENTS

Attachment A: Review Agenda

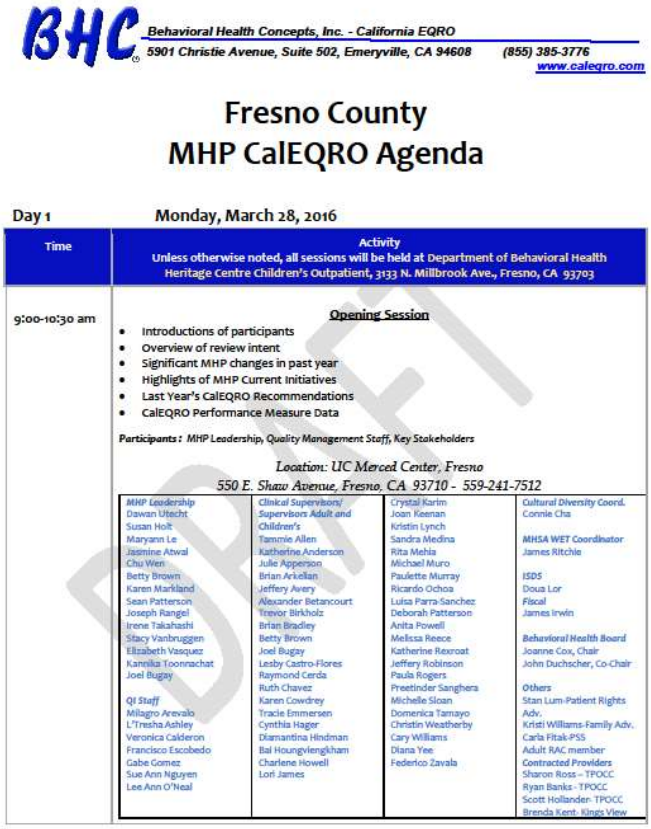
Attachment B: Review Participants

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 MHP On-Site Review Agenda:



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Fresno County
MHP CalEQRO Agenda

Day 1 **Monday, March 28, 2016**

Time	Activity Unless otherwise noted, all sessions will be held at Department of Behavioral Health Heritage Centre Children's Outpatient, 3133 N. Millbrook Ave., Fresno, CA 93703
9:00-10:30 am	**Opening Session** • Introductions of participants • Overview of review intent • Significant MHP changes in past year • Highlights of MHP Current Initiatives • Last Year's CalEQRO Recommendations • CalEQRO Performance Measure Data **Participants:** *MHP Leadership, Quality Management Staff, Key Stakeholders* *Location: UC Merced Center, Fresno* *550 E. Shaw Avenue, Fresno, CA 93710 - 559-241-7512*

MHP Leadership	*Clinical Supervisors/ Supervisors Adult and Children's*		*Cultural Diversity Coord.*
Dawan Utecht	Tammie Allen	Crystal Karim	Connie Cha
Susan Holt	Katherine Anderson	Joan Keenan	
Maryann Le	Julie Apperson	Kristin Lynch	*MHSA WET Coordinator*
Jasmine Atwal	Brian Arkelian	Sandra Medina	James Ritchie
Chu Wen	Jeffery Avery	Rita Mehta	
Betty Brown	Alexander Betancourt	Michael Muro	*ISDS*
Karen Markland	Trevor Birkholz	Paulette Murray	Doua Lor
Sean Patterson	Brian Bradley	Ricardo Ochoa	*Fiscal*
Joseph Rangel	Betty Brown	Luisa Parra-Sanchez	James Irwin
Irene Takahashi	Joel Bugay	Deborah Patterson	
Stacy Vanbruggen	Lesby Castro-Flores	Anita Powell	*Behavioral Health Board*
Elizabeth Vasquez	Raymond Cerda	Melissa Reece	Joanne Cox, Chair
Kaneska Toonnachat	Ruth Chavez	Katherine Rexroat	John Duchscher, Co-Chair
Joel Bugay	Karen Cowdrey	Jeffery Robinson	
	Tracie Emmersen	Paula Rogers	*Others*
QI Staff	Cynthia Hager	Preetinder Sanghera	Stan Lum-Patient Rights Adv.
Milagro Arevalo	Diamantina Hindman	Michelle Sloan	Kristi Williams-Family Adv.
L'Tresha Ashley	Bal Houngviengkham	Domenica Tamayo	Carla Fitak-PSS
Veronica Calderon	Charlene Howell	Christin Weatherby	Adult RAC member
Francisco Escobedo	Lori James	Cary Williams	*Contracted Providers*
Gabe Gomez		Diana Yee	Sharon Ross – TPOCC
Sue Ann Nguyen		Federico Zavala	Ryan Banks - TPOCC
Lee Ann O'Neal			Scott Hollander- TPOCC
			Brenda Kent- Kings View

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, MS, MA, NCC, LMFT, Lead Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Dr. Gale Berkowitz, DrPH, Deputy Director
Marilyn Hillerman, 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

Department of Behavioral Health
Heritage Centre Children's Outpatient
3133 N. Millbrook Ave., Fresno, CA 93703

CONTRACT PROVIDER SITES

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

Participants Representing the MHP

Name		Position	Agency
Anderson	Katherine	Principal Staff Analyst	DBH
Apperson	Julie	Clinical Supervisor	DBH
Arevalo	Milagro	Clinician--QI	DBH
Arkelian	Brian	Clinical Supervisor	DBH
Ashley	L'Tresha	Staff Analyst	DBH
Atwal	Jasmine	Chief Child Psych	DBH
Avery	Jeffrey	Clinical Supervisor	DBH
Banks	Ryan	Deputy Regional Director	Turning Point
Beckwith	Elika	Clinical Associate Director	EMQ Families First
Betancourt	Alex	Clinical Supervisor	DBH
Birkholz	Trevor	Clinical Supervisor	DBH
Brown	Betty	Clinical Supervisor	DBH
Brown	Richard	IT	DBH
Bugay	Joel	Division Manager	DBH
Cabrera	Hector	Administrator	Central Star
Calvillo	Matt	Systems & Procedures Analyst	DSS

Cerda	Raymond	Senior Substance Abuse Specialist	DBH
Cha	Connie	Diversity Services Coordinator	DBH
Collins	Mitch	Program Director	Turning Point
Coudrey	Karen	Supervising Acct Clerk	DBH
Escalante	Margarita	Senior Licensed Mental Health Clinician	DBH
Escobedo	Francisco	Sr. Staff Analyst	DBH
Escoto	Elizabeth	Program Director	Turning Point-Vista
Evans	Joanne	SLMHC	DBH
Fitak	Carla	Peer Support Specialist II	DBH
Flores	Lesby	Clinical Supervisor	DBH
Garcia	Maria	LMHC	DBH
Gee	Mathieu	Program Technician	DBH
Goins	Diasha	Peer Support Specialist I	DBH-TAY
Gomez	Gabriel	QI-Clinician	DBH
Guidry	Shannon	Program Manager	MHS
Gutierrez	Chanale	Peer Support Specialist I	DBH-SEES
Hager	Cynthia	Clinical Supervisor	DBH
Hager	Robert	Systems & Procedures Analyst	DBH
Hernandez	Elsa	UMHC	DBH
Holt	Susan	Deputy Director-Clinical Operations	DBH
Howell	Charlene	Supervising OA	DBH
James	Lori	Clinical Supervisor	DBH
Keenen	Joan	Clinical Supervisor	DBH
Kent	Brenda	Regional Director	Kings View
Khoun	Phaly	UMHC	DBH
Langroodi	Matin	SLMHC	DBH
Le	Maryann	Deputy Director-Business Operations	DBH
Lor	Doua	Senior SPA	DBH
Lum	Stan	Patients' Rights Advocate	MHPRA Program
Macedo	Norma	Director, Patient Programs	United Health Centers
Markland	Karen	Division Manager	DBH
Martindale	Katherine	Program Manager	DSS
Medina	Sandra	Clinical Supervisor	DBH
Mehia	Rita	Clinical Supervisor	DBH
Miller	Michael	Systems & Procedures Analyst	DBH
Muro	Michael	Senior Staff Analyst	DBH
Nguyen	Sue Ann	Program Technician	DBH
Ochoa	Ricardo	Supervising Acct Clerk	DBH
O'Neal	Lee Ann	QI Coordinator	DBH
Patterson	Deborah	Clinical Supervisor	DBH
Patterson	Sean	Business Manager	DBH
Perez	Lucy	CMHS	DBH
Perez	Beatrice	Clinical Services Officer	United Health Centers

Pettengill	Natasha	EMR Systems Analyst	Turning Point
Ramirez	Josefina	Peer Support Specialist II	DBH-Trinity
Ramirez	Leonard	Peer Support Specialist I	Santa Clara
Rangel	Joseph	Division Manager-Contracted Services	DBH
Rexroat	Katherine	Clinical Supervisor	DBH
Ritchie	James	WET Coordinator	DBH
Rivett	Deanna	VP	MHS
Robinson	Jefferey	Clinical Supervisor	DBH
Rogers	Jon	Staff Analyst	Managed Care
Ross	Sharon	Regional Director	Turning Point
Sanghera	Preet	Principal Staff Analyst	DBH
Schreiber	Chris	Utilization Review Specialist	DBH
Schroeder	Claudia	SLMHC	DBH
Shepherd	Jill	Peer Support Specialist II	DBH
Sosa	Naomi	Clinical Manager	Clinica Sierra Vista
Stoick	Joshua	Quality Support	EMQ Families First
Stone	Elizabeth	SLMHC	DBH
Takahashi	Irene	Division Manager	DBH
Tamayo	Domenica	Sr. Staff Analyst	DBH
Tan	David	Assistant Progam Director	Turning Point
Tobias-Gatewood	Deborah	Program Director	Central Star
Toonnachat	Kannika	Division Manager-QI	DBH
Torres	Joel	Senior Accountant	DBH
Toscano	Marco	Senior Admitting Interviewer	DBH
Urrutia	Maria	Peer Support Specialist II	DBH-SEES
Utecht	Dawan	Director	DBH
Vanbruggen	Stacy	Division Manager-Adult	DBH
Vang	Blia	Accountant	DBH
Vasquez	Elizabeth	Compliance Officer	DBH
Vasquez	Joyce	SLMHC	DBH
Villalobos	Reyna	Director	Clinica Sierra Vista
Vital	Tammie Allen	SOA II	DBH
Weatherby	Chris	Clinical Supervisor	DBH
Williams	Cary	Clinical Supervisor	DBH
Williams	Kristi	Family Advocate	Family Advocacy Services
Winslow	Mark	Systems & Procedures Analyst	DBH
Xiong	Chao	Sr. Staff Analyst	DBH
Yang	Peter	Peer Support Specialist I	Turning Point
Yee	Diana	Managed Care Coordinator	DBH
Yemenjian	Sona	SLMHC	DBH
Zapata	Paula	Senior Staff Analyst	DBH
Zavala	Michelle	Administrative Director	CPI
Zavala	Teresamaria	Medical Social Worker	Fresno Public Health

Zavala	Freddie	Senior Admitting Interviewer	DBH

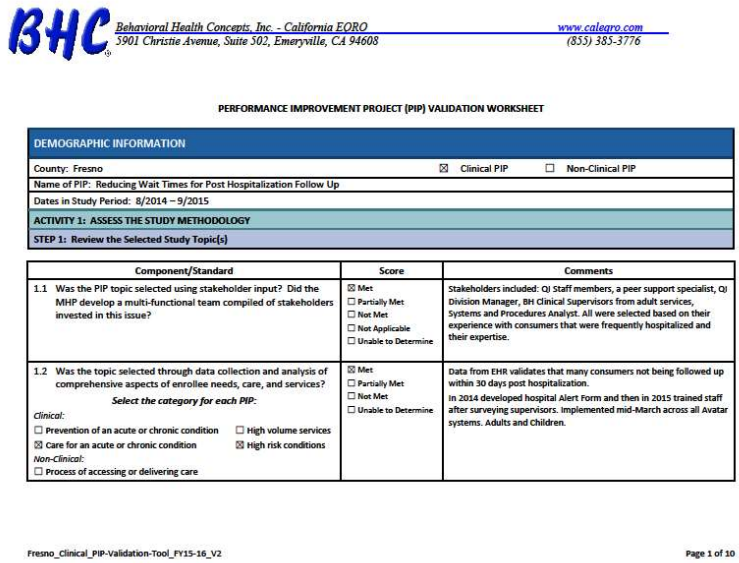
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



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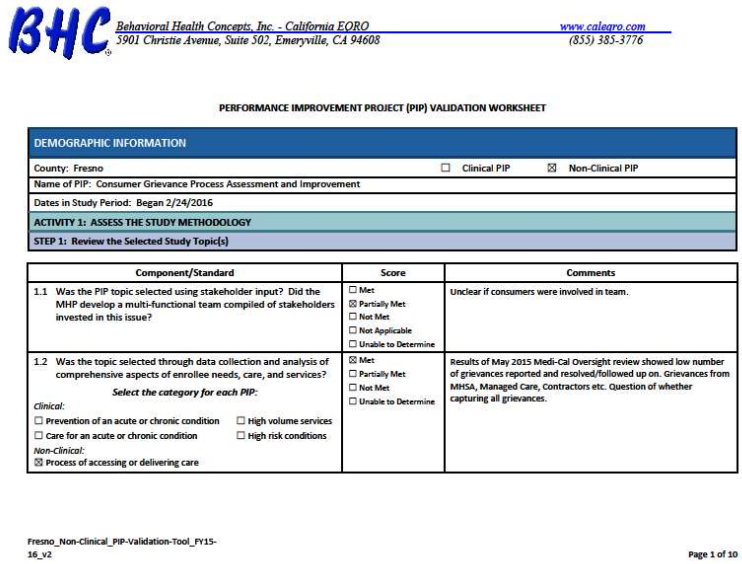
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Fresno	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Reducing Wait Times for Post Hospitalization Follow Up		
Dates in Study Period: 8/2014 – 9/2015		
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	Stakeholders included: QI Staff members, a peer support specialist, QI Division Manager, BH Clinical Supervisors from adult services, Systems and Procedures Analyst. All were selected based on their experience with consumers that were frequently hospitalized and their expertise.
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	Data from EHR validates that many consumers not being followed up within 30 days post hospitalization. In 2014 developed hospital Alert Form and then in 2015 trained staff after surveying supervisors. Implemented mid-March across all Avatar systems. Adults and Children.

Fresno_Clinical_PIP-Validation-Tool_FY15-16_V2 Page 1 of 10

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Fresno	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Consumer Grievance Process Assessment and Improvement		
Dates in Study Period: Began 2/24/2016		
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	Unclear if consumers were involved in team.
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	Results of May 2015 Medi-Cal Oversight review showed low number of grievances reported and resolved/followed up on. Grievances from MHSA, Managed Care, Contractors etc. Question of whether capturing all grievances.

Fresno_Non-Clinical_PIP-Validation-Tool_FY15-16_v2 Page 1 of 10