

FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Fresno

***Conducted on
March 8-10, 2017***

Prepared by:



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

TABLE OF CONTENTS

FRESNO MENTAL HEALTH PLAN SUMMARY FINDINGS	4
INTRODUCTION	6
PRIOR YEAR REVIEW FINDINGS, FY15-16	8
STATUS OF FY15-16 REVIEW RECOMMENDATIONS	8
<i>Assignment of Ratings</i>	8
<i>Key Recommendations from FY15-16</i>	8
CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP—IMPACT AND IMPLICATIONS.....	11
PERFORMANCE MEASUREMENT	13
TOTAL BENEFICIARIES SERVED.....	13
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY	14
HIGH-COST BENEFICIARIES	18
TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE	19
DIAGNOSTIC CATEGORIES.....	20
PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS.....	21
PERFORMANCE IMPROVEMENT PROJECT VALIDATION	23
FRESNO MHP PIPs IDENTIFIED FOR VALIDATION	23
CLINICAL PIP—IMPROVING CARE COORDINATION AND TIMELINESS OF POST-HOSPITAL FOLLOW-UP	25
NON-CLINICAL PIP—FRESNO MHP ACCESS LINE.....	26
PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS.....	28
PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS	30
<i>Access to Care</i>	30
<i>Timeliness of Services</i>	31
<i>Quality of Care</i>	32
KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS	34
CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)	37
CONSUMER/FAMILY MEMBER FOCUS GROUP 1	37
CONSUMER/FAMILY MEMBER FOCUS GROUP 2	38
CONSUMER/FAMILY MEMBER FOCUS GROUP 3	39
CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS.....	40
INFORMATION SYSTEMS REVIEW	42
KEY ISCA INFORMATION PROVIDED BY THE MHP	42
CURRENT OPERATIONS.....	43
PLANS FOR INFORMATION SYSTEMS CHANGE	44
ELECTRONIC HEALTH RECORD STATUS.....	44
MAJOR CHANGES SINCE LAST YEAR	45
PRIORITIES FOR THE COMING YEAR	46
OTHER SIGNIFICANT ISSUES	46
MEDI-CAL CLAIMS PROCESSING	46
INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS.....	47
SITE REVIEW PROCESS BARRIERS.....	49
CONCLUSIONS	50

STRENGTHS AND OPPORTUNITIES	50
<i>Access to Care</i>	50
<i>Timeliness of Services</i>	50
<i>Quality of Care</i>	51
<i>Consumer Outcomes</i>	51
RECOMMENDATIONS	52
ATTACHMENTS.....	53
ATTACHMENT A—REVIEW AGENDA.....	54
ATTACHMENT B—REVIEW PARTICIPANTS.....	55
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA	60
ATTACHMENT D—PIP VALIDATION TOOL	61

FRESNO MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—13,529
- MHP Threshold Language(s)—Hmong and Spanish
- MHP Size—Large
- MHP Region—Central
- MHP Location—Fresno
- MHP County Seat—Fresno

Introduction

Fresno County's MHP is categorized as a Large, Central region MHP. The MHP's official name is the Department of Behavioral Health, which includes mental health and substance abuse services. The MHP provides adult, children's, and transitional age youth outpatient services, adult and youth inpatient services, crisis stabilization services, and school-based services. The majority of the MHP's consumer population are located in the Fresno metropolitan area. The MHP's service sites are located in Fresno, on Kings Canyon Road, their main campus, and on Millbrook Avenue, for children's outpatient services. The MHP has a new administrative office in separate location in Fresno.

During the FY16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality and Outcomes of MHP and its contract provider services. Further details and findings from EQRO mandated activities are provided in the rest of the report.

Access

The main access issue for the MHP has been staff departures and vacancies in clinical positions. Access challenges have translated to delays in initial access to services and ongoing access to medications. The MHP has attempted to improve access through increasing the scope of their contract providers, enabling them to provide more services. However, contract providers also have capacity restraints as evidenced by their long wait times and wait lists for services. For access to medications, the MHP has increased the use of telepsychiatry. The MHP is also working to address the proximate causes of their vacancies, looking at salaries and benefits to make them more competitive. A secondary access issue has been the availability of services in the rural and outlying communities of East and West County. The MHP has entered into a partnership with Kings View to begin the Multi-Agency Access Program (MAP) that facilitates multiple points of access to a variety of health and supportive services, including mental health. MAP uses a common screening tool to trigger consumer's linkages to appropriate resources. The MHP has made some internal changes to

facilitate access, including restructuring of the school-based programs, development of a medium intensity program to address a gap in services for high-need consumers, and combining programs in adult system of care.

Timeliness

Compared to the last year's Self-Assessment of Timely Access, the MHP's timeliness to services, declined, marked by increased average times to appointments, decreased percentage of appointments that met the standards, and longer total range of time to appointments. The MHP cited several reasons why the time to services has increased, including the increase in the number of beneficiaries, continued vacancies of clinical positions, increased no-shows, inconsistency in categorization of services (e.g., urgent versus non-urgent), and inaccurate tracking or reporting of timeliness. Stakeholder also confirmed that there has been an increase in time to initial services. The MHP has a PIP that relates in part to initial access to services; if effective, it will position the MHP to make improvements in time to initial services. To better understand the decline in timeliness performance, the MHP would benefit from closer review of all timeliness metrics and analysis of extreme or outlying times.

Quality

The MHP provides a variety of services that meet the needs of consumers with diverse linguistic, cultural/ethnic, and racial backgrounds. However, stakeholders reported continued need for outreach to immigrant communities that are not engaged in services and that a barrier to access and ongoing services was transportation. The MHP employs peers and individuals with lived experienced directly and through contract providers. The opportunities within the MHP for designated peer positions are limited, but the MHP contends that peers are represented throughout their personnel. The MHP has increased their use of reporting and data to guide decision-making; they expect this to be particularly aided by the recent implementation and use of Sisense dashboards.

Outcomes

The MHP has adopted Reaching Recovery as an outcome tool and level of care instrument, which provides a consistent and robust measure of consumer outcomes. Reaching Recovery includes multiple measures that provide a comprehensive picture of consumer outcomes. The MHP also uses Child and Adolescent Needs and Strengths (CANS) assessment.

INTRODUCTION

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

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

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

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

(1) VALIDATING PERFORMANCE MEASURES¹

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

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

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS²

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES³

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

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

Key Recommendations from FY15-16

- Recommendation #1: 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.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

 - The MHP filled some of the vacant clinical positions, but experienced additional departures of staff, resulting in vacancy in 32 positions currently. The MHP has designated some of these clinical positions (e.g., psychologists and clinical supervisors) as 'hard to fill' and has focused on their recruitment.
 - The MHP works the County Human Resources and is in discussion with the Board of Supervisors to review salaries and benefits; these are primary contributors to retention and recruitment of staff.
 - The MHP is using other strategies to meet programmatic needs, including increased telepsychiatry, hiring of unlicensed positions (enabling licensed staff to provide more clinical care), and increasing scope of contract providers.

- Recommendation #2: 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.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP has both a Clinical and Non-Clinical PIP that are considered active.
- The Clinical PIP is intended to improve engagement in services, thereby reducing the risk of acute conditions that require rehospitalization. The Clinical PIP succeeds in addressing consumer outcomes.
- The Non-Clinical PIP has the potential to improve consumer outcomes; however, the consumer-focused components were not sufficiently featured.
- Neither of the PIPs have consumers as part of the PIP team. However, both PIPs have peers on the team. For the Non-Clinical PIP, the MHP recruited one consumer to conduct test calls, with the plan to include four more consumers.

- Recommendation #3: Fresno continues to have low penetration rates in comparison with statewide 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.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP conducted an analysis of penetration rates for CY13-CY15 by county region and found a much lower penetration rates in the rural, eastern and western areas of the county than the central (metro) region.
- The MHP held Client Advisory and stakeholder meetings in 2016 to identify access barriers and concluded that the primary barriers were transportation, program capacity, staff recruitment and retention, and a lack of bi-lingual practitioners.
- The MHP has issued an RFP for proposals for expansion and augmentation of contract programs.
- To further improve access to services, the MHP is part of a newly formed initiative, the Multi-Agency Access Program (MAP), which connects individuals throughout Fresno County to needed services including mental health.

- Recommendation #4: 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.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP's career ladder for peers consists of two classifications, Peer Support Specialist I and Peer Support Specialist II. Peers may also take a case manager position as they become available.
- The MHP contends that they do not need a designated supervisory position for peers because, according to a 2015 Lived Mental Health Experience Survey, 81% of MHP staff, some who are in supervisory positions, identified as being a family member or having lived experience. The survey captures some demographic information (e.g., gender, educational level), but it does not specifically ask about staff's position.
- Similarly, the MHP's argument is that individuals with lived experienced advance from peer positions to other classifications within the MHP, but the MHP does not actually track or maintain this information.
- Recommendation #5: Support integration of Avatar Electronic Health Record (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.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP has met with several contract providers to discuss their interest in utilizing the County EHR. Planning meetings have been held with Exodus Recovery, Inc. who operates the psychiatric health facility (PHF), the crisis stabilization unit (CSU), and the Central Star Youth PHF, but neither a project plan nor timeline have been developed.
- The MHP has not formally surveyed all organizational providers regarding their current EHR nor their preferences for integration or data exchange.
- Additional resources for electronic data exchange will become available when the EHR contract renewal is finalized in June 2017.
- The MHP is planning to implement Avatar Web Services for electronic data exchange with providers.
- Recommendation #6: Develop a project plan and timeline to implement Netsmart Technologies Managed Service Organization (MSO) and Provider Connect applications as soon as practical to support electronic transactions for the network provider organizations.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has licensed Netsmart MSO and ProviderConnect in the EHR contract renewal.

- The MHP is planning to begin implementation of MSO and ProviderConnect in July 2017 and expects to complete the process in mid-2018.
- The MHP has added two analyst positions to support this effort, but has not filled the positions.

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 contracted with Exodus Recovery, Inc. as the new access line service provider, beginning in September 2016. The access line is now staffed by an agency whose focus and expertise is in mental health services. Since the new contract, the MHP has logged more calls and has had an increase in the number of referrals for services.
 - The MHP has experienced additional vacancies in clinical staffing, which has adversely affected access to services, as evidenced by reports by some stakeholders of protracted time to initial appointments and assessments for medication.
 - The MHP has contracted with Kings View and two subcontractors (Center La Familia and Poverello House) to implement the MAP. The MAP provides an integrated screening process to connect consumers and pre-consumers throughout Fresno County to health and supportive services (e.g., housing). Each MAP Point (wherein a point is a business or community entity that individuals may frequent) serves as an access site, with a common screening tools to identify areas of need and to trigger linkages to appropriate resources for assessments or services.
- Timeliness of Services
 - In April 2016, the MHP restructured the school-based programs, designating one clinical supervisor and staff to each of three school districts (East, West, and Central). The restructuring provides consistent staffing in the schools and timelier service, by limiting the geographic area that staff have to cover.

- Quality of Care
 - The MHP has a number of projects that address the social determinants of health and improving the quality of services for consumers. The MHP has contributed to developing a Strategic Housing Plan and Sequential Intercept Mapping project on de-incarceration and the intersection of the criminal justice system and mental health services.
- Consumer Outcomes
 - The MHP has fully implemented Reaching Recovery program into their adult system of care and in the EHR. Reaching Recovery is an evidenced-based model for recovery. Reaching Recovery includes four outcome measures that capture the consumer's and clinician's perspectives on progress and outcomes.

PERFORMANCE MEASUREMENT

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

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

TOTAL BENEFICIARIES SERVED

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

Table 1—Fresno MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	51,175	13.5%	3,419	25.3%
Hispanic	223,461	58.9%	5,766	42.6%
African-American	24,948	6.6%	1,516	11.2%
Asian/Pacific Islander	48,685	12.8%	1,003	7.4%
Native American	2,150	0.6%	115	0.9%
Other	28,655	7.6%	1,710	12.6%
Total	379,071	100%	13,529	100%
<p><i>*The total is not a direct sum of the averages above it. The averages are calculated separately.</i></p> <p><i>The actual counts are suppressed for cells containing n ≤11.</i></p>				

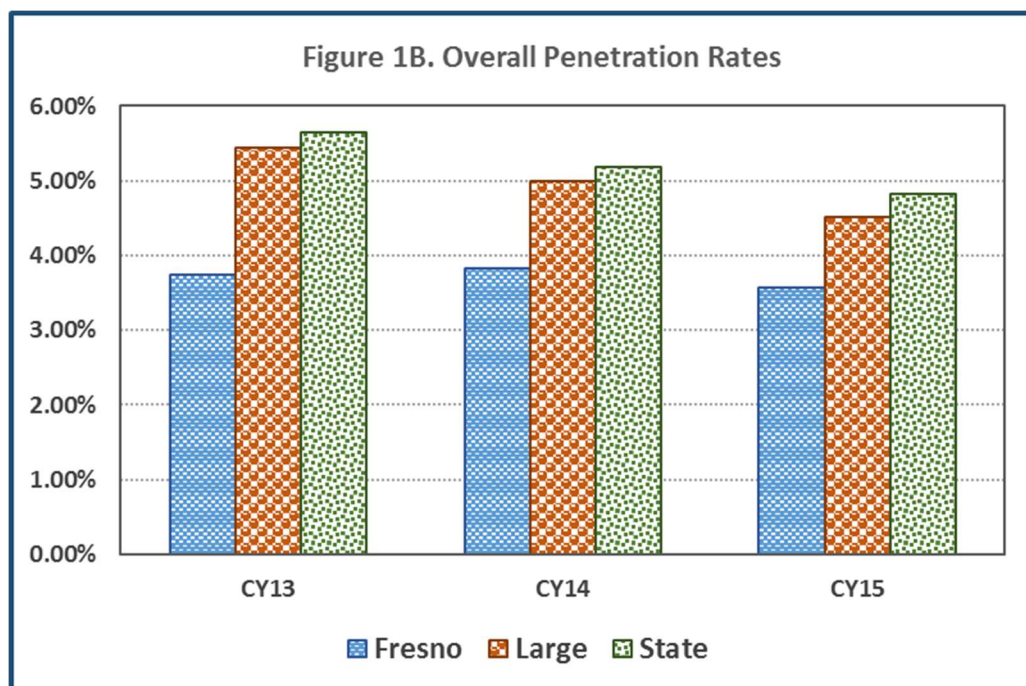
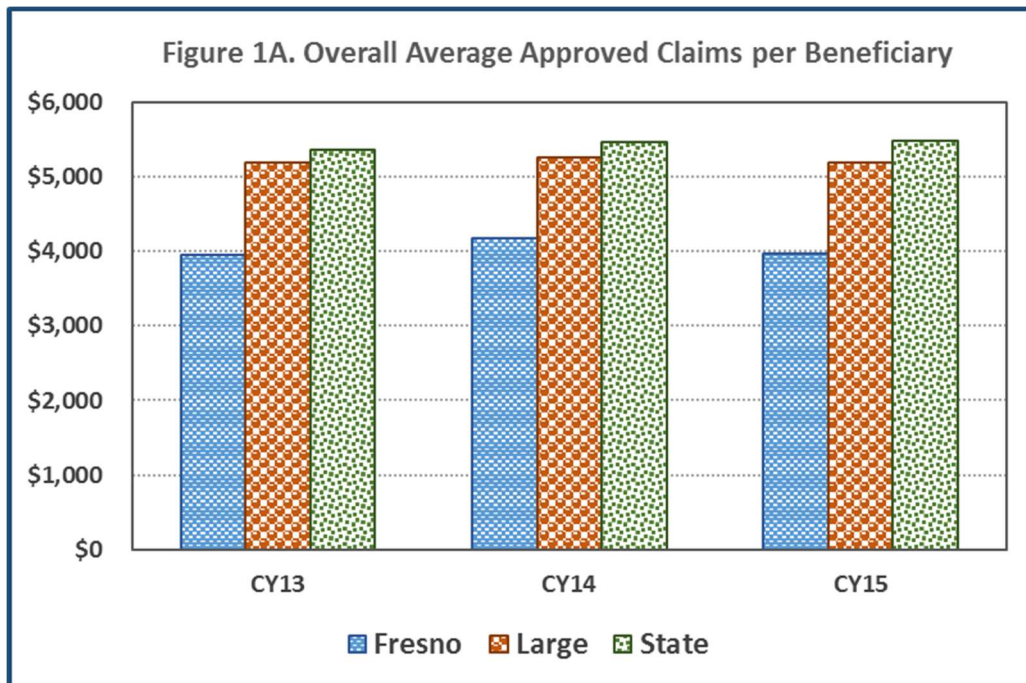
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

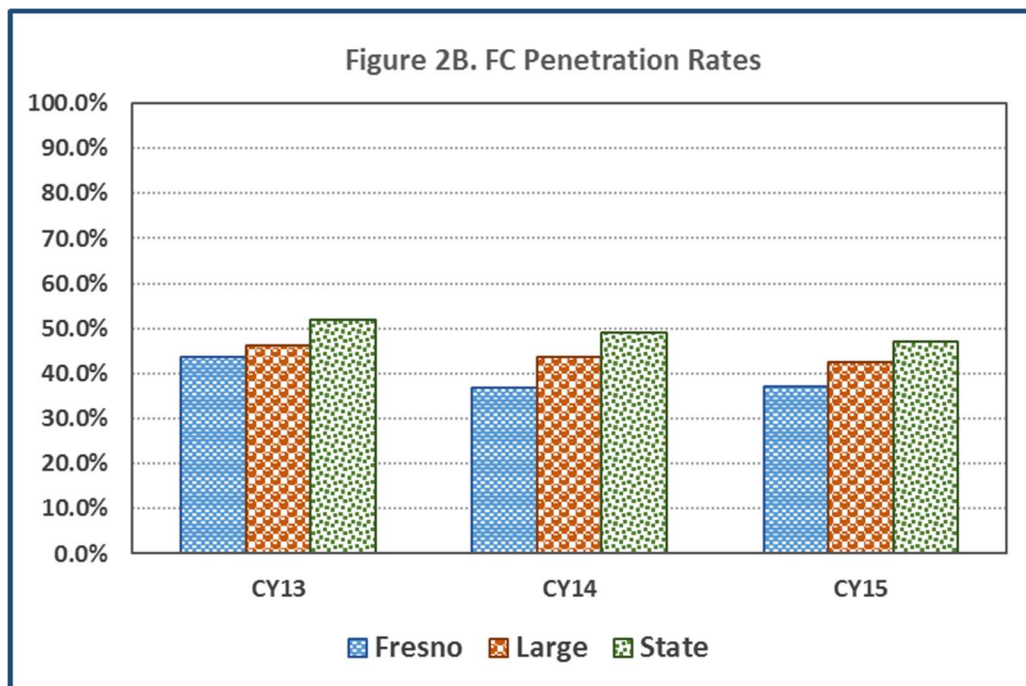
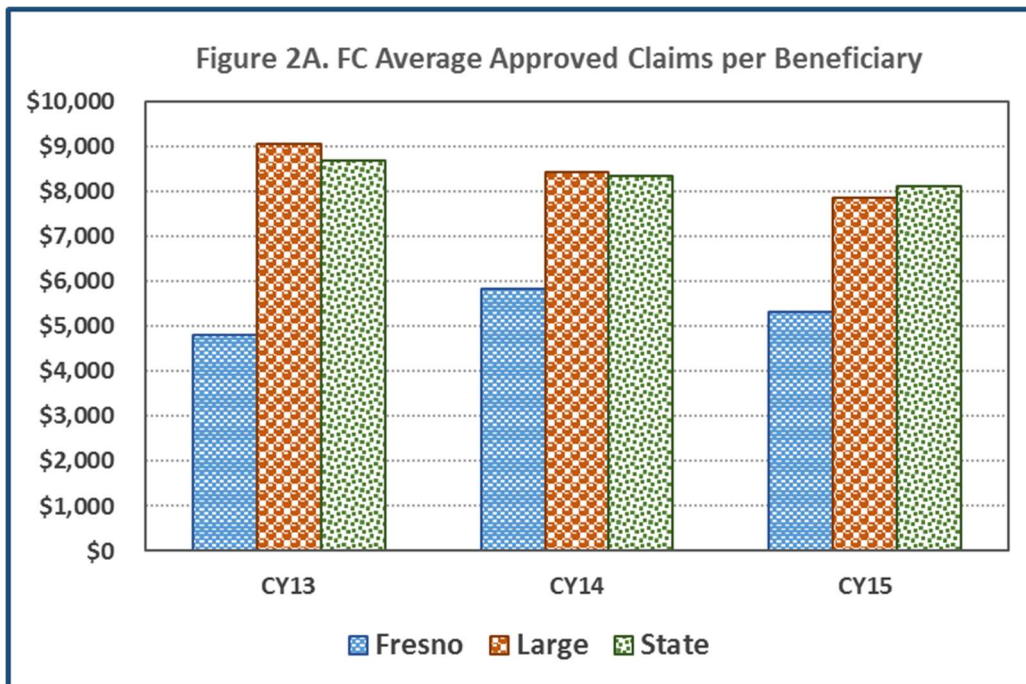
Regarding calculation of penetration rates, the Fresno MHP:

- ☒ Uses the same method as used by the EQRO.
- ☐ Uses a different method.
- ☐ Does not calculate its penetration rate.

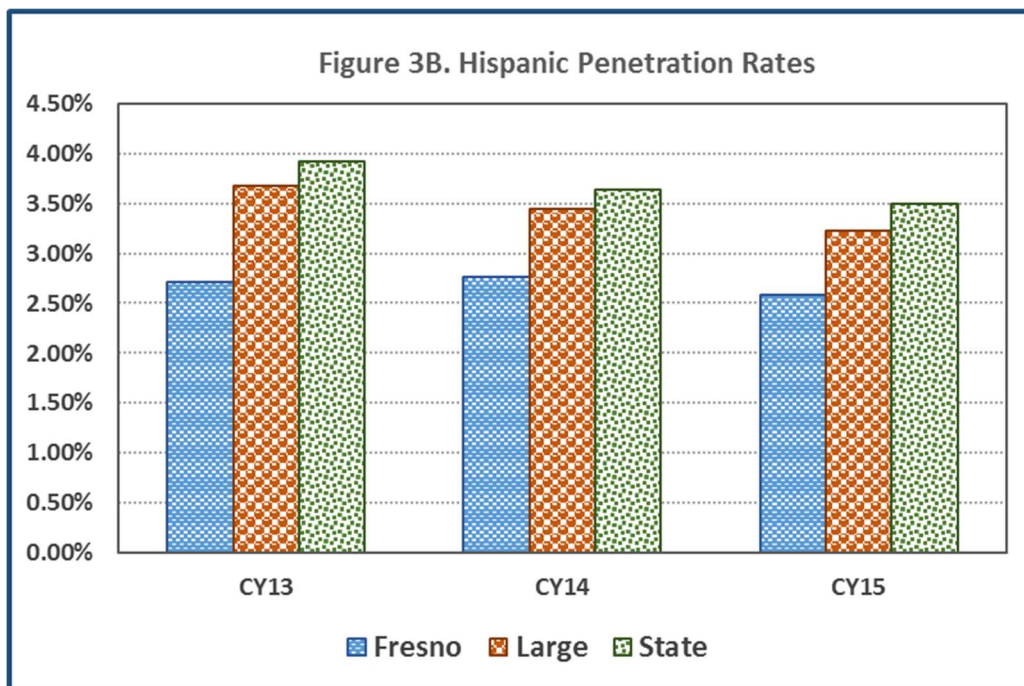
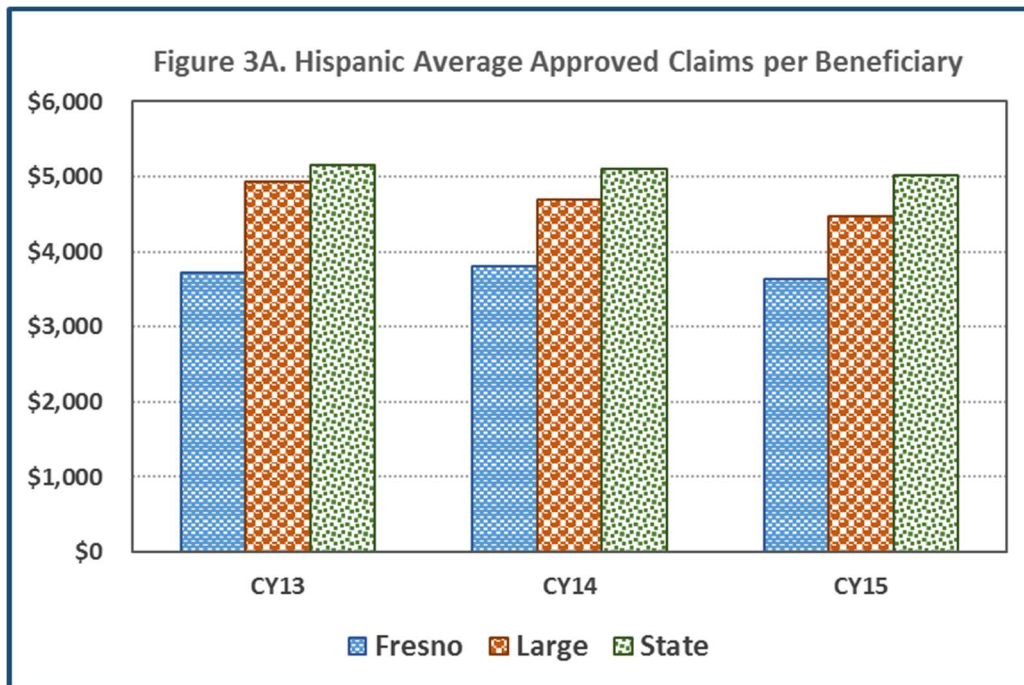
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



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



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



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

HIGH-COST BENEFICIARIES

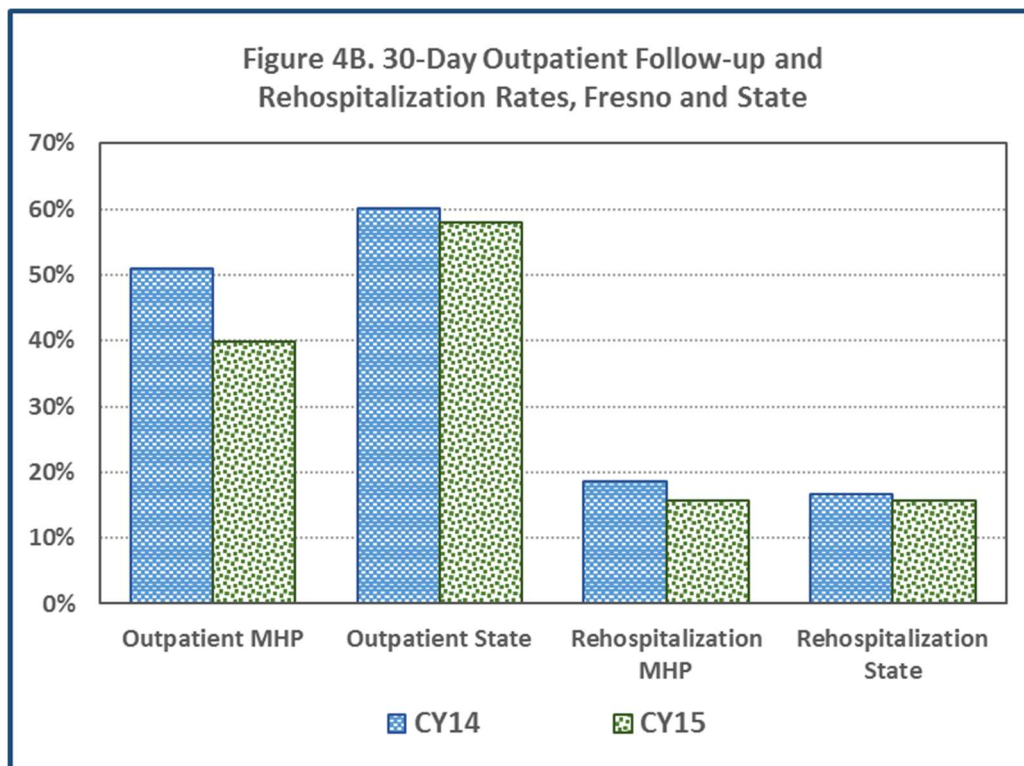
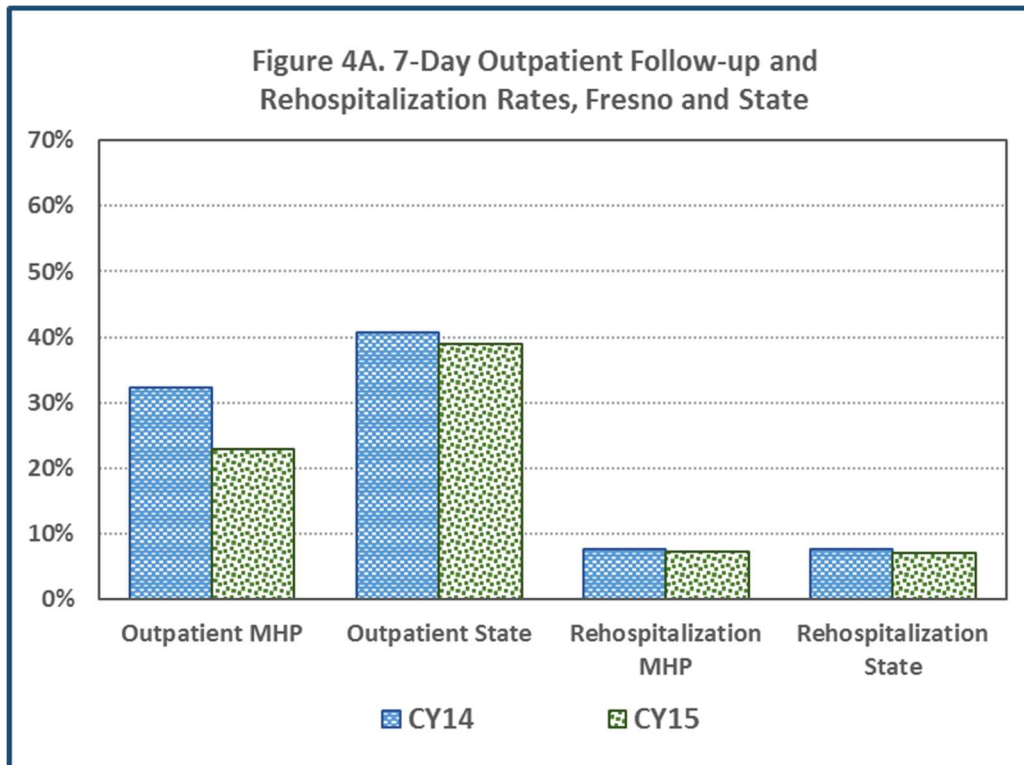
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than \$30,000 in a year.

Table 2—High-Cost Beneficiaries							
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	\$51,635	\$715,196,184	26.96%
Fresno	CY15	247	13,529	1.83%	\$53,330	\$13,172,622	24.51%
	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%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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

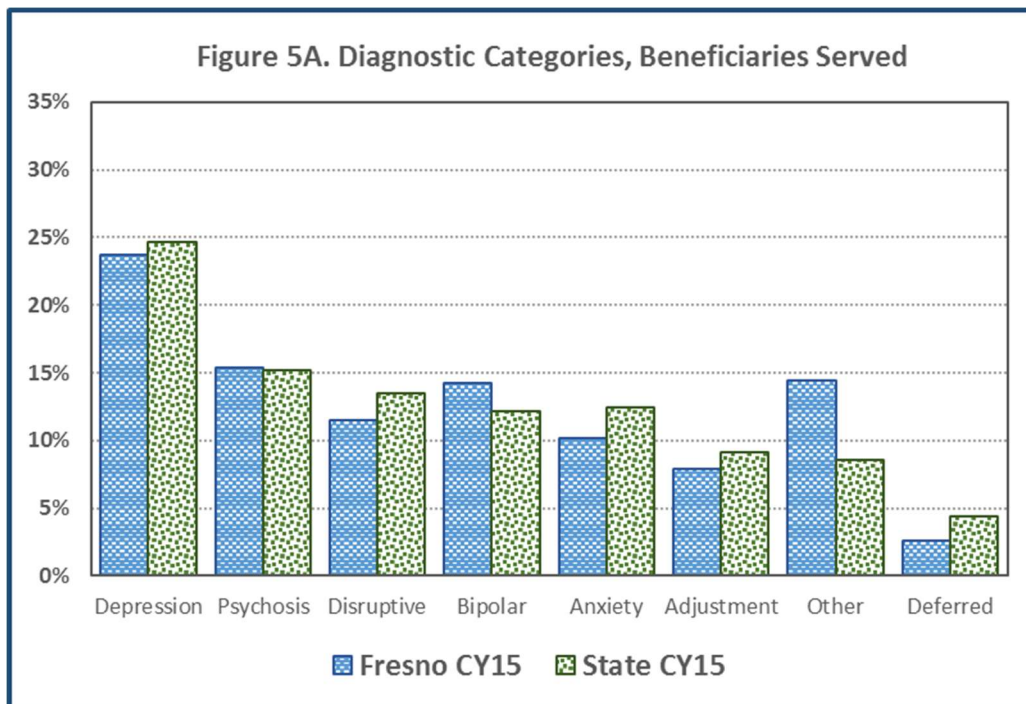


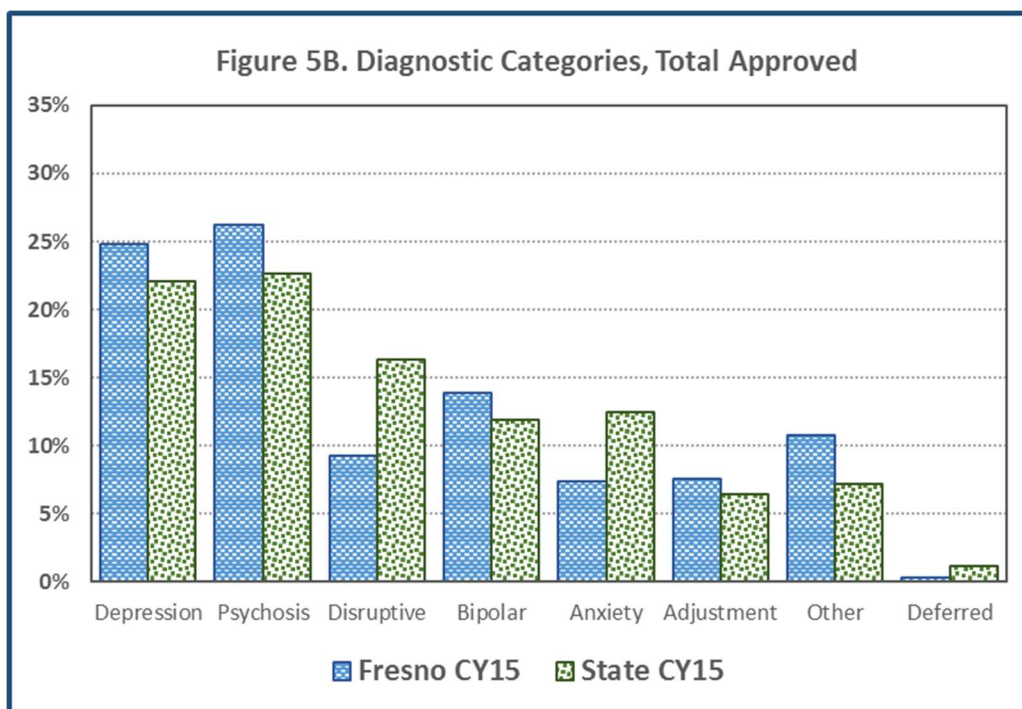
DIAGNOSTIC CATEGORIES

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

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

7.27%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The total number of Medi-Cal eligibles increased from 369,898 in CY14 to 379,071 in CY15 while the number of beneficiaries served decreased from 14,161 to 13,529. This resulted in a decrease in the penetration rate from 3.83% to 3.57%.
 - The MHP's Affordable Care Act (ACA) eligibles for CY15 total was 95,341 and the beneficiaries served was 4,044, resulting in a penetration rate of 4.24% for this sub-group (see Table C1 in Appendix C).
 - When combining the Medi-Cal and ACA data, the MHP's CY15 average monthly eligibles increased to 474,412 with 17,573 beneficiaries served during the period.
 - The MHP overall penetration rate for CY15 remains lower than the statewide average of 4.82% and for other Large MHP average at 4.52%, as it has been for the past two years. The MHP has concluded, based on data analysis of penetration by zip code, that very low penetration rates in the rural areas of the county were a significant factor.
 - The MHP average claims per beneficiary served of \$3,972 was lower than the statewide average of \$5,480 and the \$5,179 average for similar sized MHPs.

- Timeliness of Services
 - The MHP post-discharge outpatient follow-up rate of 23% at 7 days was substantially lower than the statewide average of 39%. The 30-day rate of 40% was also well below the statewide average of 58%.
 - Rehospitalization rates for the MHP matched the statewide averages for CY15 for both the 7-day and 30-day measures.
- Quality of Care
 - Although the number of high cost beneficiaries in CY15 increased to 247 from the 178 found in CY14, they compromised 1.83% of all beneficiaries compared to the statewide average of 2.86%.
 - The percentages of beneficiaries served by diagnosis closely followed the statewide averages with the exception of the Other category, which accounted for 14% of beneficiaries seen as compared to the 9% statewide average. The high percentage of diagnoses in this category can largely be attributed to a single ICD-9 diagnosis code of 290.40 (vascular dementia, uncomplicated) which accounted for 43.8% of this group.
 - The MHP's claims by diagnosis were higher than the statewide average for Depression, Psychosis, Bipolar, and Other, while lower than the average for Disruptive, Anxiety, and Deferred.
- Consumer Outcomes
 - No outcome performance measures were reviewed.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

FRESNO MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3—PIPs Submitted		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Care Coordination and Timeliness of Post-Hospital Follow-up
Non-Clinical PIP	1	Fresno MHP Access Line

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	PM	PM
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	PM

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	M	PM
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	NM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	M
		5.2	Valid sampling techniques that protected against bias were employed	NA	NM
		5.3	Sample contained sufficient number of enrollees	NA	M
6	Data Collection Procedures	6.1	Clear specification of data	PM	M
		6.2	Clear specification of sources of data	PM	M
		6.3	Systematic collection of reliable and valid data for the study population	NM	PM
		6.4	Plan for consistent and accurate data collection	UTD	PM
		6.5	Prospective data analysis plan including contingencies	NM	M
		6.6	Qualified data collection personnel	M	PM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NM	PM
		8.2	PIP results and findings presented clearly and accurately	NA	PM
		8.3	Threats to comparability, internal and external validity	NM	PM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA

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

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

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

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	6	8
Number Partially Met	6	10
Number Not Met	3	1
Number Applicable (AP) (Maximum = 28 <u>with</u> Sampling; 25 <u>without</u> Sampling)	18	22
Overall PIP Rating $((\#Met*2)+(\#Partially\ Met))/(\#AP*2)$	50%	59%

CLINICAL PIP—IMPROVING CARE COORDINATION AND TIMELINESS OF POST-HOSPITAL FOLLOW-UP

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

- “Will the 30-day readmission rate decrease with improved care coordination, communication, and more timely post CSPHF follow-up by Fresno FMHP’s outpatient program managed by Fresno County DBH?”
- Date PIP began: October 2016
- Status of PIP:

- ☒ Active and ongoing
- ☐ Completed
- ☐ Inactive, developed in a prior year (*Not Rated*)
- ☐ Concept only, not yet active (*Not Rated*)
- ☐ Submission determined not to be a PIP (*Not Rated*)
- ☐ No PIP submitted (*Not Rated*)

The purpose of this PIP is to reduce the 30-day readmission rates for youth. The MHP speculates that a contributor to readmission within 30 days is not having any post-discharge follow-up or a timely one, defined as within 14 days. However, the MHP does not present data or information that explains this correlation. Rather, it appears that most youth (75%) have follow-ups and that most of these follow-ups occur within 14 days. (The MHP reported that 45% of follow-ups occurred within 14 days, but this percentage is actually greater when compared to only those that received any follow-up). The MHP identified four barriers that have been purported to influence timely follow-up and focused on two of them for the PIP: (1) not having a specific appointment time for the follow-up outpatient visit and (2) communication challenges between the PHF and the outpatient provider regarding follow-up care. The PIP targets youth who have been hospitalized and are not receiving services, but are eligible for such services. With this population, the MHP has limited the study to youth who contribute to a fraction (36%) of the readmissions, not the majority of the readmissions. Nevertheless, the MHP intends to reduce the risk of readmission through two interventions: daily conference calls among the PHF, the outpatient program, and other relevant stakeholders and through home visits subsequent to a missed follow-up appointment. The first intervention addresses the two barriers above. The second intervention would only occur, presumably, if the MHP's prior efforts have not worked. As the study continues, the MHP should develop and track intermediary indicators (e.g., daily conference calls, 14-day appointments, reminder calls to youth/caregivers) to ensure that their intervention is working. The MHP should also collect and analyze data monthly per their data collection plan.

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 recommendations to (1) articulate their process for ensuring and maintaining 14-day follow-up, given that their prior standard of 30 days for youth follow-up was met 59% of the time, and (2) to clarify the process for communication during the weekends.

NON-CLINICAL PIP—FRESNO MHP ACCESS LINE

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

- “If the FMHP replaces the existing, non-mental health exchange messaging service contractor provider with a clinical licensed/un-licensed mental health multidisciplinary team contractor provider, then, the FMHP 24-hour, 7-days/week Access Line will improve services to all users?”
- Date PIP began: September 2016
- Status of PIP:
 - ☒ Active and ongoing
 - ☐ Completed
 - ☐ Inactive, developed in a prior year (*Not Rated*)
 - ☐ Concept only, not yet active (*Not Rated*)
 - ☐ Submission determined not to be a PIP (*Not Rated*)
 - ☐ No PIP submitted (*Not Rated*)

The driving force for the PIP was that the MHP had not met certain State standards during test calls to the Access Line. The MHP identified five areas in which they were underperforming and that could affect consumer access to services: (1) logging of calls; (2) accuracy and completeness of the logged information; (3) assessment of crisis; (4) provision of information about how to access specialty mental health services; and (5) offer of language assistance. The MHP also presented timeliness to service as an area for improvement. The MHP did not speculate on reasons why these specific areas were not met on test calls, but decided that the solution was changing the Access line vendor. The MHP's intervention was to change to a new the vendor with expertise in mental health, including staffing by licensed mental health professionals who could better determine how calls should be routed. Since the intervention, in September 2016, the MHP has noted improvements in most of the areas of the calls, except the number of calls placed in an 'Other' category (i.e., that the call is not a complaint, emergency, literature request, etc.) has increased. This finding merits further investigation and also a review of the previous vendor's categorization of all calls, not just the 'Other' categorization. The MHP did not present interim data on the timeliness to services subsequent to the call, citing the need to improve the data collection process and recalculate the pre-intervention baseline data. During the review, CalEQRO discussed with the MHP that timeliness to services, the only consumer-specific parameter in the study, is not the responsibility of the Access Line vendor. Rather, the MHP staff schedule appointments. Thus, changing the vendor alone would not necessarily improve timeliness to appointments. During the review, the MHP also discussed their plans to incorporate consumer feedback through a satisfaction survey. As the MHP had no prior input from consumers about their interaction with the previous Access Line vendor, the survey would likely serve as a benchmark for the new vendor.

The PIP addresses an area that needs improvement and has an impact on consumers, as the Access line is often the consumer's first contact with the MHP. However, the PIP's focus is on the procedural aspects of the Access line rather than on consumer's interaction, provision of

information, and consumer's connection to services. Related, the PIP is lacking in addressing timeliness to services, an important consumer indicator. There is the potential for consumer benefit with a change in Access Line vendor. CalEQRO recommended that the MHP focus more on the impact on consumers than on the process components (e.g., logging of calls, accuracy of test calls).

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 to sample logged calls from the previous vendor and then: (1) track time to service resulting from those calls and to (2) conduct detailed review of all category of calls not just those placed in 'Other'.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The Clinical PIP improves access to care for youth who need services (i.e., based on their recent inpatient hospitalization), but were not receiving outpatient services prior to their hospitalization.
 - Given that youth who are already receiving services contribute to the majority of readmissions, the MHP missed an opportunity to include a population who would benefit from interventions to address readmission.
 - The Non-Clinical PIP is intended to improve a primary interface and entry point for consumers. However, the MHP has not gathered and/or presented sufficient information to make the connection between the change in vendor and access to services.
- Timeliness of Services
 - If the MHP is able to more consistently provide 14-day follow-up appointments, this will improve the timeliness of follow-up appointments for youth.
 - The MHP presented improvement in time to services as an outcome of the Non-Clinical PIP. Given that scheduling of appointments is beyond the scope of the Access Line vendor, the MHP may not be able to draw this conclusion based solely on their intervention.
- Quality of Care
 - The focus of the Clinical PIP is coordination of stakeholders involved in youth hospitalization and post-discharge services. As yet, the PIP does not have indicators nor a means to track the efficacy of this coordination.
 - Within five months of the Non-Clinical PIP, the MHP has been able to show improvements that relate to quality. On the test calls, the MHP has noted an increase in the offer of language assistance, provision of information about

specialty mental health services, and provision of information about services during urgent conditions.

- Consumer Outcomes
 - The Clinical PIP improves outcomes for youth by engaging them in services, thereby reducing the need for more acute services.
 - The Non-Clinical PIP does not have enough information to show consumer outcomes or benefit.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP has a number of means to meet the needs of consumers of diverse cultural, linguistic, and racial backgrounds. The MHP has programs and partnerships for Spanish-speaking/Latino, Hmong, Punjabi consumers and community (e.g., Cultural Based Access and Navigation Services). The Cultural Diversity Committee Work Plan referenced the Disaggregated Data Collection Taskforce as a means to gather data about populations served and address disparities. However, from a review of the Cultural Diversity Committee meeting minutes, it did not appear that this taskforce materialized, and there was also limited evidence of the other efforts to capture and use data related to different populations served.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP assess, identifies, and implements strategies to provide the types and numbers of practitioners needed. For example, supervisors reported adjusting their program staffing to accommodate current needs, development of a screening tool to manage the influx of referrals to children's' system of care, and changing the designation of some unfilled positions to meet the current need (e.g., from case manager to clinician). Nevertheless, the MHP is challenged by staffing shortfall and long wait times, particularly, in psychiatry.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP demonstrated multiple areas of collaboration with community based providers, public and private agencies, and contract providers to better increase access for all consumers and serve consumers of diverse backgrounds. MAP Point, Cultural Based Access and Navigation Services, and presentation at/by local churches were examples of this collaboration.

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

Timeliness of Services

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

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	The MHP's standard is 30 days, which they met 63% overall. Time to services has increased for adults and children since last year. Children's time to 1st appointment within 30 days was at 41%. The MHP provided some reasons why the time to services has increased for children, including increase in beneficiaries (though ACA and Healthy Families), departure of experienced staff, and that while the start of the timing/clock begins at request, the MHP must actually wait until all paperwork (by the parent/caregiver) is provided before services are rendered. MHP reported quarterly review of timeliness through Access committee meeting. The Self-Assessment of Timely Access only included county-operated points of access, contractor provided are routinely monitored, but tracked elsewhere.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP's standard is 30 days, which they met 68% overall. Time to psychiatry (i.e., from the referral specifically to psychiatry) has increased, especially for adults (from 20 to 36 days) and the range is up to 326 days. The MHP did not do an analysis of outliers or the protracted time (e.g., 326 days). The MHP only speculated at the reason for the increase in time: increase in no shows and cases not being closed (but should have been). The MHP intends to expand telepsychiatry to meet the demand, but no other plans/strategies were presented.
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP's standard is 3 days for urgent conditions. Time to urgent for children was reported as 13.42 days, almost six times the number of days from the previous year. MHP reported lack of clarity and understanding by new staff on the criteria for urgent and also a capacity issue in meeting the demand. The MHP is considering same-day services for children's system of care.
2D	Tracks and trends timely access to follow up	PC	MHP's standard is 30 day, which they met 48% of time, and averaged at 18 days. The MHP's standard is more moderate than industry recommendations, at 7 days.

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
	appointments after hospitalization		MHP indicated that the follow-up process starts when the clinician goes to the hospital, before the client is discharged; however, the data do not reflect this. The MHP has a PIP to improve follow-up for youth who have been hospitalized and has an initiative to improve follow-up for adults that involves case managers and peer support members coordinating discharge activities.
2E	Tracks and trends data on rehospitalizations	FC	The MHP's readmission rate (22%) was just under their standard (25%). The PIP is meant to affect readmission rates, although it does not specifically target individuals with multiple readmissions. The MHP is beginning to drill down and identify which of the unique 440 individuals contribute the most to the readmission rate.
2F	Tracks and trends no-shows	PC	It appeared that the No Show rate for adults decreased substantially (from 15% to 3%), but MHP staff suspect that the calculation was erroneous and reflected underreporting. The MHP also reported variability/inconsistency in how no shows are tracked in adults. Data on contractor no shows were not included, even though they provide much of the services. No Show policies do not appear to be enforced. However, one strategy that the MHP uses to decrease no shows is to have case managers support and help consumers get to their appointments.

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

Quality of Care

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

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	MHP has a QI work plan and evaluation. The department has become much more data-driven. The addition of the epidemiologist is positive; helping the MHP to collect data that is relevant and captures what they are doing. The QI coordinator position is currently vacant, so the responsibilities are shared by many. The

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			quality management is structured in such a way that allows input from stakeholders at multiple levels, including leadership.
3B	Data are used to inform management and guide decisions	FC	Through IT department, the MHP produces numerous reports which gives diverse information about services and programs. Supervisors reported use of data and looked forward to Sisense dashboards which would be able to quickly give them information/snapshots on services. Again, the hire of epidemiologist and his input on data and its relationship to quality is beneficial.
3C	Evidence of effective communication from MHP administration	PC	Communication among stakeholders was through meetings, emails, and by phone. While consumers have the Review Advisory Committee (RAC), overall communication with consumers appeared to be unidirectional. Leadership meets with contractors monthly. Internal stakeholders identified a need for improved communication, particularly related to staffing changes, and consistency in relay of communication among managers.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	Stakeholders have some opportunities to be involved in system planning (e.g., RAC for consumers and projects, like the newly formed suicide prevention task force open to contract providers). There were however some mixed comments about the level and depth of involvement, beyond surveys, in system planning.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	The MHP has a number of strong partnerships with other agencies and community providers to promote quality. Contract providers meet with each other and with the MHP. Contract providers reported a change/turnover in contract analysts, but the current manager is well liked and is responsive to needs and concerns.
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP developed a new program, Medium Intensity, to address a gap in services. They may develop another program to facilitate transition from moderate to mild. They MHP uses Reaching Recovery's outcome tool, Recovery Needs Level. The MHP also uses an outcome tool specifically for TAY. They use a variety of evidenced-based practices (e.g., DBT, new model, Transition to Independence, and Pro-ACT). Telepsychiatry may be used to address current gaps and monitor medications.
3G	Evidence of individualized, client-driven treatment and recovery	FC	There are volunteer opportunities within programs and at wellness centers. Reaching Recovery emphasizes consumer input, which they have been implementing over the past year. Consumers can 'graduate' from programs. There are WRAP groups and WRAP is used to support clients.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The RAC has strong consumer presence and is a channel to executive team. The MHP has two peer classifications, with a minimal options for advancement. While the MHP reported that individuals with lived experience are present in all levels of staff, including supervisory, none were identified.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	Through contract providers, the MHP has consumer run/driven programs. The consumer programs are focused on recovery; the agencies also using Reaching Recovery.
3J	Measures clinical and/or functional outcomes of consumers served	FC	Reaching Recovery is utilized by all county run programs and being expanded to contract programs. Reaching Recovery was purported to be more objective than LOCUS. The MHP also collects and aggregates CANS.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP analyzed and compared the CPS results from previous years. They conducted/facilitated other surveys including one on housing. The MHP shares results at various meeting. Survey findings are used to guide decision-making

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - Through provision of language services, partnerships with organizations linked to the community, and increasing scope of contract providers, the MHP provides access to services to their diverse consumer population.
- Timeliness of Services
 - The provision of same-day services in the adult system of care (ASOC) is a means to provide timelier access to services. If the children's system of care is able to do the same, the MHP may be able to curb the increasing time to services experienced in the past year.
 - The MHP reported some averages and range of time to services that were extreme (e.g., 326 days for an assessment with a psychiatric provider and 13.42 days for children's urgent condition). The frequency with which these occur and/or if these are outliers or erroneous were yet to be determined.
 - The MHP's reporting of timeliness does not include intakes by contract providers.

- Quality of Care
 - By reviewing readmissions and identifying those with multiple readmissions, particularly in a short amount of time, the MHP can develop targeted treatments and services for high need consumers.
 - Enforcing the no show policy places some of the onus on the consumer/family member and enables other consumers the opportunity to have more timely access to appointments.
 - That individuals with lived experience are represented throughout the MHP personnel recognizes peers as equals. Conversely, by not formally acknowledging that the positions are held by peers, there may be the perception that disclosure has some negative consequences and stigmatization.
- Consumer Outcomes
 - The MHP use of Reaching Recovery demonstrates the MHP's focus on a continuum of care and recovery. Reaching Recovery includes a Consumer Recovery Measure which provide consumers with a regular measures of outcomes, in addition to the other measures completed by staff and the consumer and staff together.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

CalEQRO requested a group of Hmong adult beneficiaries and parents/caregivers of child/youth beneficiaries whose preferred language is Hmong, including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held at the Fresno Center for New Americans (Center), 4879 E. Kings Canyon Road. All participants were currently receiving services at the Center.

Number of participants –3

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

- That it took several months to begin services and that it was difficult to get services following the referral from social services.
- Another reported not receiving a referral to outpatient care when discharged from the hospital and eventually being referred by a primary care physician.
- All reported being admitted for treatment immediately once they were referred to the Center.

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

- A variety of services were available, including groups, individual therapy, crisis stabilization, and medications, and that all were equally helpful.
- Services are provided in their native language at the Center and that when interpreters are utilized for psychiatry it is a comfortable exchange.
- Several participants reported difficulty in communication with staff during hospitalizations.

- Medication services were accessed at Metro but that transportation was sometimes difficult.

Recommendations for improving care included the following:

- Provide transportation to the Metro campus and the Center, ensuring that those who need to use the shuttle bus qualify.
- Provide or incorporate additional services, including spiritual support/meditation and access to medical care at the Center.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a culturally diverse group, including, if possible, Punjabi speakers, of adult beneficiaries, transitional age youth, and parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held in Selma, at the Fresno County Library, 2200 Selma Street.

Although Punjabi is not a threshold language, the population of Punjabi-speakers in Fresno County and served by the MHP has steadily increased. The focus group was meant to target Punjabi-speakers, but only one of the participants was Punjabi. Alas, this participant excused himself from the session, shortly after the focus group began. .

Number of participants – 8

There was only one participant *who entered services within the past year*.

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

- There was sufficient availability of a variety of services including case management, psychiatry, and groups at sufficient intervals.
- They received timely response during crisis and emergency.
- Transportation was a barrier to services.

Recommendations for improving care included the following:

- Provide more timely assessments for medications.

- Establish a wellness center in Selma, as the travel to Fresno, factoring in cost of transportation and consumer ease/comfort with this commute, is a barrier to desired services.
- Outreach and raise awareness of services at events and places where Punjabi-speakers frequent, for example at Sikh temples.

Interpreter used for focus group 2: ☐ No ☒ Yes Language(s): Punjabi (not needed) and Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

CalEQRO requested a group of Hispanic/Latino adult beneficiaries and transitional age youth (TAY) beneficiaries, whose preferred language is Spanish, including a mix of existing and new clients who have initiated/utilized services within the past 12 month. The focus group was held at the Urgent Care Wellness Center, at 4441 E. Kings Canyon Road.

Number of participants – 10

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

- Seamless, following discharge from hospitalization.
- Taking four months to begin and after being put on a waitlist.

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

- Good availability of services, including individual therapy, medications, case management, and groups.
- Frequency of therapy or counseling was reported to be twice a month.
- Services included a variety of activities for TAY including art, writing, relationship-building, volunteer opportunities, and job preparedness. The youth also felt that they were helped with preparation and transition to adult services (e.g., by being walked through the release of information process).
- There has been a change in scheduling of appointments; now, clients are scheduled for the whole year.
- There has been an increase in the number of case managers in the TAY program.

Recommendations for improving care included the following:

- Provide more information about mental health, wellness, and available mental health services, targeted to Latino communities.
- Increase the opportunities for consumers to talk to mental health professionals, as this helps clients improve.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
 - Participants described a variety of mental health services and programs available through the MHP. Participants use these services and find them beneficial.
 - Some participants remarked on the limited locations for services, all restricted to Fresno, and that transportation was not consistent and presented a barrier to access.
 - Most participants received outpatient services in their preferred language, directly through their clinicians/case manager or through interpreters. A few participants expressed a desire for more multi-lingual staff, particularly Spanish-speaking psychiatric providers.
- Timeliness of Services
 - Some participants had delays in initial access to services, though the specific nature of the delay was not articulated. A few participants also had protracted wait for ongoing psychiatric provider appointments, causing them to run out of their medications.
 - Participants who had needed urgent and emergency services reported that they were received timely.
- Quality of Care
 - Few participants recalled being asked for their input on services and programs; however, all were aware of the Consumer Perception Surveys and had participated at one time or another.
 - Participants felt that there is a need for outreach in immigrant communities to address stigma lack understanding about mental illness.

- Participants liked the diversity of services that they received and would like the incorporation of more activities that reinforce social interaction, that increase their understanding of mental illness, and that melds cultural or spiritual practices (e.g., meditation).
- Consumer Outcomes
 - Participants felt that they were involved in the development of their treatment or care plans.
 - Participants use their ability to interact appropriately with others as a measure of their own progress. Participants expressed a desire for more opportunities to talk and socialize with others.

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	45%
Contract providers	52%
Network providers	3%
Total	100%

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

2.7%

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

☐ Yes

☐ In Testing/Pilot Phase

☒ No

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

☒ Yes

☐ In Testing/Pilot Phase

☐ No

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

2

- The MHP reported an increase in the number of consumers receiving tele-psychiatry services from 2,351 the prior year to 3,698 for the current year.
- Direct services through tele-psychiatry practitioners are available in the following languages (does not include the use of additional translators): English and Spanish.
- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
9	2	0	1

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

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

- The following should be noted with regard to the above information: The MHP expects approval to hire to additional analysts for the MHO implementation.
- The MHP Division Manager for IT is also acting as Manager for QI and Medical Records.

CURRENT OPERATIONS

- The MHP is currently utilizing the MyAvatar Suite from Netsmart Technologies for practice management and EHR. The software is hosted by Netsmart on an Application Service Provider (ASP) basis.
- Free standing databases are utilized for call tracking, 5150s, conservatorship tracking, homeless management, policy and procedures management, and child welfare matching. A contract analyst database is currently under development.
- The MHP recently implemented Sisense Business Intelligence Software which will be utilized to generate dashboard reports. It is currently being used to create supervisor reports for monitoring line staff.

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

Table 12— Primary EHR Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar PM	Practice Management	Netsmart Technologies	6	Netsmart
Avatar CWS	EHR	Netsmart Technologies	6	Netsmart
Avatar InfoScriber	e-prescribing	Netsmart Technologies	6	Netsmart

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace the current system.
- The MHP is planning to implement Netsmart Managed Service Organization (MSO), ProviderConnect, Web Services, and MyHealthPoint Client Portal modules in the next year.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar CWS	X			
Assessments	Avatar CWS	X			
Document imaging/storage	Netsmart	X			
Electronic signature—consumer	Topaz	X			
Laboratory results (eLab)	OrderConnect		X		
Level of Care/Level of Service	CANS	X			
Outcomes	Reaching Recovery	X			

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Prescriptions (eRx)	InfoScriber	X			
Progress notes	Avatar CWS	X			
Treatment plans	Avatar CWS	X			
Summary Totals for EHR Functionality		9	1		

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

- All non-electronic forms are being scanned and linked to EHR records.
- OrderConnect is not fully compatible with Quest Labs at this time. Lab results are being received electronically.
- Reaching Recovery access limited to county operated adult programs and contract FSP provider.
- 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 access.

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

☐ Paper

☐ Electronic

☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- Avatar contract renewal approved.
- Implementation of inbound lab results into EHR.
- Contract signed with Netsmart for MSO implementation.
- Netsmart Technologies ScriptLink implemented.
- Sisense Business Intelligence implemented.

- Policy and Procedures tracking system implemented
- Contract signed for MAP database.
- Contract with Data Dimensions approved for claims/payments reconciliation.

PRIORITIES FOR THE COMING YEAR

- Completion of Reaching Recovery Implementation.
- Implementation of MSO and ProviderConnect.
- Implementation of MAP Phase II.
- Medication inventory management.
- MyHealthPoint Kiosk.
- Outbound lab order interface with Quest.
- Drug Medi-Cal – Organize Delivery System (DMC-ODS) Substance Use Disorder Waiver implementation.
- Health information exchange (with Community Regional Health Center and Central Valley Health Information Exchange).

OTHER SIGNIFICANT ISSUES

- Contract providers do not have direct access to Avatar reports or Sisense dashboards.
- Many contract programs still need to perform double data entry for billing.
- Timeliness tracking does not include consumers directly admitted by contract providers.
- Many of the links on the Mental Health Services main webpage are broken or misdirected.

MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

Data Dimensions

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 14—Summary of CY15 Processed SDMC Claims—Fresno

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
191,814	\$39,747,787	\$1,438,225	3.62%	9,642	\$38,309,562	\$536,497	\$37,773,065

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

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
 - The MHP 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).
 - The MHP has increased the number of clients receiving tele-psychiatry.
- Timeliness of Services
 - Timeliness to initial service is tracked by utilizing a Call Tracking database and Avatar.
 - Quarterly wait time report for new intakes shows monthly wait times to first service and to assessment for each threshold population (English, Spanish, and Hmong speaking) and non-threshold populations.
- Quality of Care
 - Reaching Recovery tools are embedded in Avatar and directly used by county operated adult programs and contract FSP provider.

- Consumer Outcomes
 - Dashboard reports are being developed for wait times and re-hospitalizations.
 - CANS and Level of Care Utilization System (LOCUS) tool are embedded 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 to conducting this review.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
 - The MHP's increased focus on access to services for rural beneficiaries has resulted in reduced hospitalizations.
 - The MHP's partnership and implementation of MAP Point stands to provide much needed access to rural communities.
- Opportunities:
 - The MHP should continue their efforts to recruit and retain qualified clinical staff to meet the demand for services.
 - The MHP should take the opportunity to develop plans and strategies to provide additional contract providers with Avatar EHR full access. While EHR planning meetings have been held with Exodus Recovery Inc., and Central Star, the MHP has not formally surveyed all providers regarding their current EHR or their preferences for integration or data exchange.
 - The MHP reported that rural residents, TAY, and elderly consumers remain underserved. The MHP should take the opportunity to further investigate and reduce barriers to access for these populations.
 - The MHP should assess the impact of access to services given their new Access Line vendor that was contracted because of their skill and expertise in mental health.

Timeliness of Services

- Strengths:
 - Through the Clinical PIP, the MHP is reviewing their timelines for post-discharge follow-up for youth and is developing processes to improve this metric.

- Opportunities:
 - There is an opportunity to more frequently review the time to service metrics, investigate extreme times, and implement corrective action related to protracted times to services.
 - The MHP should consider including contractors' time to services in their review and calculation of initial clinical and psychiatric assessments. Contractors provide a significant portion of the services and protracted times and long wait lists were reported for their programs.
 - There is an opportunity to review the MHP's parameters for urgent conditions and train staff to make appropriate determinations of urgent and non-urgent conditions.

Quality of Care

- Strengths:
 - The MHP's new business intelligence software allows for near real-time availability of dashboard reports.
- Opportunities:
 - The MHP should revise or correct the resource information on their website that is out of date or inadequate.
 - There is a need for stable management of QI department such that projects occur timely and that there is consistent oversight and accountability of QI subcommittees.
 - There is a need for outreach to immigrant communities, which focuses on mental health, wellbeing, and de-stigmatization. The outreach should incorporate media (e.g., radio and television) and venues (e.g., Sikh temples) with whom these communities are familiar.
 - The MHP should consider the expansion of coordination of care, the focus of Clinical PIP, to adult PHF and other post-acute and intensive services where coordination was reported to be wanting.

Consumer Outcomes

- Strengths:
 - The MHP is using Reaching Recovery as a recovery-focused model for adults along with their suite of outcome instruments.
- Opportunities:
 - No opportunities are identified.

RECOMMENDATIONS

- Review all of the timeliness metrics in greater depth, investigate: (1) extreme times and (2) when the percentage of appointments/metric does not meet a predetermined minimum standard, and implement corrective action.
- Develop and implement a plan for monitoring penetration rate and other indicators of access in the rural areas of the county related to the new initiatives to increase access to services (e.g., Multi-Agency Access Program Point).
- Create a stakeholder work group to develop a comprehensive plan for electronic data exchange with organizational providers and hospitals. Begin tracking wait-times and waiting list status for all providers.
- Conduct a new staff survey on lived experience that specifically identifies the level or classification of the respondent's position and ensure that at least 70% of the MHP staff participate.
- Review and update resource information including MHP website.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Table A1—EQRO Review Sessions - Fresno MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview –Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Access Call Center Site Visit
Wellness Center Site Visit
Contract Provider Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Ewurama Shaw - Taylor, PhD, Quality Reviewer
Saumitra SenGupta, PhD, Executive Director, Quality Reviewer
Jerry Marks, Information Systems Consultant
Tilda DeWolfe, 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
Administrative Services
1925 E. Dakota Avenue,
Fresno, CA 93726

Urgent Care Wellness Center
4441 E. Kings Canyon Road
Fresno, CA 93702

Exodus Recovery Crisis Center & Exodus Psychiatric Health Facility
4411 E. Kings Canyon Road
Fresno, CA 93702

Modular F
4463 E. Kings Canyon Road
Fresno, CA 93702

Children's Mental Health Services
3133 N. Millbrook
Fresno, CA 93703

CONTRACT PROVIDER SITES

Fresno Center for New Americans, 4879 E. Kings Canyon Road, Fresno, CA 93272

Kings View, Blue Sky Youth Empowerment Center, 4910 E. Ashlan Avenue, Suite 118,
Fresno, CA 93726

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
Dawan Utecht	Director of Behavioral Health, Administration	Department of Behavioral Health (DBH)
Susan Holt	Deputy Director, Clinical Operations	DBH
Maryann Le	Deputy Director, Business Operations	DBH
Betty Brown	Division Manager, Managed Care	DBH
Irene Takahashi	Division Manager, Children's Mental Health	DBH
Stacy Vanbruggen	Division Manager, Adult System of Care	DBH
Karen Markland	Division Manager, Adult System of Care, Urgent Care Wellness Center (UCWC)/Housing	DBH
Kannika Toonnachat	Division Manager Quality Improvement (QI)/Information Technology (IT)/Medical Records	DBH
Joseph Rangel	Division Manager, Contract Services	DBH
Amina Flores Becker	Division Manager, Administration	DBH
Sean Patterson	Business Manager, Business Office	DBH
Elizabeth A Vasquez	Compliance Officer, Compliance	DBH
Dr. Connie Cha	Cultural Diversity Coordinator	DBH
Dr. James Ritchie	Workforce Education & Training Coordinator	DBH
Bai Hounaviengkham	Senior Staff Analyst, Personnel	DBH
Rebeca Guerrero-Silvas	Program Technician, Personnel	DBH
Francisco Escobedo	Senior Staff Analyst, QI	DBH
Gabe Gomez	Senior Licensed Mental Health Clinician, QI	DBH
Mila Arevalo	Senior Licensed Mental Health Clinician, QI	DBH
Sue Ann Nguyen	Program Technician, QI	DBH
Pa Ge Xiong	Staff Analyst, QI	DBH
Jeffrey Elliott	Epidemiologist, QI and Information System Decision Support (ISDS)	DBH
Doua Lor	Senior Systems and Procedures Analyst, ISDS	DBH
Michael Miller	Systems and Procedures Analyst, ISDS	DBH
Robert Hager	Systems and Procedures Analyst, ISDS	DBH
Mark Winslow	Systems and Procedures Analyst, ISDS	DBH

Name	Position	Agency
Brian Arkelian	Clinical Supervisor, Clinical Team	DBH
Trevor Birkholz	Clinical Supervisor, Older Adult Mental Health	DBH
Cynthia Hager	Clinical Supervisor, Children Mental Health-Outpatient (CMH-O)	DBH
Aimie Rojas	Clinical Supervisor, Youth Wellness Center (YWC)	DBH
Jeffery Robinson	Clinical Supervisor, UCWC	DBH
Luisa Parra-Sanchez	Clinical Supervisor, School-Based Team (SBT)	DBH
Lesby Flores	Clinical Supervisor, CMH-O	DBH
Jeffery Avery	Clinical Supervisor, ASOC and Assertive Community Treatment	DBH
Cary Williams	Clinical Supervisor, Medium Intensity Team (MIT)/ Supported Education and Employment Services (SEES)	DBH
Sonia Sahai-Bains	Clinical Supervisor, UCWC, Mobile Access/Housing	DBH
Lori L. James	Clinical Supervisor, Perinatal Program	DBH
Veronica De Alba	Program Director	Turning Point of Central California (TPOCC)
Emma Mejia	Staff Analyst, Mental Health Contracts	DBH
Mike Muro	Senior Staff Analyst, Mental Health Contracts	DBH
Mee Xiong	Staff Analyst, Mental Health Contracts	DBH
Angela Allen	Activities Coordinator/Case Manager	Blue Sky Wellness Center
Kristi Williams	Family Advocate	Contractor
Ricardo Ochoa	Supervising Account Clerk, Business Office	DBH
Tanimara Puente	Senior Staff Analyst, Business Office	DBH
Tracie Emmersen	Supervising Accountant, Business Office	DBH
Qi Sun	Supervising Accountant, Business Office	DBH
Chao Xiong	Senior Staff Analyst, Business Office	DBH
Diana Yee	Coordinator, Managed Care	DBH
April Ornelas	Community Mental Health Specialist, YWC	DBH
Dr. Sukhjit Brar	Medical Director	Central Star
Hector Cabrera	Administrator	Central Star
Andrew Constant	QA Coordinator	Central Star
Erica Avina	Clinical Director	Central Star
Ana Garcia	Program Manager, Access Line	Exodus Recovery, Inc.

Name	Position	Agency
Dominica Tamayo	Senior Staff Analyst, Administration	DBH
Preetinder Sanghera	Principal Staff Analyst, Mental Health Contracts	DBH
Sharon Ross	Regional Director	TPOCC
Marilyn Bamford	Regional Executive Director	Uplift Family Services
Brenda Kent	Regional Behavioral Health Director	Kings View
Dr. Ghia Xiong	Program Director, Living Well Program	Fresno Center for New Americans
Deborah Tobias-Gatewood	Assistant Administrator	Central Star
Karen Tombs	Program Director	Exodus Recovery, Inc.
Earliana Vang	Staff Analyst, Mental Health Contracts	DBH
Ryan Banks	Deputy Regional Director	TPOCC
Deborah Patterson	Clinical Supervisor, Child Welfare Mental Health Team	DBH
Kristin Lynch	Senior Staff Analyst, Mental Health Contracts	DBH
Kathy Rexroat	Clinical Supervisor, Managed Care	DBH
John Dufresne	Program Manager, Placement Services	Department of Social Services (DSS)
Cornell Archie	Senior System and Procedure Analyst, IT	DSS
Natalie Bennett	Unlicensed Mental Health Clinician, SBT	DBH
Leiann Green	Community Mental Health Specialist, SBT	DBH
Andrew Beasley	Unlicensed Mental Health Clinician, SBT	DBH
Raquel Rodriguez-Campos	Unlicensed Mental Health Clinician, Clinical Team	DBH
Danielle Penuna	Community Mental Health Specialist	DBH: Recovery with Inspiration, Support & Empowerment (RISE)
Arica Washington	Unlicensed Mental Health Clinician, Pathways to Recovery	DBH
Shangri-La Dhaliwal	Community Mental Health Specialist, MIT	DBH
Kristen Clute	Licensed Mental Health Clinician, First Onset	DBH
Patrick Neely	Mental Health Clinician	TPOCC
Dylan Loy	Staff Analyst, Administration	DSS
Lisa Lopez	Licensed Mental Health Clinician, UCWC	DBH
Lindsey Sorondo	Staff Analyst, Mental Health Contracts	DBH
Gilberto Rivas	Program Manager	Kings View

Name	Position	Agency
Farisa Ikner	Licensed Mental Health Clinician, Law Enforcement	DBH
Tina Hindman	Supervising Office Assistant, UCWC	DBH
Brian Lee	Assistant Director, Vista Program	TPOCC
Claudia Schroeder	Senior Licensed Mental Health Clinician, SBT	DBH
Karla Moreno	Peer Support Specialist, Perinatal Program	DBH
Trin Gibney	Peer Support Specialist, UCWC	DBH
Jill Shepherd	Peer Support Specialist, Clinical Team	DBH
Darrel Adams	Peer Support Specialist	TPOCC
Enette Lopez	Peer Support Specialist	TPOCC
Rebecca Alcala	Peer Support Specialist	TPOCC
David Lopez	Program Manager, Central Valley Suicide Prevention Hotline	Kings View
Brittany Storle	Senior Licensed Mental Health Specialist, Expansion Day Treatment	DBH
Alvina Mojarras	Unlicensed Mental Health Clinician, Expansion Day Treatment	DBH

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

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

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

Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary Fresno					
Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	\$533,318,886	\$4,060
Large	1,497,986	63,298	4.23%	\$263,166,307	\$4,158
Fresno	95,341	4,044	4.24%	\$18,341,754	\$4,536

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

Table C2—CY15 Distribution of Beneficiaries by ACB Range Fresno								
Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
\$0K - \$20K	13,069	96.60%	94.46%	\$35,424,041	\$2,711	\$3,553	65.92%	61.20%
>\$20K - \$30K	213	1.57%	2.67%	\$5,138,994	\$24,127	\$24,306	9.56%	11.85%
>\$30K	247	1.83%	2.86%	\$13,172,622	\$53,330	\$51,635	24.51%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

CLINICAL PIP

GENERAL INFORMATION

MHP: Fresno

PIP Title: Improving Care Coordination and Timeliness of Post-Hospital Follow-up

Start Date (MM/DD/YY): 10/30/16

Completion Date (MM/DD/YY): Ongoing

Projected Study Period (#of Months): 12 months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 03/08-10/17

Name of Reviewer: Shaw – Taylor and SenGupta

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

- ☒ Active and ongoing (baseline established and interventions started)
- ☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

- ☐ Concept only, not yet active (interventions not started)
- ☐ Inactive, developed in a prior year
- ☐ Submission determined not to be a PIP
- ☐ No Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP is to improve care coordination and communication between Central Star Youth Psychiatric Health Facility (PHF) and Fresno County Department of Behavioral Health-Children's Outpatient. Specifically, the MHP intends to provide more timely post hospitalization follow-up, within 14 days, thereby reducing the 30-day readmission rates.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP topic was selected through input of stakeholders who were/are involved with hospitalization for youth. While the PIP team did not include any consumers, a peer support specialist was part of the brainstorming session for the PIP.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team makes a link between timely follow (i.e., within 14 days) from the PHF and re-admission rates. They provided data on re-admission rates over the past year and data on time to follow-up, percentage of follow-ups that occurred within a certain time period. However, none of the data directly link time to follow-up with re-admission. Similarly, the data do not show that those who are not receiving mental health services have greater rates of readmission than those who are receiving ongoing mental health services.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input checked="" type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input type="checkbox"/> Process of accessing or delivering care

<p>1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?</p> <p><i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team presented a 19% readmission rate for youth admitted to Central Star, but did not include a context for this rate. Is this rate an increase from the previous year's? Is it greater than when compared to readmission rates at other youth facilities? The only context for the rate is a comparison to a federal reporting of 15% readmission rate, which includes all inpatient facilities (i.e., for adults and youth). In addition, in a related PIP documented (presented during the review), the MHP's readmission rate is described as "respectable" and below some published rates of psychiatric readmission. The PIP team makes a link between readmission and post-discharge follow-up, particularly within 14 days. As above, the PIP team did not make a link between the readmission rate and days to follow-up. Actually, the majority of discharged youth (75%) had follow-up appointments and most of these appointments (59%) occurred within 30 days of discharge: 45% within 14 days and another 14% occurred within 15-30 days. The PIP team did not sufficiently articulate or explain the problem that they were addressing. Nevertheless, they presented four reasons/barriers as to why discharge follow-ups were not occurring and focused on two of them: no scheduled appointments and communication challenges between the PHF and the outpatient services, which have the potential to affect broad aspects of enrollee care and services.</p>
<p>1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?</p> <p><i>Demographics:</i></p> <p><input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input checked="" type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP is meant to address youth re-admissions/hospitalizations. The study includes youth who were hospitalized at Central Star, the county's youth PHF. Age and gender of the youth are provided.</p>
Totals		<p>2 Met 2 Partially Met 0 Not Met 0 UTD</p>

STEP 2: Review the Study Question(s)									
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> Text	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The study question is clear and has a measurable impact. The PIP team intends to affect other aspects of services, including no show rates, but this is not included in the study question.							
Totals		1	Met	0	Partially Met	0	Not Met	0	UTD
STEP 3: Review the Identified Study Population									
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP includes Medi-Cal enrollees and the intent is to increase the number of enrollees who are engaged in and receive ongoing services.							
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i> <input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input checked="" type="checkbox"/> Other: Central Star Admission Records	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Both youth who receive ongoing services and youth who are not receiving ongoing services contribute to the readmission rate. The PIP team has limited the study to those youth who are hospitalized and not already receiving services, effectively excluding part of the population to which the study is relevant and that would benefit from this study.							
Totals		1	Met	0	Partially Met	1	Not Met	0	UTD

STEP 4: Review Selected Study Indicators

4.1 Did the study use objective, clearly defined, measurable indicators?

List indicators:

1. Percentage of clients who were admitted within 30 days
2. Percentage of clients who received follow-up within 14 days of discharge
3. Post Discharge No Show for 2nd Scheduled Appointment

- ☐ Met
☒ Partially Met
☐ Not Met
☐ Unable to Determine

Indicator 1 is the same as the outcome measure. Indicator 2 is a good measure of the team's efforts to improve follow-up. However, indicator 3 is not very informative. By the time the youth has missed the 2nd scheduled appointment, it suggests that other parts of the team's processes are not working as they should. Other indicators would have been more informative, including: occurrence of daily conference calls per each day the patient is hospitalized; the number that responded to and confirmed their follow-up appointment; the number who were assisted with addressing barriers after the missed follow-up appointment; the number of missed follow-up appointments that had subsequent home visits; and the number of home visits that resulted in subsequent appointments.

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p> <input checked="" type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction </p> <p>Are long-term outcomes clearly stated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Indicators 1 and 2 assess change in functional status, the ability to access timely services which then facilitates continuity of care. The long-term outcomes are that youth have fewer readmissions and that youth are routinely engaged in services.</p>
Totals		1 Met 1 Partially Met 0 Not Met 0 UTD
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>No sampling is used. The entire population of hospitalized youth who are not receiving services are the targets.</p>
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame</p> <p>_____ N of sample</p> <p>_____ N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		0 Met 0 Partially Met 0 Not Met 0 UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	For the indicators mentioned, the PIP team has specified the data to be collected. There are other data elements that the team should collect (see 4.1) that were not included.
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i> <input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: Avatar	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Avatar is indicated as the source of data, which can track dates and time-to-services. But there are other data elements (e.g., the daily conference calls), whose data source is not indicated.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team indicated that they plan to measure/pull data on a monthly basis, but they also indicated that the PHF service/day entry is 15-50 days in arrears. The PIP team is trying to affect a process with a short turn-around (of 14 to 30 days). If data can be up to 50 days in arrears, it does not permit the team to have a true picture of current status and to make changes /interventions as needed.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other: Text if checked	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	There is nothing to suggest that Avatar would not yield consistent and accurate data during the study period. The issue is the lag/delay in obtaining the information from the PHF. Given the variability in time to obtain, it is difficult to determine if consistent and accurate data will be collected.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team did not articulate an analysis plan. The only plan was for monthly reviews; however, after four months, the PIP team did not provide an update of progress.

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name: Cynthia Hager and Erica Avina</p> <p>Title: Clinical Supervisor and Clinical Director, PHF</p> <p>Role: Overseeing planned interventions and discharge, respectively</p> <p><i>Other team members:</i></p> <p>Names: See PIP document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team includes clinical, quality management, and IT staff who would have the skills and expertise to design, guide, and monitor the study.</p>
Totals		1 Met 2 Partially Met 2 Not Met 1 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ol style="list-style-type: none"> Daily conference call between PHF stakeholders MHP-CMH visits client's home 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team has presented only two interventions. They do not include the process or intervention related to scheduling appointments (such that they occur in 14 days). While the home visits are a good back-up intervention, there ought to be some interventions geared toward preventing no shows or conversely ensuring adherence to appointments. During the on-site review, the team mentioned that reminder calls, both live and automated, are used.</p>
Totals		0 Met 1 Partially Met 0 Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>This is Not Met as no analysis plan was articulated.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is ongoing and results and findings have yet to be determined.</p>

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>While the study is ongoing, they PIP team indicated monthly review (i.e., repeated measure); however, no results were provided for the four months that the study has occurred and data were collected.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> Text</p> <p><i>Conclusions regarding the success of the interpretation:</i> Text</p> <p><i>Recommendations for follow-up:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is ongoing and results and findings have yet to be determined.</p>
<p style="text-align: right;">Totals</p>		<p>0 Met 0 Partially Met 2 Not Met 2 NA 0 UTD</p>
<p>STEP 9: Assess Whether Improvement is “Real” Improvement</p>		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is ongoing. The team is not at this stage.</p>

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is ongoing. The team is not at this stage.
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is ongoing. The team is not at this stage.
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is ongoing. The team is not at this stage.
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is ongoing. The team is not at this stage.
<p>Totals</p>		<p>0 Met 0 Partially Met 0 Not Met 5 NA 0 UTD</p>

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Text

Recommendations:

Text

Check one:

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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

NON- CLINICAL PIP

GENERAL INFORMATION

MHP: Fresno**PIP Title:** Fresno MHP Access Line**Start Date (MM/DD/YY):** 09/01/16**Completion Date (MM/DD/YY):** Ongoing**Projected Study Period (#of Months):** 10 months**Completed:** Yes ☐ No ☒**Date(s) of On-Site Review (MM/DD/YY):** 02/08-10/17**Name of Reviewer:** Shaw – Taylor and SenGupta**Status of PIP (Only Active and ongoing, and completed PIPs are rated):****Rated**

- ☒ Active and ongoing (baseline established and interventions started)
- ☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

- ☐ Concept only, not yet active (interventions not started)
- ☐ Inactive, developed in a prior year
- ☐ Submission determined not to be a PIP
- ☐ No Non-Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The purpose of this PIP is to improve the quality of interaction and process of calls to/on the MHP's toll-free 800 Access Line by replacing the existing contractor, an answering service, with a licensed mental health multidisciplinary team.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP topic was selected based on review of Access line services and that the MHP was not meeting certain state standards. The stakeholders involved were those who were familiar with the Access line and analysts who would pull relevant data from the access line. The PIP also included consumers and stakeholders as part of the implementation. During the review, the PIP team shared that consumers were invited to be on the PIP team, but declined or were unable to attend meetings.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team presented data on the access line, tracking of calls/inquiries and assistance to consumers, by the previous vendor. This data showed underperformance in a number of areas and not meeting State standards. No data are presented that related to consumer use of the Access line.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input checked="" type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The Access line is a primary means for consumers to access services and receive information about the MHP. The PIP is meant to address components of access that are assessed on test calls (e.g., request for information, language differences, urgent conditions, etc.), but it does not specifically address issues that consumers may present with when using the Access line.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP pulls data from calls and test calls to the Access line, which are used by consumers, pre-consumers, and others.

Totals	2	Met	1	Partially Met	1	Not Met	0	UTD
---------------	----------	-----	----------	---------------	----------	---------	----------	-----

STEP 2: Review the Study Question(s)						
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i></p> <p>If the FMHP replaces the existing, non-mental health exchange messaging service contractor provider with a clinical licensed/unlicensed mental health multi-disciplinary team contractor provider, then the FMHP 24-hour, 7-days/week Access Line will improve services to all users? The improvements include: meeting State mandated Test Calls goals; call placement; number of calls logged; timeliness to first service for assessment; consumer participation/feedback; and communication between the county, contract provider, and consumers utilizing the FMHP Access Line.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>While the study question is stated clearly, with detail about the outcome measures, only one of the outcome measures has a direct impact on the consumers—timeliness to 1st service assessment. Consumer participation/feedback is an important component, but the design of the study only captures consumer input after the intervention is applied, not before. The focus of the study question is more process and procedural than on benefit to the consumer.</p>				
Totals		0	Met	1	Partially Met	0 Not Met 0 UTD
STEP 3: Review the Identified Study Population						
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team indicated that the study includes all users of the MHP's Access line, including consumers, family members/friends, enrollees, and other callers. The PIP team indicated that they receive 124 calls per month, they do not provide detail on whom these callers might be.</p>				
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification</p> <p><input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team's data collection approach is from the perspective of the MHP and the need to have an Access Line that meets certain parameters and requirements. It is not from the perspective of the consumer/pre-consumer/caller and what their intentions/needs are for making the call. The study does not capture enrollee information.</p>				
Totals		1	Met	0	Partially Met	1 Not Met 0 UTD

STEP 4: Review Selected Study Indicators

4.1 Did the study use objective, clearly defined, measurable indicators?

List indicators:

1. Accuracy of Test Calls, Verbal and Written Logs
2. Accuracy of calls logged, by database category
3. Recording/documentation of test calls
4. Average days from called date to 1st service assessment
5. Consumer Participation
6. Misplaced calls in the 'Other' tab of Access Log

- ☐ Met
☒ Partially Met
☐ Not Met
☐ Unable to Determine

Most of the study indicators are clear and measurable, and will show a change in the handling of various components of the Access Line. Per discussion with the PIP team, scheduling of appointments is not the responsibility of the access line vendor. The PIP team did not articulate how changing vendors is then supposed to change time to appointments. Therefore indicator 4 is not relevant to the intervention. Indicator 5, Consumer participation, is an *action* and in and of itself does not indicate anything.

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Only one of the indicators—average days from called date to 1st service assessment—measures change in a consumer /enrollee functional status. However, as mentioned above, this measure would not be related to a change in vendor. As part of the Consumer Participation, the PIP will include a consumer satisfaction survey, which the PIP team was recently awarded approval. However, the survey is only a post-intervention and will not be able to show change. Per discussion during the review, the survey serves more as a benchmark of the new vendor's performance.</p>
Totals		<p>0 Met 1 Partially Met 1 Not Met 0 UTD</p>
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP team intends to conduct a satisfaction survey of individuals who call the Access Line. The PIP team included the estimated number of calls to the Access line annually, the confidence interval, and margin of error.</p>
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p> <p>Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP document does not describe the sampling technique.</p>
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p><u>3452</u> N of enrollees in sampling frame</p> <p><u>346</u> N of sample</p> <p><u> </u> N of participants (i.e. – return rate)</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The sampling is based on the number of calls to the Access Line and not the number of individuals that call. The PIP team did not speculate as to whether there is a one-to-one relationship between calls and enrollees/consumers/pre-consumers. Based on the number of calls, the PIP team has a sample size that would give them enough information about the satisfaction and experience with the Access Line.</p>
Totals		<p>2 Met 0 Partially Met 1 Not Met 0 UTD</p>

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The data to be collected are those that were listed in indicators.
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i> <input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: Avatar, Access Log, and Test Calls	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Three sources of data were indicated.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The study captures process/procedural data related to the Access line and not consumer data related to using the access line. The PIP team indicated monthly collection of data.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other: Text if checked	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	While the logs and Avatar will provide consistent and accurate data, some elements (will) require the PIP team to do a deeper and manual review. For example, to determine if calls are placed appropriately (or misplaced), someone will need to review the detail of the calls. This process was not articulated.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The study includes a prospective analysis plan. The PIP team indicated that they will present all data, including those unfavorable, as a way to address and correct untoward results.

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name: Francisco Escobedo</p> <p>Title: Senior Staff Analyst</p> <p>Role: Lead/Coordinator</p> <p><i>Other team members:</i></p> <p>Names: See PIP document</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The staff who are collecting the data appear to be analysts, except the office assistant. A clinical perspective is needed on the data collection team to make determinations about whether calls are appropriately logged/placed and possibly determining what is urgent/emergency.</p>
Totals		3 Met 3 Partially Met 0 Not Met 0 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <p>Replacement of non-clinical exchange service provider with a multi-disciplinary unlicensed/licensed staff provider</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team's only intervention is a change in vendor of the Access Line. This intervention does not address the time-to-appointment, which the PIP team also intends to improve.</p>
Totals		0 Met 1 Partially Met 0 Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is ongoing and data is still being collected. Nevertheless, the analysis plan indicates monthly review of data, but only aggregate data following four months of the intervention was provided.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team provides pre- and post-intervention data, showing an increase in performance in a number of areas of calls. No data were provided on the time to test calls and no explanation is given as to why the 'Other' category has increased with the new vendor.</p>

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The analysis indicates repeated measure. They PIP team has satisfied repeated measure with this interim results; however, they indicated monthly review of the data. As stated above monthly review was not provided.</p> <p>No statistical analyses are indicated. They presented percent of change.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> Text</p> <p><i>Conclusions regarding the success of the interpretation:</i> Text</p> <p><i>Recommendations for follow-up:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is not at this stage.</p>
Totals		0 Met 3 Partially Met 0 Not Met 1 NA 0 UTD
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The study is not at this stage.</p>

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is not at this stage.
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is not at this stage.
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is not at this stage.
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	The study is not at this stage.
<p style="text-align: right;">Totals</p>		<p>0 Met 0 Partially Met 0 Not Met 5 NA 0 UTD</p>

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

Text

Recommendations:

Text

Check one:

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