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FY 2018–19
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

FRESNO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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INTRODUCTION

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

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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 fiscal year (FY) 2018-19 findings of an EQR of the Fresno County MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Central

MHP Location — Fresno

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 18,172

MHP Threshold Language(s) — Spanish and Hmong

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY 2017-18

Recommendation 1: Show regular (monthly or quarterly) monitoring and evaluation of timeliness in the Access or Outcomes Committees and be able to identify/distinguish outliers from the average time to services. As necessary, review cases open for longer than 90 days (or some other fixed timeframe) with no activity to determine if the cases should be closed.

(This recommendation is related carry-over from FY 2016-17.)

Status: Partially Met

- While several meetings included a discussion of timeliness between June and October of 2018, none were held after October 2018.
- Regarding the review cases (service requests) open for longer than 90 days, the MHP quality improvement (QI) team began the review in August 2018 and the case initial disposition update/closing started in October 2018 and is not complete.
- The review of cases led to the discovery of a discrepancy in selecting "Initial Disposition" in the county-operated Children's Division where many service requests were entered with an initial disposition of "other" instead of "Referred to

mental health provider" or "Scheduled Appointment." This portion of the service requests, approximately 87 percent, were excluded from the timeliness report.

- The review of cases also found duplicate entry of service requests and other inappropriate initial dispositions such as initial disposition of "other" used instead of "service refused".
- These discoveries prompted: (1) Data review and update; (2) IT script/programing to block duplicate data entry; (3) A few additional initial dispositions; (4) User guide update and training; and, (5) Continued data review and update, which is in progress.
- Timeliness data remains an area in which there continues to be significant opportunities for improvement in that reporting is partial and continued discoveries of inaccurate recording have been identified which call into question any analysis of this data for improvement purposes.

Recommendation 2: Calculate penetration rates and monitor timeliness of service delivery in the rural areas, relative to the efforts (e.g., Multi-Agency Access Program) to increase access.

(This recommendation is a carry-over from FY 2016-17.)

Status: Partially Met

- The MHP did monitor penetration rates in the rural areas and reported a slight increase in the penetration rate between CY 2016 and 2017.
- The MHP's response did not directly address the timeliness component of this recommendation.

Recommendation 3: Initiate a log that records both trouble/problem calls with the Avatar system and the resolution to the call, and monitor the log monthly to identify trends and potential threats to system.

Status: Not Met

- The MHP does not have a Help Desk system.
- The MHP worked with the County IT, and requested to use a help desk logging system purchased and adopted by the County. This request was denied, and County IT offered to seek a solution that would better suit the MHP's needs.
- This leaves the MHP's information systems (IS) team with inadequate tools to support the users of their mission-critical Avatar EHR.
- The decision to develop a Help Desk system when there are many good systems available on the market continues to delay this needed functionality.

Recommendation 4: Hire an individual with the skills necessary to manage a quality improvement program and, if certification is still deemed necessary, make it a condition of employment within a fixed period.

Status: Not Met

- The Quality Improvement Coordinator position has been posted as a continuous recruitment over 484 days. This position remains vacant.
- The Certified Professional in Healthcare Quality (CPHQ) Certification requirement is being reviewed as it may be the reason the position is so difficult to fill.

Recommendation 5: Pilot the use of flexible staff hours for those employees delivering services to children.

Status: Partially Met

- MHP has not piloted the use of flexible staff hours for those employees delivering services to children; however, the topic of flexible staff hours has been delegated to the Department of Behavioral Health (DBH) Morale Committee to further explore.
- The MHP stated that when it is necessary to meet the needs of a child, hours outside the usual working hours can be arranged within the discretion of the MHP.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 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 (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Fresno MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	66,112	13.4%	3,950	21.7%
Latino/Hispanic	286,930	58.1%	6,852	37.7%
African-American	30,378	6.1%	1,629	9.0%
Asian/Pacific Islander	34,103	6.9%	705	3.9%
Native American	2,952	0.6%	177	1.0%
Other	73,723	14.9%	4,859	26.7%
Total	**494,196**	**100%**	**18,172**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

During CY 2017, the MHP experienced claims submission delays that resulted in a significant number of claim transactions not being included in the analysis below for CY 2017 results. It is possible that the number served is underreported because of this issue.

Penetration Rates and Approved Claims per Beneficiary

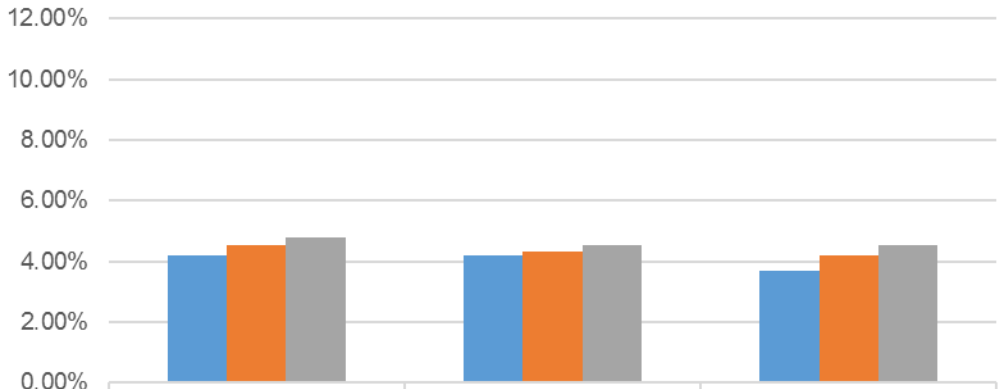
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

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

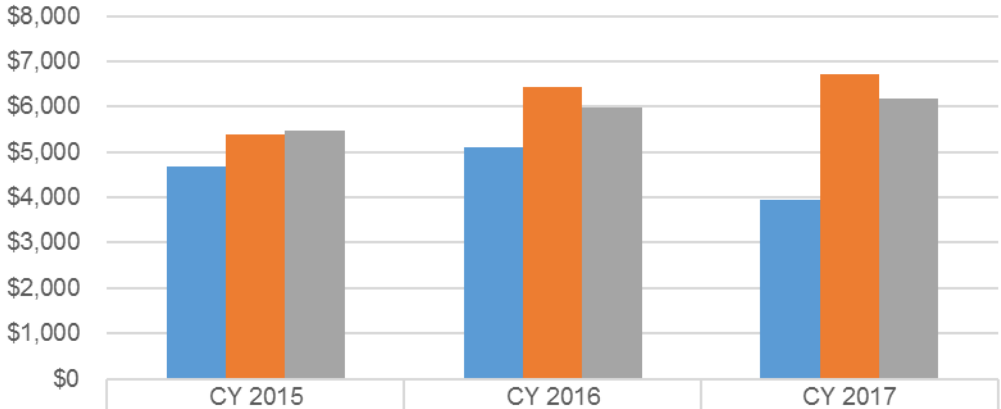
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	4.18%	4.21%	3.68%
Large	4.53%	4.30%	4.19%
State	4.78%	4.53%	4.52%

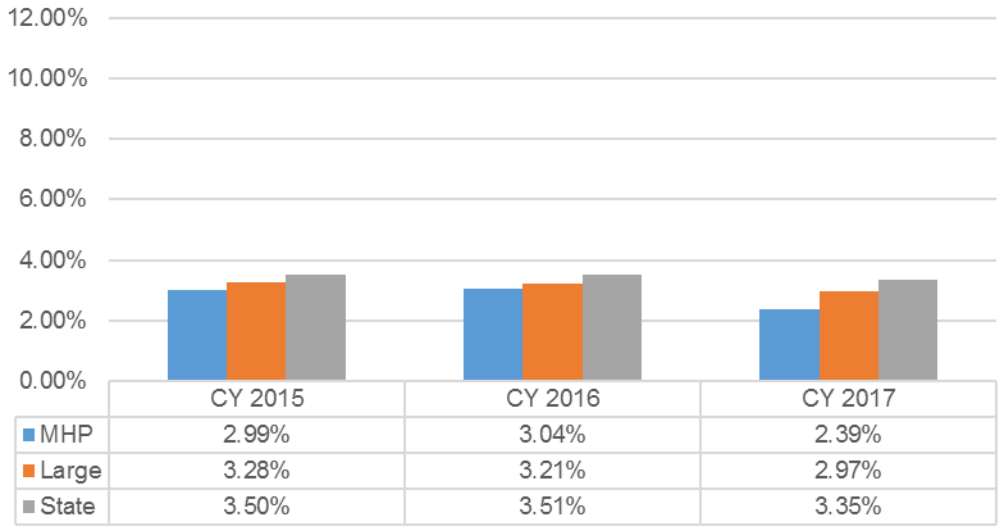
Figure 1B. Overall ACB
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	$4,692	$5,092	$3,946
Large	$5,393	$6,430	$6,723
State	$5,458	$5,978	$6,170

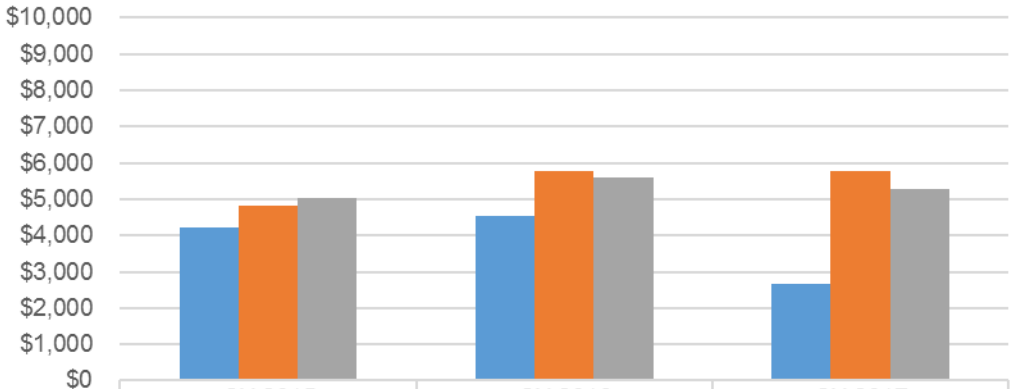
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	2.99%	3.04%	2.39%
Large	3.28%	3.21%	2.97%
State	3.50%	3.51%	3.35%

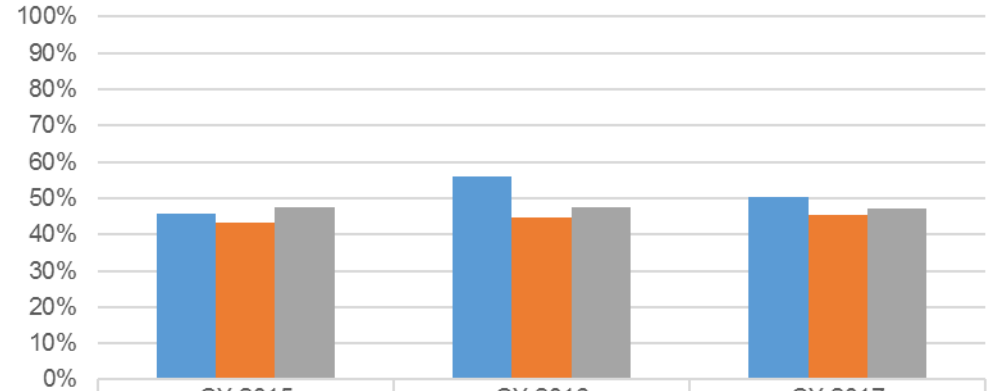
Figure 2B. Latino/Hispanic ACB
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	$4,237	$4,524	$2,662
Large	$4,804	$5,785	$5,758
State	$5,029	$5,588	$5,278

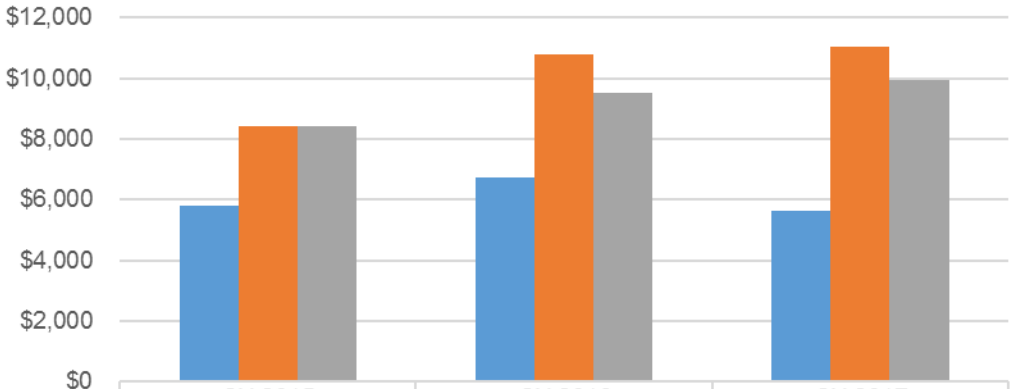
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	45.69%	56.16%	50.42%
Large	43.42%	44.78%	45.37%
State	47.52%	47.48%	47.28%

Figure 3B. FC ACB
Fresno MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,783	$6,718	$5,626
Large	$8,425	$10,805	$11,064
State	$8,432	$9,521	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
Fresno MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	321	18,172	1.77%	$51,227	$16,443,768	22.93%
	CY 2016	553	20,824	2.66%	$53,017	$29,318,345	27.65%
	CY 2015	489	19,769	2.47%	$54,072	$26,441,425	28.51%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

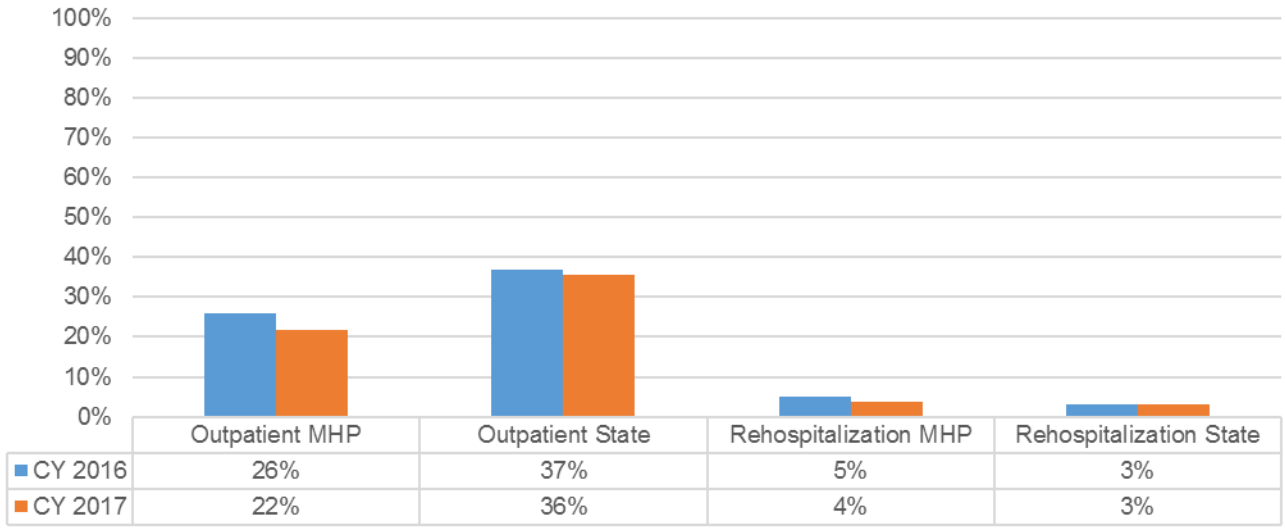
Table 3. Psychiatric Inpatient Utilization - Fresno MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	2,465	7,364	7.11	$10,163	$25,052,846
CY 2016	2,554	7,022	7.27	$10,068	$25,714,051
CY 2015	2,215	6,898	6.96	$7,359	$16,299,920

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

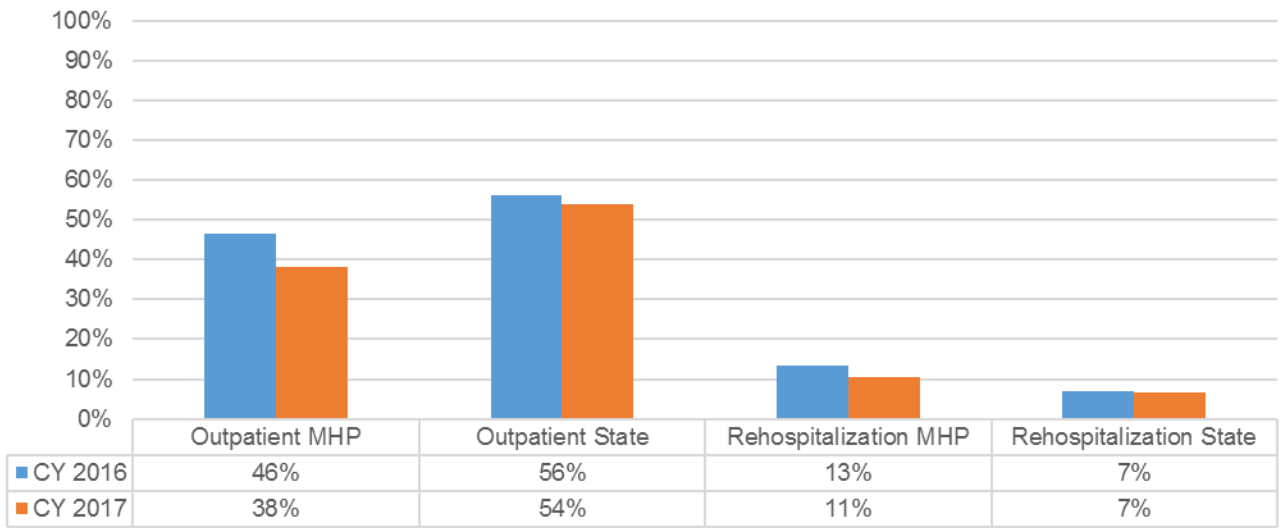
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Fresno MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	26%	37%	5%	3%
CY 2017	22%	36%	4%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Fresno MHP



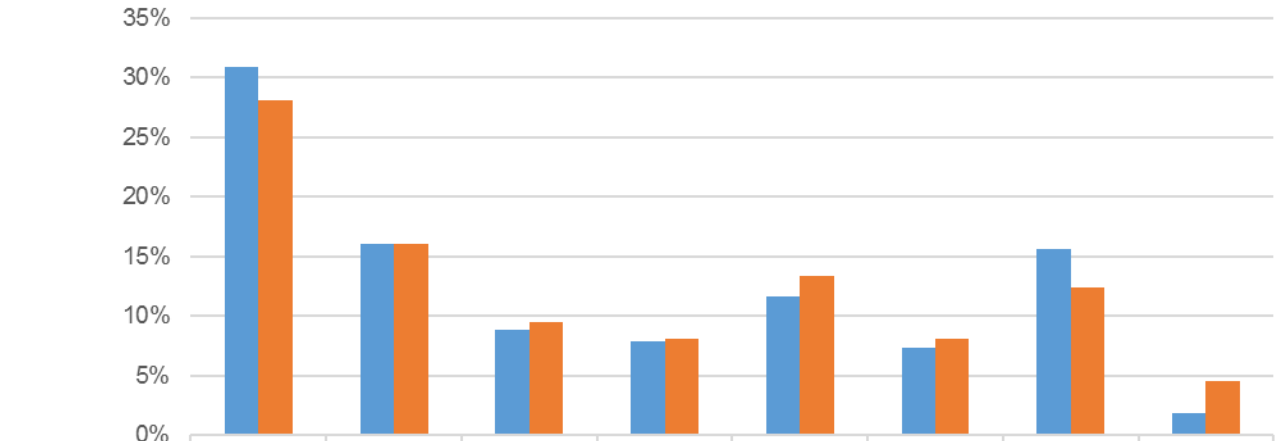
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	46%	56%	13%	7%
CY 2017	38%	54%	11%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

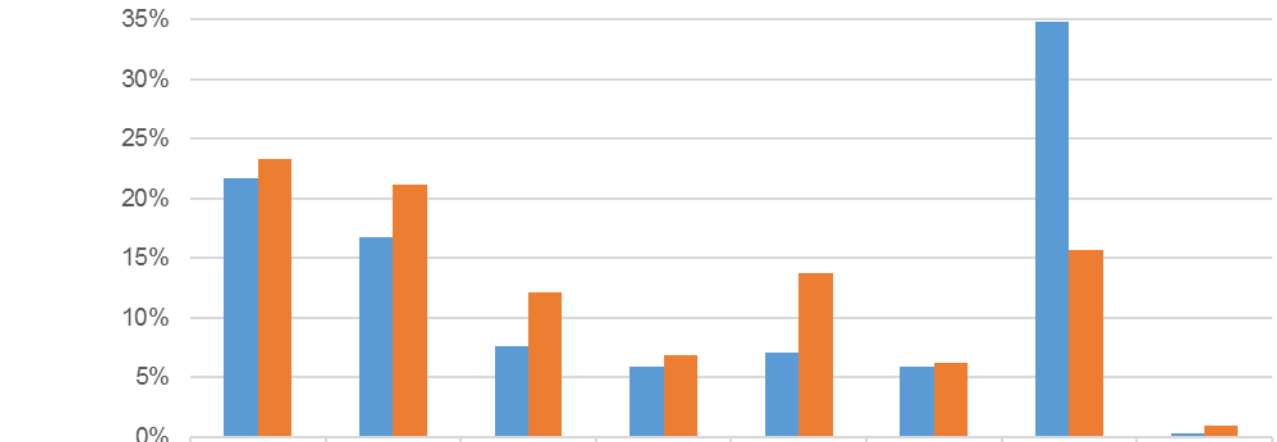
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 12.6 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Fresno MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	31%	16%	9%	8%	12%	7%	16%	2%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

Figure 5B. Diagnostic Categories, Total Approved Claims
Fresno MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	22%	17%	8%	6%	7%	6%	35%	0%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

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." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Fresno MHP PIPs Identified for Validation

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

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.[5]

Table 4: PIPs Submitted by Fresno MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Hospital Engagement (Adults)
Non-clinical PIP	1	Improving Access Through School-Based Services

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

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

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		6.4	Plan for consistent and accurate data collection	M	UAD
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NA	NA
		8.2	PIP results and findings presented clearly and accurately	NA	NA
		8.3	Threats to comparability, internal and external validity	NA	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA
		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

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	16	15
Number Partially Met	0	0
Number Not Met	0	0
Unable to Determine	0	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16	16
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**100%**	**93.7%**

Clinical PIP—Hospital Engagement (Adult)

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

"Will directly engaging with and assessing individuals ages 18 and older who are unlinked to outpatient FDBH services *during hospitalization* and then supporting their access to follow-up care improve: 1) their average time to follow-up services; 2) the percentage of initial follow-up outpatient service within 3 days; and 3) decrease their likelihood of re-hospitalizations within 30 days?"

Date PIP began: June 2018

Projected End date: June 2019

Status of PIP: Active and ongoing

The MHP developed this PIP with the intent of improving the outcomes of those who experience an acute hospital admission and are not open to outpatient services at the time. Specifically, the MHP expects to improve both timely follow-up after discharge and reduce the 30-day readmission rates.

The identified interventions include specific engagement activities with hospitalized, "unlinked" beneficiaries and initiation and completion of the outpatient clinical assessment prior to discharge. The intent is to resolve potential barriers to care, produce engagement, and ensure resolution of challenges that might produce barriers, such as transportation.

Suggestions to improve the PIP: The MHP should consider modifying the engagement indicator to target those who receive a service level better-associated with retention in care, for example from single event currently utilized to three or more which the MHP proposes as indicative of true retention. In addition, the MHP might consider utilizing an evidence-based practice (EBP), such as Motivational Interviewing, to test a structured approach to the engagement activities that are the key clinical intervention in this PIP.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of discussion with the MHP both onsite and following the review. Since the MHP has a focus on the timeliness of post-hospital services and readmission rate, the engagement parameter would provide more actionable information if the goal was greater than a single service. Application of an EBP to the engagement intervention would provide a stronger clinical approach. The MHP submitted a revised PIP following the review which addressed feedback provided onsite.

Non-clinical PIP—Improving Access Through School-Based Services

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

"Will increased capacity provided through school-based programs and a 'no wrong door' approach overcome service access barriers for unserved and underserved youth and families in need of specialty mental health services and increase the county's penetration rate in targeted school districts by 1.5 percentage points by January 1, 2020?"

Date PIP began: January 2019

Projected End date: December 2019

Status of PIP: Active and ongoing

The MHP evaluated the penetration rates for its school-based services across four key districts. It was discovered that all districts were significantly lower than the Metro Fresno service area, which has a 4 percent penetration rate.

The MHP was aware of the needs in the school system from recent community input sessions and an awareness of factors that make in-school mental health services more accessible than clinic-based services. For example, transportation, caregiver responsibilities, and managing home life needs were presented as obstacles to clinic-based services. Therefore, increasing availability of services within the schools is seen as a more effective and efficient approach to making services available to children and youth. This was also supported by a literature review, which the MHP performed in the development of this PIP.

The foundation of this PIP included a no-wrong-door training provided to all staff of the school systems, encouraging any of the school personnel who perceives a child/youth experiencing a mental health need to make a referral.

Suggestions to improve the PIP: Since the MHP is relying on various types of trained and untrained school personnel to identify children/youth with needs, the MHP may wish to track and quantify referral sources. This may offer information regarding unexpected sources and successes, and it may also identify additional training needs.

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

The TA provided to the MHP by CalEQRO consisted of both onsite discussion of possibilities for this and other PIPs and a post-site PIP TA call in which the two PIPs that were rated for this review cycle were discussed in depth.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 1.4 percent.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	57.17%
Contract providers	39.27%
Network providers	3.56%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 4

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

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☒ To serve outlying areas within the county
- ☐ To serve beneficiaries temporarily residing outside the county
- ☐ To serve special populations (i.e. children/youth or older adult)
- ☐ To reduce travel time for healthcare professional staff
- ☐ To reduce travel time for beneficiaries

- Telehealth services are available with English- and Spanish-speaking practitioners (not including the use of interpreters or language line).
- Approximately 3,105 telehealth sessions were conducted in Spanish.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
13	2	0	3

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
1	0	0	0

The following should be noted about the above information:

- There were problems in the county-operated Children's Division, where many service requests were entered with an initial disposition of "other" for "Referred to mental health provider" or "Scheduled Appointment." This meant that 87 percent of requests for services in the Children's Division were excluded from the timeliness self-assessment. This problem originates back to 2016 and was only recently discovered. MHP employees were also not filling out the field that identified the first offered appointment, a key timeliness measure. Adequate data analytic staffing might have allowed the MHP to identify these problems sooner.
- With 1.4 percent of budget invested in IS and supporting resources, this MHP is resourced to sustain current operations, but is unlikely to have the depth of

resources necessary to address the current and future large scale strategic projects that can transform an organization.

- The MHP has added programs, staff, and functions, but IS resources have not experienced similar growth to allow them to fully support this expanded MHP.

Current Operations

- The MHP IS unit does not have a Help Desk system to track and trend incoming problem calls and their resolution.
- The MHP IS group is a unit within the Technology and Quality Management (TQM) Division. While there are likely advantages to having some of the higher utilizers of data (i.e., Quality Assurance) closely associated with IS, there is also the disadvantage of IS being viewed as a utility service rather than a strategic asset that drives change in the organization.
- The MHP has an excellent dashboard called Employee Metrics that is available to managers and supervisors. There would be considerable value in making this dashboard available to line staff to view their own metrics and summary information at the level of adult services and child services.

Table 11 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 (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
MyAvatar – CalPM	Practice Manage-ment and Billing	Netsmart	8	Netsmart
MyAvatar – CWS	Clinical Workstation	Netsmart	8	Netsmart
MyAvatar – Order Connect	ePrescrib-ing and Labs	Netsmart	8	Netsmart
MyAvatar – MSO/Provider Connect	Managed Care Auth/Billing	Netsmart	0	Netsmart

The MHP's Priorities for the Coming Year

- Continue roll out of Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.
- MSO and Provider Connect implementation.
- EHR expansion to contracted providers.
- Develop the MHP's human resources (HR) information system.
- EHR overhaul of medical team forms.
- Admission/discharge/transfer tracking.

Major Changes since Prior Year

- Migration of substance use disorder (SUD) data and claiming from Substance Abuse Information System (SAIS) to Avatar.
- Relocation of administrative support staff to the Health and Wellness Center.
- Onboard of two additional contract providers to use Avatar as EHR.
- Implemention of electronic prescribing of controlled substances (EPCS).
- Development of an access call line tracking system.

Other Areas for Improvement

- With last year's Recommendation #3 Not Met, the MHP IS organization continues to need a Help Desk system to log trouble calls and track resolution of those calls. This is a basic tool for IS supporting a complex and mission-critical system in a large organization.
- For September – December CY 2017, claims submission volume was less than ten percent of the MHP's usual claims volume. It is acknowledged that the MHP claims processing team had vacancies as high as 50 percent during this period, as well as a flood in October of that year that required moving claiming operations to another location temporarily. Contract providers report they sometimes experience long delays to get paid.
- The MHP does not currently use the ANSI X.12 270/271 eligibility electronic transaction pair with the State because of lack of resources to execute the project.
- High turnover among contract analysts means inexperienced staff and sometimes inconsistent information are provided to two programs within the same provider organization.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years)

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	Netsmart/Avatar	X			
Assessments	Netsmart/Avatar	X			
Care Coordination	Netsmart/Avatar	X			
Document Imaging/ Storage	Netsmart/Avatar	X			
Electronic Signature—MHP Beneficiary	Netsmart/Avatar	X			
Laboratory results (eLab)	Netsmart/Avatar	X			
Level of Care/Level of Service		X			
Outcomes	Netsmart/Avatar	X			
Prescriptions (eRx)	Netsmart/Avatar	X			
Progress Notes	Netsmart/Avatar	X			
Referral Management	Netsmart/Avatar	X			
Treatment Plans	Netsmart/Avatar	X			
Summary Totals for EHR Functionality:					
FY 2018-19 Summary Totals for EHR Functionality:		12			
FY 2017-18 Summary Totals for EHR Functionality*:		10		2	
FY 2016-17 Summary Totals for EHR Functionality:		9	1		

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

Progress and issues associated with implementing an EHR over the past year are summarized below:

- The MSO and Provider Connect modules have been installed and are, as of the EQRO Review, awaiting an update from the vendor in anticipation of production use beginning July 2019. With the implementation of Provider Connect, network providers will be the first group of contract providers who can eliminate paper claims submission.
- The development of a human resources (HR) system is a conversion of an existing ACCESS database to SQL Server with the user interface developed in Visual Studio.
- The EHR overhaul of medical team forms is sponsored by the Medical Director with the intent of improving workflow and documentation efficiency for clinical staff.
- Admission/discharge/transfer tracking functionality, which will track program assignment for beneficiaries, has been built into Avatar and is awaiting the availability of resources to complete the implementation and bring it into production use. The target date is July 2019.
- The MHP had established a secure electronic connection with the Fresno Community Hospital using the Avatar CareConnect inbox. The purpose was for the hospital to send the MHP notice of any MHP beneficiaries about to be discharged with a continuity of care document (CCD) that contains clinical information to assist in planning the beneficiary's treatment post-hospitalization. The hospital participated in the secure connection for a period of time and then stopped. This is a lost opportunity that warrants effort to reinstate the practice of electronic notification with the attached CCD.
- For the HR and the Help Desk systems, the MHP referred to an in-house solution approach. Although this strategy is contrary to what most IS organizations consider best practice, given that there are good solutions in both categories available on the market, the MHP asserts the need to capture client roster, leave of absence, on-the-job-injury precludes off-the-shelf solutions.

Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☐ Within the next year
☒ Within the next two years	☐ Longer than 2 years

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimensions

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims
Fresno MHP

Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
244,085	$52,258,848	**3,541**	$836,118	1.60%	$51,422,730	$1,249,669	$50,173,061

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent.**

During CY 2017 the MHP experienced claims submission delays which resulted in a significant number of claim transactions not being included in the below analysis for CY 2017 results.

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial
Fresno MHP

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Medicare or Other Health Coverage must be billed prior to submission of claim.	2,354	$456,519	55%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	605	$226,304	27%
Service not payable with other service(s) rendered on same day.	260	$61,304	7%
TOTAL	3,541	$836,118	NA

The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.

Denied claim transactions with reason “Medicare and Other Health Coverage must be billed prior to submission of claim” are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

The first focus group was requested to consist of 10 to 12 Hispanic/Latino adult beneficiaries, the majority of whom first initiated services within the prior 6 to 15 months. Five adult beneficiaries, two adults and three older adults, participated. The majority were Hispanic/Latino and the remainder were API and Native American (NA). All were fluent in English. This session was conducted at the Fresno County Behavioral Health offices located at 1925 East Dakota Avenue, Fresno, California.

Number of participants: Five

As only one person entered services within the past year, the summary of experiences is withheld to maintain anonymity.

Participants' general comments regarding service delivery included the following:

- The majority receive psychiatric services.
- Several receive group therapy.
- Others have experienced the use of arts and crafts as a therapeutic modality, resulting in relaxing and being able to share experiences with others.
- Telehealth is used by one individual. That modality was generally accepted. The biggest benefit is that sessions last longer than face-to-face psychiatric sessions.
- Most report the ability to request and receive services outside of regularly scheduled appointments. Response to phone calls and messages was reported.
- Several reported needing crisis urgent and crisis services.
- Most reported feeling like they have a voice in treatment.

- In the last year, arts and crafts were discontinued, which was reported as a loss.
- It is difficult to find a Spanish-speaking therapist.
- None reported any current transportation difficulties, but the participants suspect that there will be if the program moves from its current location.
- Information about changes to services comes to these individuals through television notifications or from clinic staff.
- These participants recall being asked for suggestions to improve services.

Participants' recommendations for improving care included the following:

- More case managers – there are not enough.
- Provide a dedicated bus for those who have transportation problems.
- Ask for suggestions more frequently and then act upon the feedback.

Interpreter used for focus group one: No

CFM Focus Group Two

The second focus group was requested to consist of culturally diverse group of 10 to 12 parents/caregivers of child/youth beneficiaries, the majority of whom first initiated services within the prior 6 to 15 months. Three caregivers participated, all female, with the majority Caucasian and one Hispanic/Latino. All were English speakers.

The caregiver session was conducted at the Youth and Family clinic, 3133 North Millbrook Avenue, Fresno.

Number of participants: Three

There were no participants who entered services within the past year.

Participants' general comments regarding service delivery included the following:

- Except for one, all reported fairly timely initial access to care. The one individual who struggled with initial access stated it took two years, and services were finally offered once CPS became involved.
- Therapy happened within two weeks for the majority, who also received wraparound services.
- One of the participants had a child who could not tolerate individual or family therapy. Psychiatry services are used by this family.
- Case management services were utilized by only one of the participants, but these are no longer being provided.

- Telehealth services are acceptable to both who receive psychiatry services, adding that it depended upon whether or not they liked the psychiatrist.
- Obtaining an appointment sooner than regularly scheduled can be challenging. One of the group members had to call daily before finally obtaining an off-schedule appointment.
- A unique challenge was posed for one member who receives a medication that requires a treatment authorization request (TAR). This person was unsure if the problem was with the pharmacy or the psychiatrist, but reported it was difficult to have all of the necessary administrative paperwork completed and filed timely.
- All participants reported feeling very involved in treatment planning.
- The participants all receive written information about prescribed medications.
- None were aware of any communication between the psychiatrist and the primary care providers.
- All were asked about their children's symptoms when seeing the psychiatrist.
- Uplift and Central Star, two contract providers, received high reviews by the participants.
- All the participants reported positive changes during the last year, including individual sessions, as well as additional supplemental services from Uplift and other wraparound programs.
- One family sought a change of therapist for the child. This resulted in a therapist who was a better fit, including the ability to take the child on outside activities. The child is responding better.
- Transportation is a challenge for only one of these participants. The therapist arranged for a ride with Lyft twice. At other times, bus passes were provided.
- These beneficiaries did not recall seeing information about services.
- None could recall ever being asked for feedback regarding how services could be improved.
- One individual attended a support group, and found it helpful to be with others going through a similar experience.

Participants' recommendations for improving care included the following:

- To be able to receive more intensive services before the situation becomes urgent and a crisis.
- Provide more information about services, including on the county website.

- Continue to target stigma reduction surrounding individuals accessing services.
- Provide education and awareness about mental health conditions.

Interpreter used for focus group two: No

CFM Focus Group Three

Focus group three was requested to consist of a culturally diverse group of 10 to 12 transitional age youth (TAY), the majority of whom initially accessed services within the prior 6 to 15 months.

Eight TAY beneficiaries participated, the majority were male and Hispanic/Latino, with a contingent of African-Americans and Hmong. All were English speakers, with one bilingual Hmong speaker.

The session was conducted at Fresno County Behavioral Health TAY services, at 3127 North Millbrook Avenue, Fresno, California.

Number of participants: Eight

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

- Initial access took approximately one week or less.
- The services these participants receive include individual and group therapy, case management, and home visits.
- The time to first psychotherapy session ranged from the next day to one month.

Participants' general comments regarding service delivery included the following:

- One participant was initially uncomfortable with therapy, but became accustomed to it within two weeks.
- For some participants, group and individual therapy occurs two days per week, and case management two days per week, with the occasional home visit.
- Participants experienced different services depending on which provider they were referred to, in some instances school books, clothing and food was part of the program services, and was experienced as helpful.
- Many participants cited differences in how participants were treated and the perceived attitudes of staff.
- Some mentioned feeling left to their own resources when served by the Stars program, which also is intended to develop independent living skills.

- All receive some type of therapist contact each week. The frequency was considered sufficient. The therapist also meets in whatever location is most convenient to the youth.
- A few participants attend focus groups at Blue Sky Wellness Center, and also feel that the confidentiality there is weak.
- Universally, all had negative experiences relating to acute hospitalization. Some of the complaints included being placed on too many medications, and being kept too long.
- Fresno County Behavioral Health Heritage Center Children's Services, a directly-operated program received positive feedback by some participants.
- All feel their input on their treatment is welcomed.
- The transition from STARS to Turning Point was identified as not going well, following a change of contract providers by the MHP. It took a year to obtain another therapist.

Participants' recommendations for improving care included the following:

- Increase the numbers of therapists.
- Provide help with school and hygiene supplies, snacks, and food.
- Hire committed professionals who are well trained.
- Hire people who care about the beneficiaries.

Interpreter used for focus group three: No

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 15: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	PM

The updated cultural competency plan, locally referred to as culturally responsive plan (CRP), was finalized in December 2018. Data are being collected regarding access, by language, and will be compared with prior year access.

The Avatar fields within the assessment form identify the language categories that meet the requirements of the Culturally Responsive Plan – preferred language, family's language, and beneficiary's primary language. However, data collection has thus far been limited to the beneficiary's language derived from the demographics section. This creates a barrier to the MHP's tracking of linguistic needs of its beneficiaries.

The MHP is working with HR to credential staff who speak threshold languages. The MHP is seeking to increase bilingual staffing positions by 74 in order to achieve a 22 percent bilingual capability.

The MHP is seeking approval from the board of supervisors (BOS) for a contract with JP Marketing to help develop a communication plan, support press coverage, and create a strategy for engaging the community. There are numerous identified areas that include reducing stigma of mental health treatment for the African-American (AA)

Table 15: Access to Care Components		
Component		**Quality Rating**
population, address the needs of the LGBTQ population, and improving services to the Southeast Asian and Pacific Islander (API). The MHP's top three priorities include language needs within the department and community-based organizations (CBOs), LGBTQ training, and development of peer support inclusion activities. The Latino/Hispanic average approved claims data produced by EQRO for CY 2017, reflects a significant decrease that the MHP needs to explore, reduction from $4,524 to $2,662 average cost per beneficiary. There was also a slight downward shift in penetration rates, but the approved claims decrease was particularly notable and unexplained.		
1B	Manages and adapts its capacity to meet beneficiary service needs	M
The MHP is producing reports that reflect useful operational information such as caseload, intakes, and discharges. Review participants were aware of the caseload system that describes higher level service individuals who receive significant amounts of clinical services, and individuals who are primarily medication services. Rural children's services are provided by contracts with local and regional providers. Full Service Partnership (FSP) services are provided by contracted CBOs. Mild to moderate are referred to BH managed care resources or managed care plan (MCP) if medical necessity criteria are not met. In the past year the MHP has experienced greater success in the recruitment and retention of psychiatrists. This service is now exclusively delivered by contract psychiatrists, including the medical director. Telehealth is also increasingly utilized. Data on access to psychiatry is tracked by routine and urgent criteria.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP's relationships with both governmental and CBOs is broad. As mentioned, extensive CBO contracts deliver services to rural areas, and to specialized populations. The MHP also has increased its work with local law enforcement (LE) agencies, including co-response to crisis events. The MHP and the LE agencies are pleased with the reduction in use of force that appears to be associated with this training and relationship with MHP staff.		

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	PM
The 'First Appointment Offered' field was not consistently filled in by MHP employees, resulting in under-reporting of these events. The Timeliness Self-Assessment was based on data from only 29 percent of the access requests that were completed due to under-reporting. The MHP has a 14-day calendar day initial access standard because the EHR system reportedly cannot calculate business days. The material produced for the onsite review did not include FC data. The MHP resubmitted the timeliness self-assessment with this element included. It would appear that FC tracking was not part of the previous efforts in tracking timeliness. The MHP's submitted data for first offered clinical appointment reflects a mean of 9.29 days for adults and 31.38 days for children and youth. Non-urgent FC reflected a 22 day mean. The quality improvement work plan (QIWP) identifies a 10 day standard currently for the first offered clinical appointment.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
The MHP reported a 30-day standard for this metric for the review period. The submitted data indicated a 39 day mean for adults and an 11-day mean for children and youth. FC data indicated a 29-day mean. The MHP states in the QIWP a current standard of 15 business days for FY 2018-19.		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
The MHP identified a two-day standard for urgent conditions. It tracks only those associated with admissions. The results indicate a 5.43-day mean for adults, 13.09 day mean for children and youth, and 13.5 days for FC. The MHP needs to develop a system for tracking urgent requests that occur outside of the intake period.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP utilizes a 7-day standard for post-hospital follow-up, and reported results of: 50.72 day mean for adults and 18.74 day mean for children and youth. No data were reported for FC youth. The MHP has a multi-year PIP intended to improve follow-up for youth, and a recently started PIP for adults. This area continues to need improvement, and it is clear that this is an area of focus for the MHP.		
2E	Tracks and trends data on rehospitalizations	M
The MHP's rehospitalization rates for adults is 23 percent and children/youth is 16 percent. No FC data were reported. Aftercare timeliness and process have been the focus of MHP PIPs over the past several years. From this current data, it appears continued efforts in this area are merited.		
2F	Tracks and trends no-shows	M
The MHP has a standard of 20 percent no-show for both psychiatry and other clinical staff. The psychiatry no-show rate for adults is 28 percent and children/youth 18 percent. No FC data were provided. Clinician no-shows average 13 percent for adults and 19 percent for children and youth. The adult psychiatry no-show rate merits further analysis and efforts to improve.		

Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including CFM 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 17: Quality of Care Components

Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
The MHP has a current QIWP, and has an extensive analysis of the prior work plan drafted. That evaluation should be completed within several months of the new fiscal year; that said, the MHP merits recognition for the detailed effort to address numerous quality issues in a detailed, quantifiable manner. The current QIWP reflects numerous timeliness measures that approximate the expectations of DHCS as manifest in information notices (INs). The MHP possesses a robust quality improvement team even while the search for a QI coordinator continues. The previous requirements limited candidates to those who possessed a certified professional in healthcare quality (CPHQ) credential. This stipulation is reportedly being removed from the next iteration of recruitment for this key position. The MHP's quality activities include PIPs that involve adult and children's systems of care, and currently also target the expansion of school-based services. In the prior year, the MHP's timeliness standards have been more generous than currently permitted by network adequacy, but for the current fiscal year changes have been made, updating to the new criteria. Regardless of adopted access standard, the MHP has recently struggled with data accuracy, discovering issues with accuracy and completeness of timeliness data. These issues compromise improvement efforts in that the data used to evaluate progress is partial and inaccurate.		
3B	Data used to inform management and guide decisions	PM

The MHP does engage in measuring and monitoring quality data, including that which relates to timeliness. Dashboards provide caseload information and also furnish supervisors with staff no-show rates. No-show analysis identified high rates for rural areas, resulting in increased efforts to provide services in schools. The timeliness findings also resulted in same-day triage at youth wellness centers, which provided families with a specific appointment.

As noted in other sections, the MHP is struggling with data fidelity, particularly in regards to timeliness. Ensuring that data are correctly entered is an ongoing challenge.

3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM

MHP leadership uses a number of strategies for internal communication, including emails and periodic all staff meetings. While providing choice regarding participation in these sessions, some stakeholder feedback indicated these meetings might be more successful if participation was expected, not optional. It would help ensure staff were informed and would also have the opportunity to obtain clarification on any issues.

External communication with contract providers occurs through a venue attached to the local contractors' association meetings. MHP management staff attend, and often the MHP director. Stakeholder feedback indicated that it would be helpful for the MHP to perform a survey of these providers, to determine if another approach would be more useful for keeping providers informed of potential and coming changes.

Some beneficiaries and family members mentioned experiencing a lack of continuous information from the MHP about services and changes once fully engaged in care and beyond the initial intake period. Information still comes to beneficiaries and family members by the treating clinicians. But they are not periodically reminded of the full scope of resources available to them.

The CalEQRO review team did hear of some beneficiaries and family members who were involved in MHP sessions designed to solicit community input, and felt included in the communication process.

3D	Evidence of a systematic clinical continuum of care	M

The MHP continues to build out its clinical continuum of care. At the higher level of service, a crisis residential treatment (CRT) program opened the week before this review. The facility is a striking presentation of modern design, with an open architecture that provides beneficiaries with a soothing environment.

The MHP's PIP that targets improving access through the school-based services is another strategy for increasing services to individuals more rural areas, where the school setting provides the best opportunity for children and youth to access care.

The MHP does utilize numerous instruments to track clinical progress of beneficiaries. The Recovery Needs Level instrument, for adults, is used to assist with determining level of care, and guides admission, placement, transition on an individual basis.

Outside of the adult system of care, providers use one of many instruments, with the CANS for all children and youth, the Difficulty in Emotional Regulation Scale (DERS) with dialectical behavior therapy (DBT), and others that are diagnostically related.

There is an awareness among MHP staff of the various service levels and programs is available, which span from clinical individual and group therapy, case management and psychiatry/medication management, and at the lower end primarily medication management services.

3E	Evidence of peer employment in key roles throughout the system	M

The MHP has positions designated for beneficiaries and family members, with two levels providing a limited career ladder. The positions include opportunities to function in a supervisory role. The MHP is making efforts to support these individuals and is looking for opportunities to broaden their roles. Peer employees confirmed the existence of a career ladder, and their awareness for how to pursue advancement.

3F	Peer-run and/or peer-driven programs exist to enhance wellness and recovery	M

The Blue Sky Wellness Center program, the Youth Empowerment Center and the Supported Employment Education Services (SEES) program are consumer-driven. All focus on wellness and recovery, with SEES focused upon employment and education.

Some participants identified the location of the TAY program as rather isolated and less than ideal in the public-facing aspect of the site.

3G	Measures clinical and/or functional outcomes of beneficiaries served	PM

The MHP uses the Reaching Recovery tools for adult beneficiaries, including the Recovery Needs Level for level of service. The CANS and other tools specific to diagnoses and EBPs are also in use. The results of data collection for a number of aspects of care are available on the web, and a user-interactive dashboard is in the process of development.

3H	Utilizes information from beneficiary satisfaction surveys	PM

The MHP provided a report of the May and November 2018 Consumer Perception Survey (CPS) in which it also compared these results to those from 2017. The MHP's analysis notes that wide variability exists in the scoring, and that some areas were potential targets for improvement. No specific areas or strategies were noted for improvement at this time.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Fresno County MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Recommendations:

- Apply an EBP, such as motivational interviewing, to provide more structure and support to the engagement process for the clinical PIP.
- For the non-clinical PIP, formally track the numbers of referrals by school employee type to assist the MHP in evaluating the effectiveness of this training and identify targets for re-training.

Access to Care

Changes within the Past Year:

- Overall penetration rates, Latino/Hispanic penetration rates and FC penetration rates have all declined between CY 2016 and CY 2017. Overall penetration rates and Latino/Hispanic penetration rates remain below other large counties and the State average.
- Between CY 2016 and CY2017, there was a very slight increase in the number of Medi-Cal enrollees in Fresno County and a 4.6 percent decline in beneficiaries served by the MHP. It is possible that the number served is underreported because of the significant decline in claims submitted for September -December 2017.
- The Sequential Intercept Mapping Team is an expansion of the Crisis Intervention Team that includes 14 staff serving the rural areas. They will be adding four more clinicians.
- A 15-bed CRT program opened the week prior to this review.
- The perception of telehealth at this MHP tends to be positive, particularly with the sessions having a longer duration than face-to-face psychiatry, and also impacted by the demeanor and approach of the psychiatrist.

Strengths:

- There is a Brief Treatment team for unlinked children who are discharged following a psychiatric hospitalization. The program provides up to four sessions for the children.
- The relationship between the MHP and law enforcement agencies has led to multiple programs aimed at reducing incarceration and hospitalization for MHP beneficiaries and others with mental health issues. These programs are particularly important in rural areas where other resources to address a mental health crisis are less available.
- The SEES Program, an MHP directly-operated program, is currently being put out for bid to gain additional flexibility in the employment options available to participants.

Opportunities for Improvement:

- Based on available data at the time of this review, CY 2017 average approved claims per Latino/Hispanic beneficiary is approximately 58 percent of the previous year, a dramatic decrease.
- Providers of field-based services to children and their families in rural areas would prefer to meet beneficiaries at a location other than the home when issues relating to privacy or clinical need arise.
- Documentation of an assessment can take up to twice the time of performing the clinical aspect of the assessment.
- There are currently not enough residential treatment options within Fresno County. The MHP is applying for Proposition 4 funds and they have submitted three No Place Like Home applications for approximately 60 apartments, which are mostly single occupancy. They are using some Mental Health Services Act (MHSA) funding for Shelter Plus Care and there is also a hotel/motel temporary housing program.
- Beneficiaries see value in offering higher level services when the beneficiary identifies the need, instead of waiting for a crisis event to occur.
- CBOs are receiving child/youth referrals for FSP or Assertive Community Treatment (ACT) post-hospitalization, but the programs have a two- to four-month waiting list. In the interim, these children may be taken into a lower level of care. There may be an opportunity to manage the flow in and out of those programs as well as the overall capacity to more timely serve this population.

Recommendations:

- Undertake an analysis of the significant decrease in average approved claims for Latino/Hispanic beneficiaries in order to develop strategies to address this concerning phenomenon.
- Review county facilities in rural areas, including Multi-Agency Access Program sites, for opportunities to use a private, confidential room to see MHP beneficiaries outside of their homes.
- Review the assessment documentation forms in Avatar to determine if there are opportunities to simplify them or improve the workflow.
- Continue to pursue all available options for residential treatment expansion.
- Develop a higher-level response system for adults and parent/caregivers of children and youth as soon as a potential need is identified, and before the onset of a crisis, particularly in children's services.
- Review the flow of children into and out of Children's Full Service Partnership and Assertive Community Treatment programs, as well as the overall program capacity, to reduce the long waitlist for children coming out of the hospital.

Timeliness of Services

Changes within the Past Year:

- The MHP has made efforts to improve access to care with both adults and children/youth, in some cases that involved increasing capacity such as adding psychiatry dedicated to youth post-hospital. In the same post-hospital youth area, a dedicated four-session, brief treatment resource was added.
- Adult post-hospital follow-up timeliness and effectiveness is also an improvement topic for this current year. The MHP is testing strategies for improving engagement and reducing the barrier presented by the outpatient assessment requirement through accomplishing this step while the beneficiary is hospitalized.

Strengths:

- Timeliness has improved as a result of increased staff hires and retention due to higher salaries. The MHP hired 23 new clinicians in December for positions reallocated to outpatient services. Of those, 11 went to Children's Services.
- The MHP has identified barriers to accurate timeliness data and is working to address these issues.

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Opportunities for Improvement:

- The 'First Appointment Offered' field was not consistently filled by MHP employees. The Timeliness Self-Assessment response for First Appointment Offered was based on data from only 29 percent of the access requests that were completed.
- Eighty-seven percent of requests for services in the Children's Division were excluded from the Timeliness Self-Report because they were incorrectly coded.
- The MHP does not have complete and accurate timeliness data for the services it delivers.
- The MHP implemented the Avatar scheduling module without linking appointments to documentation. There is reason to revisit this decision to determine if linking appointments to documentation could address some of the timeliness issues. It may also streamline the documentation process for clinicians.

Recommendations:

- Ensure that the 'First Appointment Offered' field is completed by MHP employees all of the time for those requesting access to MHP services. Consider making the field mandatory, and provide any necessary training and monitoring to assure that this is done.
- Provide training as necessary to assure that the MHP's timeliness monitoring and the next Timeliness Self-Assessment represents all services provided by the MHP and its contract providers, including children in foster care (FC). Where necessary to assure compliance, consider making some fields mandatory.
- Investigate the option of linking appointments in Avatar scheduling to clinical documentation in order to streamline the documentation process and improve timeliness data.

Quality of Care

Changes within the Past Year:

- Staff turnover, as high as 25 percent per year at some sites, for both the MHP and the CBOs was identified as an issue, particularly for children's services. Until new staff are fully trained, programs are not able to operate at their expected capacity.

Strengths:

- The MHP's QIWP incorporates numerous timeliness standards and other performance measures that reflect state mandated requirements.

- The MHP is a member of the Central Valley Health Information Exchange; however, they are not yet actively participating in electronic exchange of clinical information. Taking full advantage of this functionality/ability may require resources beyond what is currently available within the MHP.

- The MHP has hired a full-time clinical pharmacist who will be involved in medication monitoring, among other duties.

- The MHP has expressed an interest in establishing a Coordination of Care Unit, recognizing that this is their next big opportunity for service improvement.

Opportunities for Improvement:

- Based on available data, the overall ACB has declined since CY 2016 and in CY 2017 was only 59 percent of that for other large counties. For Latino/Hispanic beneficiaries and children in FC, the ACB is approximately half that of other large counties and well below the State average.

- Fresno MHP beneficiaries receive fewer services than the average beneficiary statewide. In the Fresno MHP, 42.62 percent of beneficiaries received four services or less compared to 29.04 percent statewide in CY 2017. Statewide, 39.77 percent of beneficiaries received more than 15 services; in the Fresno MHP, only 25.76 percent of beneficiaries received more than 15 services, an amount that is typically associated with managed care providers that serve a much healthier population. There is currently inadequate information to determine what this means for beneficiary outcomes.

- Both the 7-day and 30-day post-psychiatric inpatient follow-up rates for the MHP have declined between CY 2016 and CY 2017 and remain well below the state average.

- The MHP has electronic laboratory orders and results established with one vendor, Quest Diagnostics. The MHP has two other laboratory services vendors are not yet connected electronically to Avatar.

- The MHP's standard for entry of MHP services/progress notes is within five days is overly generous and creates vulnerability in information and coordination of care. The value of a real-time integrated health record system such as Avatar lies in clinicians having access to the latest clinical beneficiary information whenever and wherever they turn up in the system seeking services.

Recommendations:

- Considering the low approved claims and fewer encounters per beneficiary compared to other large MHPs and the statewide average, review the adequacy of services provided to the MHP's beneficiaries through careful review of levels of care needs and treatment outcomes.

- Reverse the decline in the 7-day and 30-day post-psychiatric inpatient follow-up rates for the MHP and bring them at least to the statewide average.
- Work with Fresno Community Medical Center to re-establish the practice of electronic notification of a pending discharge of an MHP beneficiary, including with it the Continuity of Care Document.
- Establish electronic laboratory orders and results with the two vendors (LabCorp and First Choice) not currently connected to Avatar.
- Review the current five-day standard for entering MHP service/progress notes and consider lowering it to reduce beneficiary vulnerability caused by the absence of current clinical information in Avatar.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP is implementing Reaching Recovery with the CBOs. This is already in use internally.

Strengths:

- Increased roles within treatment services for individuals with lived experience are part of current planning.

Opportunities for Improvement:

- Beneficiaries report inadequate numbers of case managers to assist them with their needs.
- Beneficiaries reported survey fatigue as related to the consumer perception survey process. The same questions are asked, the survey is too long, and they are never informed of the results.
- There are insufficient numbers of therapists to meet the treatment needs of beneficiaries, as validated by a DHCS Network Adequacy sanction letter (4/18/2019) that specifically focused upon Children's Services.
- The need for transportation assistance is reported by beneficiaries for those late notice circumstances which are not assisted by the managed care plans' transport role.
- The MHP's feedback process largely consists of the CPS information and community meetings such as the MHSA input sessions, and does not routinely capture clinic site feedback and analyze it in real time. Current mechanisms are slow to provide feedback to beneficiaries regarding issues identified and actions taken to correct issues.

Recommendations:

- Increase the number of clinical positions, specifically within Children's Services, and evaluate the capacity of Adult Services.
- Develop a mechanism for concurrent sharing of consumer perception results with the beneficiaries in a format that includes interpretation and action plan statements, so that they realize the benefit of participation.

Foster Care

Changes within the Past Year:

- Between December 2017 and November 2018, 661 FC subclass beneficiaries were identified. Of this total, 347 received Intensive Care Coordination (ICC) and 237 received Intensive Home-Based Services (IHBS).
- The MHP is currently developing a new process for tracking the identification of subclass members. The prior method of having analyst staff from the MHP and CWS data match caseloads is being replaced. The exact process has yet to be finalized.
- The majority of beneficiaries served by the Katie A vendors are FC youth who meet medical necessity criteria but are not subclass members. Subclass comprise about 7 percent of all FC served by mental health.

Strengths:

- All children and youth are screened and referred to a mental health provider upon entering FC. Each individual is screened for crisis needs, and then referred to one of three vendors for an assessment.
- Monthly timeliness tracking of the three CBOs began in January 2018. Starting in late spring 2018, psychiatry timeliness tracking was also initiated. Crisis referrals have a three-day standard and routine referrals have a ten-day standard.
- After releasing a request for proposal to 50 foster family agencies (FFAs), two agencies submitted proposals, and the selected agency now has six therapeutic foster care (TFC) homes established, with two currently able to take referrals. No placements have yet been made.
- The MHP, social services and public health are partnering to hire a public health nurse (PHN) who will monitor all JV220s. When hired, the PHN may also identify issues relating to SB1291 requirements.

Opportunities for Improvement:

- The Intensive Case Management (ICC) process is internally facilitated, creating challenges for who will track and ensure that the various tasks and plan of care items are accomplished. There is also a potential conflict for individuals who have a treatment responsibility to also have case management responsibilities.

- The MHP's timeliness self-reporting submitted did not initially contain the FC data elements. Subsequently, a submission update was provided with data for the review period. However, it seems that QI is not routinely tracking and evaluating FC timeliness data.
- The previous subclass identification tracking process has been eliminated, and a new process is yet to be finalized.
- The MHP's children and youth providers are not utilizing Avatar and the associated e-prescribing system, thus SB 1291 prescribing information is not easily available and currently is reliant upon sampling chart review.

Recommendations:

- Perform an evaluation of the benefits of contracting with an outside agency for Intensive Care Coordination facilitation and action plan tracking duties.
- Complete the development of an automated subclass identification system that bridges both the MHP and Child Welfare Services caseload systems.
- Ensure that FC timeliness tracking data is included in the quality improvement work plan and with regular timeliness data review throughout the year.
- Incorporate with the public health nurse process for JV220 review the monitoring of SB1291 requirements.

Information Systems

Changes within the Past Year:

- The NTST Avatar MSO/Provider Connect modules have been loaded and configured and are awaiting a software update prior to finalizing the implementation and putting the modules into production use in July 2019.
- The MHP developed a "bi-directional referral" form for beneficiaries transitioning between the MHP and a mild-to-moderate level of care with Beacon. One other county has adopted the form.
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- The MHP is expanding the use of Avatar by contract providers. For contract providers without an EHR, this is a clear benefit. For contract providers who have their own EHR, there is currently no plan to integrate with those systems.

Strengths:

- Within the Technology & Quality Management Division, there are three licensed mental health clinicians. These staff are valuable resources for ensuring that IT

initiatives are informed about the reality of delivering and documenting clinical services.

- The MHP has a useful dashboard called Employee Metrics that is available to managers and supervisors reflects caseload data and productivity, among many other metrics.

Opportunities for Improvement:

- The MHP IS group is a unit within the TQM Division. While there are likely advantages to having some of the higher utilizers of data (i.e., Quality Assurance) closely associated with IS, there is also the disadvantage of IS being viewed as a utility service rather than a strategic asset that drives change in the organization.

- The MHP does not currently use the ANSI X.12 270/271 eligibility electronic transaction pair with the State because of lack of resources to execute the project.

- Data analytic staffing of one FTE seems inadequate in a large MHP.

Recommendations:

- Review both the placement of IS resources in the MHP organization structure and the role of IS as a strategic resource and driver of change in the MHP.

- If licensing limitations with the MHP's dashboard software can be addressed, make the Employee Metrics dashboard available to line staff to see their own productivity metrics as well as summary level information, but with appropriate controls to prevent line employees from viewing the metrics of their colleagues.

- Consider engaging Netsmart Technologies (NTST) resources to facilitate the implementation of the American National Standards Institute (ANSI) X.12 270/271 eligibility electronic transaction pair with the State.

- Increase data analytic staffing and focus the additional resources on closely monitoring the accuracy and reliability of service access and timeliness data, including data from contract providers.

Structure and Operations

Changes within the Past Year:

- The MHP is reported to have adopted a practice of attaching the previous RFP response from the current vendor to new RFPs to rebid the service. This is an unusual practice that disadvantages the current vendor.

Strengths:

- The regulatory and content knowledge of upper and middle management personnel is strong and serves the MHP well.

Opportunities for Improvement:

- Contract providers did not feel they were getting timely or reliably accurate information from the MHP or that they had real opportunities to influence policy or procedures that affect them directly.
- The MHP rebids contracts with providers every three to five years. This has led to a lot of vendor transitions for children that are difficult, at best, and sometimes traumatic to children.
- The MHP has experienced a three-month lag in claims submissions related to the absence of personnel with this responsibility.

Recommendations:

- Ensure that CBOs are provided timely and accurate information, and that they have a voice in policy and procedure decisions that have a direct impact on their ability to serve MHP beneficiaries.
- Evaluate the potential of retaining longer-term relationships with children's' contract service providers to minimize the need for children to make transitions between programs and staff.
- Develop greater depth of key personnel who are involved in claims submission to ensure that this key function can occur continuously.

Summary of Recommendations

FY 2018-19 Recommendations:

- Apply an evidence-based practice, such as motivational interviewing, to provide more structure and support to the engagement process for the clinical PIP.
- For the non-clinical PIP, formally track the numbers of referrals by school employee type to assist the MHP in evaluating the effectiveness of this training and identify targets for re-training.
- Undertake an analysis of the significant decrease in average approved claims for Latino/Hispanic beneficiaries in order to develop strategies to address this concerning phenomenon.
- Review county facilities in rural areas, including Multi-Agency Access Program sites, for opportunities to use a private, confidential room to see MHP beneficiaries outside of their homes.
- Review the assessment documentation forms in Avatar to determine if there are opportunities to simplify them or improve the workflow.
- Continue to pursue all available options for residential treatment expansion.
- Develop a higher-level response system for adults and parent/caregivers of children and youth as soon as a potential need is identified, but before the onset of a crisis, particularly in children's services.
- Review the flow of children into and out of Children's Full Service Partnership and Assertive Community Treatment programs, as well as the overall program capacity, to reduce the long waitlist for children coming out of the hospital.
- Ensure that the 'First Appointment Offered' field is completed by MHP employees all of the time for those requesting access to MHP services. Consider making the field mandatory, and provide any necessary training and monitoring to assure that this is done.
- Provide training as necessary to assure that the MHP's timeliness monitoring and the next Timeliness Self-Assessment represents all services provided by the MHP and its contract providers, including children in foster care (FC). Where necessary to assure compliance, consider making some fields mandatory.
- Investigate the option of linking appointments in Avatar scheduling to clinical documentation in order to streamline the documentation process and improve timeliness data.
- Considering the low approved claims and fewer encounters per beneficiary compared to other large MHPs and the statewide average, review the adequacy

of services provided to the MHP's beneficiaries through careful review of levels of care needs and treatment outcomes.

- Reverse the decline in the 7-day and 30-day post-psychiatric inpatient follow-up rates for the MHP and bring them at least to the statewide average.
- Work with Fresno Community Medical Center to re-establish the practice of electronic notification of a pending discharge of an MHP beneficiary that included the Continuity of Care Document.
- Establish electronic laboratory orders and results with the two vendors (LabCorp and First Choice) not currently connected to Avatar.
- Review the current five-day standard for entering MHP service/progress notes and consider lowering it to reduce beneficiary vulnerability caused by the absence of current clinical information in Avatar.
- Increase the number of clinical positions, specifically within Children's Services, and evaluate the capacity of Adult Services.
- Develop a mechanism for concurrent sharing of consumer perception results with the beneficiaries in a format that includes interpretation and action plan statements, so that they realize the benefit of participation.
- Review both the placement of IS resources in the MHP organization structure and the role of IS as a strategic resource and driver of change in the MHP.
- If licensing limitations with the MHP's dashboard software can be addressed, make the Employee Metrics dashboard available to line staff to see their own productivity metrics as well as summary level information, but with appropriate controls to prevent line employees from viewing the metrics of their colleagues.
- Consider engaging Netsmart Technologies (NTST) resources to facilitate the implementation of the American National Standards Institute (ANSI) X.12 270/271 eligibility electronic transaction pair with the State.
- Increase data analytic staffing and focus the additional resources on closely monitoring the accuracy and reliability of service access and timeliness data, including data from contract providers.
- Ensure that CBOs are provided timely and accurate information, and that they have a voice in policy and procedure decisions that have a direct impact on their ability to serve MHP beneficiaries.
- Evaluate the potential of retaining longer-term relationships with children's contract service providers to minimize the need for children to make transitions between programs and staff.

- Develop greater depth of key personnel who are involved in claims submission to ensure that this key function can occur continuously.

FY 2018-19 Foster Care Recommendations:

- Perform an evaluation of the benefits of contracting with an outside agency for Intensive Care Coordination facilitation and action plan tracking duties.
- Complete the development of an automated subclass identification system that bridges both the MHP and Child Welfare Services caseload systems.
- Ensure that FC timeliness tracking data is included in the quality improvement work plan and with regular timeliness data review throughout the year.
- Incorporate with the public health nurse process for JV220 review the monitoring of SB1291 requirements.

Carry-over and Follow-up Recommendations from FY 2017-18:

- Initiate a log (Help Desk system) that records both trouble/problem calls with the Avatar system and the resolution to the call, and monitor the log monthly to identify trends and potential threats to system.
- Hire an individual with the skills necessary to manage a quality improvement program and, if the Certified Professional in Healthcare Quality (CPHQ) certification is still deemed necessary, make it a condition of employment within a fixed period.
- Show regular, either monthly or quarterly, monitoring and evaluation of timeliness in the Access or Outcomes Committees and be able to identify/distinguish outliers from the average time to services. As necessary, review cases open for longer than 90 days (or some other fixed timeframe) with no activity to determine if the cases should be closed. Ensure that all relevant data are entered appropriately into the system and that the data integrity problems identified in the FY 2018-19 review are resolved.
- Monitor timeliness of service delivery in the rural areas, relative to the efforts (e.g., Multi-Agency Access Program) to increase access. (This recommendation is a partial carry over from FY 2016-17).
- Survey the parent/caregivers that utilize children’s clinics and pilot an after-hours regular schedule that conforms to the identified needs by site.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Final Rule Session
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Children's Clinical Line Staff Group Interview
Adult Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Parent/Caregiver Focus Group
Adult Consumer Focus Group
TAY Consumer Focus Group
Peer Employees Group Interview
Contract Provider Group Interview
Medical Prescribers Group Interview
Forensics and Law Enforcement Group Interview
Supported Employment Site Visit and Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Access and Timeliness
Blue Skies Wellness Center Site Visit
Crisis Residential Facility Site Visit
Final Rule Session
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Quality Reviewer
Karen Baylor, 2nd Reviewer, Chief Operating Officer
Bob Greenless, Information Systems Reviewer
Walter Shwe, Consumer-Family Member

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

Sites of MHP Review

MHP Sites

Fresno County Behavioral Health
1925 East Dakota Avenue
Fresno, CA 93726

Heritage Children's Mental Health Outpatient
3133 North Millbrook Avenue
Fresno, CA 93703

Fresno County Behavioral Health TAY Program
3127 North Millbrook Avenue
Fresno, CA 93703

Fresno County Behavioral Health – Millbrook Training Room
3127 North Millbrook Avenue
Fresno, CA 93703

Contract Provider Sites

Central Star Crisis Residential Treatment Program
496 South Barton Avenue
Fresno, CA 93701

Telecare Blue Sky Youth Empowerment/TAY Warehouse
4910 East Ashlan Avenue, Suite 118
Fresno, CA 93726

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Adams	Darrel	Peer Support	Turning Point of Central California (TPOCC): VISTA
Allen	Anna	Peer Support Specialist	Mental Health Systems (MHS)
Alonzo	Ron	QI Supervisor	Clinica Sierra Vista
Alvarado	Julieann	Unlicensed Mental Health Clinician	Fresno County Department of Behavioral Health (DBH): Children's Outpatient
Amezola	Maria	Licensed Mental Health Clinician	DBH: Children's Mental Health Outpatient Program
Anderson	Carrie	Social Service Coordinator	Exodus Recovery Inc.
Arkelian	Brian	Clinical Supervisor	DBH: Clinical Team
Armistead	Natalie	Clinical Supervisor	DBH: Intensive Outpatient
Arevalo	Milagro	Senior Licensed Mental Health Clinician	DBH: Quality Improvement (QI)
Avery	Jeffery	Clinical Supervisor	DBH: First On-Set
Azua-Valdez	Rosio	Unlicensed Mental Health Clinician	TPOCC: Rural Mental Health (RMH)
Bahrami	Admadreza	Division Manager	DBH: Public Behavioral Health (PBH)
Baldwin	Tabitha	Clinical Director	Fresno County Superintendent of

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Schools (FCSS): All 4 Youth
Bamford	Marilyn	Executive Director	Uplift Family Services
Baxter	April	Office Assistant	DBH: Children's Mental Health
Banks	Ryan	Deputy Regional Director	TPOCC
Bhagat	Tapasya	Therapist	Comprehensive Youth Services (CYS)
Birkholz	Trevor	Clinical Supervisor	DBH: Older Adult Mental Health
Boyd	Karla	Clinical Supervisor	DBH: School Based Team (SBT)-Central
Brown	Betty	Division Manager	DBH: Managed Care
Caldwell	Melissa	Community Mental Health Specialist	DBH: Adult Behavioral Health Court (BHC), Family Behavioral Health Court (FBHC), and Friday Court (FC)
Cancio	Rodney	Sergeant	Fresno Police Department
Carrillo	Jessica	Program Manager	Fresno County Department of Social Services (DSS): Staff Development/Core Practice Model
Hunter	Kristin	Admitting Interviewer	
James	Lori	Clinical Supervisor	DBH: Perinatal

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
James	Noelle	Clinical Director	Uplift Family Services
Jimenez	Dalila	Licensed Mental Health Clinician	DBH: QI
Johnson	Jacqueline	Unlicensed Mental Health Clinician	DBH: Children's Outpatient
Kramer	Becky	Executive Director	CYS
Lambert	Megan	Social Worker Supervisor	DSS: Wellness Recovery Action Plan (WRAP)/ Intensive Services Foster Youth (ISFC)/ Transitional Foster Care (TFC)/ Short Term Residential Therapeutic Program (STRTP)
Lambright	Laura	Peer Support Specialist	DBH: Conservator Team
Lawrence	Denise	Medical Record Coordinator	DBH: Medical Records
Le	Maryann	Deputy Director, Business Operations	DBH: Administration
Lopez	David	Central Valley Suicide Prevention Hotline (CVSPH) Program Manager	Kings View
Lopez	Rosa	Program Technician	DBH: CWMH
Lopez	Sarah	Family Partner	Uplift Family Services
Luna	Laura	Program Manager	DBH: Staff Development
Lynch	Kristin	Senior Staff Analyst	DBH: Contract – Mental Health (MH)

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Marquez	Adrian	Program Director	Central Stars: Child Welfare Mental Health
McDaniel	Sharessa	Business Systems Analyst	Fresno County Internal Services Department
Medina	Sandra	Clinical Supervisor	DBH: Psychiatric Clinic
Mehia	Rita	Clinical Supervisor	DBH: Recovery with Inspiration, Support & Empowerment (RISE)
Mejia	Emma	Staff Analyst	DBH: Contract - MH
Miller	Michael	Senior Business System Analyst	DBH: IT
Monreal	Ana	Program Director	Exodus Recovery Inc., Crisis Stabilization Unit and Access
Moreno	Karla	Peer Support Specialist	DBH: Perinatal
Muro	Michael	Senior Staff Analyst	DBH: Contract - MH
Negrete	Rosa	Peer Support Specialist	DBH: Latino Team
Nelson	Sandra	Utilization Review Specialist	DBH: Compliance
Newsome	Michele	Licensed Mental Health Clinician	DBH: CIT
Nguyen	Sue Ann	Program Technician	DBH: QI
Noland	Russell	Staff Analyst	DBH: Contract - MH
Nunn	Derek	Program Supervisor	MHS
Ochoa	Erika	Unlicensed Mental Health Clinician	DBH: SBT

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Ochoa	Ricardo	Supervising Account Clerk	DBH: Business Office
Ornelas	April	Community Mental Health Specialist	DBH: YWC
Parra-Sanchez	Luisa	Clinical Supervisor	DBH: SBT – West
Patterson	Sean	Business Manager	DBH: Business Office
Pentell	Michelle	Behavioral Therapist	Golden State Family Services (GSFS)
Puente	Tanimara	Senior Staff Analyst	DBH: Business Office
Rangel	Joseph	Division Manager	DBH: Contracts Services
Rexroat	Kathy	Clinical Supervisor	DBH: Managed Care
Reyes	Analinda	Office Assistant	DBH: QI
Reece	Melissa	Senior Admitting Interviewer	DBH: Children's Outpatient
Ritchie	James	Workforce, Education, & Training (WET) Coordinator	DBH: Staff Development
Rivas	Gilberto	Rural Triage Program Manager	Kings View
Robinson	Jeffery	Clinical Supervisor	DBH: Urgent Care Wellness Center (UCWC)
Rodriguez	Alvina	Licensed Mental Health Clinician	DBH: YWC
Rodriguez	Whitney	Unlicensed Mental Health Clinician	DBH: Transition Aged Youth (TAY)
Rogers	Jon	Senior Staff Analyst	DBH: Managed Care
Rojas	Aimie	Clinical Supervisor	DBH: YWC
Rooks	Holly	Clinical Supervisor	FCSS: All 4 Youth

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Rosen	Eric	Licensed Mental Health Clinician	DBH: Children's Outpatient
Ross	Sharon	Regional Director	TPOCC
Sahai-Bains	Sonia	Clinical Supervisor	DBH: UCWC Mobile Access, CIT, Multi-Agency Access Point (MAP): Poverello House, and Housing
Sanghera	Preetinder	Principle Analyst	DBH: Contract - MH
Santoyo	Jessica	Social Worker Practitioner	DSS: WRAP/STRTP
Schmidt	Debbie	Licensed Mental Health Clinician	DBH: SBT - Central
Seidel	Jennifer	Administrator	Central Star: Community Service, Teammates Wraparound, TAY-Full Service Partnership (FSP)
Sheperd	Jill	Peer Support Specialist	DBH: Clinical Team
Small	Trish	Pupil Personnel Director	FCSS: All 4 Youth
Sorondo	Lindsey	Staff Analyst	DBH: Contract - MH
Stoick	Joshua	Quality Support Supervisor	FCSS: All 4 Youth
Stone	Alyssa	Unlicensed Mental Health Clinician	DBH: Adult Mental Health Outpatient
Thao	Xee	Program Director	Central Stars: WRAP
Thomas	Jeffery	Licensed Mental Health Clinician	DBH: UCWC
Tobias-Gatewood	Deborah	Regional Director	Central Star

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Toonnachat	Kannika	Division Manager	DBH: Technology & Quality Management Division
Torok-Mangasarian	Julie	Clinical Director	California Psychological Institute (CPI)
Toscano	Marco	Senior Admitting Interviewer	DBH: Business Office
Tran	John	Medical Director	DBH: Medical
Tristan	Bianca	Office Assistant	DBH: CWMH
Turnmire	Donald	Clinician	Uplift Family Services
Utecht	Dawan	Director	DBH
Vanbruggen	Stacy	Division Manager	DBH: Adult Services
Vang	Sue	Staff Analyst	DBH: Contract - MH
Vang	Chen	Registered Psychologist	The Fresno Center – Living Well Center
Vasquez	Elizabeth	Compliance Officer	DBH: Compliance
Vasquez	Fatima	Clinician	Central Star
Vasquez	Joyce	Clinical Supervisor	DBH: SBT - East
Vaughan	Michelle	Licensed Mental Health Clinician	DBH: CWMH
Wang	Yuchen	Clinical Pharmacist	DBH: Children's Mental Health and Adult Services
Williams	Cary	Clinical Supervisor	DBH: Self-Healing and Improvement thru Nurturing and Engagement (SHINE)/ Supported Employment and

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Education Services (SEES)
Xiong	Pa Ge	Staff Analyst	DBH: QI
Xiong	Zia	Clinical Director	Exodus Recovery Inc.: Psychiatric Health Facility (PHF)
Yee	Diana	Managed Care Coordinator	DBH: Managed Care
Zavala	Michelle	Administrative Director	CPI
Flores	Yolanda	Quality Assurance Coordinator	Central Star
Tequillas	Yasmin	Staff Analyst	DBH Business Office

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Fresno MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	$703,932,487	$4,782
Large	1,848,772	68,086	3.68%	$362,898,987	$5,330
MHP	120,412	4,477	3.72%	$19,271,681	$4,305

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band
Fresno MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	17,533	96.48%	93.38%	$47,531,672	$2,711	$3,746	66.29%	56.69%
>$20K - $30K	318	1.75%	3.10%	$7,723,703	$24,288	$24,287	10.77%	12.19%
>$30K	321	1.77%	3.52%	$16,443,768	$51,227	$54,563	22.93%	31.11%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Fresno	
PIP Title: Hospital Engagement (Adults)	
Start Date: 6/2018 **Completion Date**: 6/2019 **Projected Study Period**: 12 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 3/18-21/19 **Name of Reviewer**:	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP targets reduction of readmissions of adults to acute inpatient of those not open to outpatient services at the point of admission, after discovering that these individuals are the most vulnerable to repeat admissions.	
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY	

STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A peer representative will be appointed to the team, but was not present or involved in the PIP origination process.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has tracked readmission rates and timely follow-up for many years For this PIP, the data go back to 2014. The MHP identified that individuals admitted to inpatient services who were not open to outpatient at the time experienced higher 30-day readmission rates.

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

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP focused on timely post-hospital follow-up, reductions in readmission rates, and improvements to engagement rates. The interventional aspects of this PIP included improving engagement and also in accomplishing the outpatient initial assessment before the beneficiary was discharged to outpatient care – eliminating a barrier to treatment, which the assessment process can pose.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All unlinked adults were included in this PIP.
	Totals	**2** Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will directly engaging with and assessing individuals ages 18 and older who are unlinked to outpatient FDBH services *during hospitalization* and then supporting their access to follow-up care improve: 1) their average time to follow-up services; 2) the percentage of initial follow-up outpatient service within 3 days; and, 3) decrease their likelihood of re-hospitalizations within 30 days?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

	Totals	**1** Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other All beneficiaries 18 and older who were not open to outpatient services at the time of inpatient admission.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Inpatient admissions	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Readmission Rate - Behavioral Health System all-cause 30-day readmission rate • Timely Access - Percentage of individuals who discharge from acute care services and who initiate follow-up within 7 days following discharge • Timely Access – Average days to first visit for clients discharged from acute care services • Engagement: Percentage of unlinked individuals who engage in services following discharge from Community Behavioral Health Center (CBHC) • Engagement: No show rate for scheduled initial outpatient visits of unlinked clients following discharge from CBHC	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused. ☒ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling is used, but the initial application is to a limited scope of inpatient care units.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **3** NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data collected include the number of individuals that have had engagement from FDBH clinical staff while admitted to the hospital. Using specific codes in the EHR, the individual who has had engagement interventions applied are identified as the study population. By tracking the study population in regard to timeliness to follow-up for outpatient services, 30-day hospital re-admissions, and no-shows, the PIP team will be able to compare the effect of the intervention applied to the study population to clients hospitalized within CBHC as well as overall hospitalizations. This comparison will include hospitalized individuals that are both linked and unlinked to outpatient services upon admission to a hospital or psychiatric health facility. If significant and sustainable progress is validated within the study population as a result of the PIP study, then the intervention will be evaluated to be applied on a larger scale for individuals who are determined to be unlinked.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data is collected from the EHR. The data collected include the date of admission and discharge from CBHC, as well as other hospitals/PHFs, as determined by the billing information entered into the EHR. The timeliness to initial and subsequent services is also compared using the billing data from the EHR. Billing data are submitted timely after services are provided and allow for reliable information regarding billing information. From the information gathered from the EHR, various dashboards have been created in order to provide ongoing results for comparison. The dashboard can be updated as often as needed or to pull in updated information from the EHR. The dashboard can be manipulated in order to look at specific data (i.e., programs, date range)
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Jolie Gordon-Browar Adult MH Outpatient Sonia Sahai-Baines Hospital D/C Unit Kathy McGuire Adult MH Outpatient Alyssa Stone Adult MH Outpatient John Enos Adult MH Outpatient May Yang Adult MH Outpatient Peggy Ellisalde Adult MH Outpatient Francisco Escobedo QIT Dalila Jimenez QI Licensed Mental Health Clinician Pa Ge Xiong QIT Mila Arevalo QIT Gabe Gomez QIT Mike Miller QIT Jeff Elliott QIT Peer Representative Peer Support Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**4** Met Partially Met Not Met UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Engagement activities, including:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Engagement served as the clinical aspect of the submitted interventions. Following the review, suggestions were made to the MHP that the engagement component incorporate an evidence-based or promising practice such as motivational interviewing to provide a stronger support to the clinical aspect.

• build rapport • introduce and explain services DBH has to offer • explore with client what they understand as symptoms of mental health they would desire help with • provide crisis emotional support • offer coping mechanisms Assessment and Supports: start outpatient intake assessments on- site and complete while an inpatient or right after discharge o Care Coordination, including activities like: • arranging for clients' transportation to follow-up care • providing clients with a tour of facility, wellness group and introduce to care providers • linking clients to services in the community • safety planning Referral: create a formal referral system to allow hospital staff to request FDBH staff to initiate engagement, assessment and care coordination activities. Tracking: • track clients admitted through their discharge and handoff to clinics • team up with hospital staff to plan clients' discharge		
	Totals	**1** Met Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	If the PIP proceeds as planned, it is about halfway through the process. Data for timely follow-up is presented for June through December 2018. Also included are average days for unlinked persons/individuals to receive first follow-up contact, and percent of unlinked with any follow-up contact post-discharge from a hospital event. The MHP is still making adjustments to the process, and does not have full analysis complete at this time. Thus a full rating on this element is not appropriate yet.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **4** NA UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **5** NA UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	Not applicable at this time.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: PIP remains in mid-process.
Recommendations: Continue with the process.
Check one: N/A ☐ 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 FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Fresno

PIP Title: Improving Access Through School Based Services

Start Date: 1/1/2019

Completion Date: 12/31/2019

Projected Study Period: 12 Months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review: 3/18-21/19

Name of Reviewer: Rob Walton

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

Rated

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

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

☐ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP reviewed literature regarding mental health services to school-aged children and youth and also looked at local school district comparative penetration rates for this population. Compared to the central Metro area, which has a penetration rate in the four percent range, the more distant, often rural districts have much lower penetration rates. Considering that the school environment is a setting that can support mental health service delivery without creating a burden on parents or caregivers (e.g., to transport children to clinic settings), this locale seemed to the MHP to be the most appropriate and likely place to yield significant gains.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP used information from a number of sources. Regional focus groups that were conducted in the west and eastern, mostly rural, sections of the county produced feedback from families about the barriers in accessing care that covered numerous reasons.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A literature review produced information supporting provision of services within the school environment. The baseline of each school district's mental health penetration rate was considered, and a goal of increasing this by 1.5 percent was established. There is no data cited that would suggest that specific improvement level, but this was the MHP's effort to create a goal to increase the rate. The MHP also cites the use of prevention and early intervention (PEI) funds to augment some school service capacity and to combat stigma.

Select the category for each PIP:

Non-clinical:

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☒ Process of accessing or delivering care
☐ High volume services
☐ High risk conditions

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Generally, the importance of the school experience for children and youth was identified as a supporting reason for seeking to increase services in that environment. A number of approaches was considered to improving school mental health service penetration rates, and one of these was a no-wrong-door referral process, encouraging all school staff to make referrals for care. This included school nurses, custodians, and bus drivers,
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	4 Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will increased capacity provided through school-based programs and a 'no wrong door' approach overcome service access barriers for unserved and underserved youth and families in need of specialty mental health services and increase the county's penetration rate in targeted school districts by 1.5 percentage points by January 1, 2020?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other – School involved children and youth	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Beneficiaries attending school	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Penetration Rate – Percentage of Medi-Cal eligible individuals served • Average Days from Initial Request to 1st Service • Percent of clients who received initial service within 14 days from initial request who are seen within target days • 1st Visit No-Shows and Cancellations Rate • Percent of clients who receive 3 or more visits in the first month of services • (EQRO Team suggested during the onsite review on 3/19/2019 to include the show rate to measure engagement)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The formal indicators listed a focus on penetration rate of Medi-Cal eligibles, not all school-aged children and youth. This is greater precision than initially stated in the PIP.
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 beneficiary-focused. ☒ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP is focused on improving access to care, which has implications for long-term outcomes.

	Totals	2 Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **3** NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	➢ Client demographics (age, gender, ethnicity, language, etc.) ➢ Referral activity (date received, disposition, etc.) ➢ Scheduled date of initial outpatient visit ➢ Actual date of initial outpatient visit ➢ Visit/activity in the first month of services
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: EHR and Medi-Cal Eligibility	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Penetration rate: There are two data components for the penetration rate calculation. The medical eligibility data come from the Medi-Cal Eligibility Data System Monthly Extract file (MMEF) provided to the County at the ITWS site/portal. This file is uploaded/appended in Avatar EHR on a monthly basis. The service data is from Avatar EHR previously entered from the clinical notes, direct service entry, or batch service upload that had been assigned with medical payor/guarantor. The two data components are used for the penetration rate. The criteria of medical eligibility from the MMEF is similar to the criteria used in EQRO claim data file. Timeliness of the first service: There are two data components for the first service calculation. The initial service request (urgent or not-urgent) data is collected in Avatar EHR through an EHR form, Access Form. The service data is also from Avatar EHR previously entered from the clinical notes. The

		first kept service is paired up with the initial service request to calculate the day different or timeliness of the first service. No-show/cancellation service: There is one data component for the no-show/cancellation service. Avatar EHR is set up with the no-show/cancellation service codes, for example, the mental health assessment service code is code 103, and the corresponding no-show code for the mental health assessment is 103N and cancelation code is 103C. The service codes with N and C are used as a criterion to pull the no-show/cancellation service data. Service intensity: The service data is from Avatar EHR previously entered from the clinical notes that had been assigned with Medi-Cal payor/guarantor. No-show/cancellation service codes are excluded for this criteria.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Avatar EHR	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	It was suggested that since the no wrong-door approach is being utilized, encouraging referrals to be made to mental health services by all school employees, that the MHP should consider tracking and quantifying the sources of referrals. This will help it identify successful sources for referral of children into treatment, and help to understand the referral trends.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Preetinder Sanghera Contracts Division Francisco Escobedo QIT Dalila Jimenez QI Licensed Mental Health Clinician Pa Ge Xiong QIT Sarah Leon QIT Mila Arevalo QIT Gabe Gomez QIT Mike Miller QIT Jeff Elliott QIT Analinda Reyes QIT Sue Vang Contracts Division Trina Frazier FCSS Tabitha Baldwin FCSS Peer Representative Peer Support Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	➢ Data in the FBHS EHR is entered by clinical staff; quality improvement team staff prepare the quarterly dashboards. See descriptions above for each indicator, their intended use and how data will be collected.
	Totals	5 Met Partially Met Not Met 1 UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* • School and Staff Engagement (see description above) • "No Wrong Door" Referral Mechanisms (see description above) • Outreach Readiness (see description above) • Outreach & Intake (see description above)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	1 Met Partially Met Not Met UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	At the time of the review, it was too early to identify possible impacts of the PIP.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **4** NA UTD	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **5** NA UTD	

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

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

Conclusions:

It is too early in the PIP to ascertain if there are improvements that are resulting from the activities.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Recommendations: The MHP should consider tracking the frequency of referrals from the various school employee sectors – bus drivers, school nurses, teachers, etc.
Check one: N/A ☐ 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