

FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Mendocino

*Conducted on
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BHC[®]

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MENDOCINO MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—1,622
- MHP Threshold Language(s)—Spanish
- MHP Size—Small
- MHP Region—Superior
- MHP Location—Ukiah
- MHP County Seat—Ukiah

Introduction

The Mendocino County MHP, Mendocino County Behavioral Health and Recovery Services, is categorized as a Small, Superior region MHP. The MHP has two locations, one in Ukiah, the primary administrative office, and the other in Fort Bragg. The MHP utilizes an administrative service organization (ASO) model, wherein the majority of their mental health services are outsourced and delivered through other entities. For all of FY15-16, the MHP had two ASOs, Redwood Quality Management Company and Ortnier Management Group. At the time of this review, the MHP was only contracted with Redwood Quality Management Company (RQMC), after having ended their contract with Ortnier Management Group who provided much of the adult specialty mental health services. Although the transition to RQMC and resumption of some services by the MHP only occurred recently (i.e., within three months of the EQRO visit), the transition influenced much of the review of the previous year’s services.

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

Access

The MHP's access for children's services appears stable, owing to RQMC's service model that gives autonomy to contract providers to meet the varied needs of consumers. The feedback from multiple stakeholders was that access for adult consumers was protracted and challenging, which differs from the MHP's self-assessment that suggests stable access to psychiatry and initial appointments. Once transition of adult services to RQMC is completed, the MHP will be better positioned to facilitate stable access for adult and youth consumers, alike. The MHP utilizes tele-psychiatry, but it remains to be seen the impact of increased tele-psychiatry hours on access. Difficulty in access and uncertainty with other contract provider's referral processes were recounted by consumers and staff, respectively. Given multiple contract providers in the ASO (each with their own processes for initiating services, eligibility requirements, and mechanisms) there is a risk of consumers caught between providers and not actually accessing care.

Timeliness

Over the past year, the MHP met and sometimes exceeded their timeliness standards. However, there is room for improvement in initial access to services and No Shows. Initial access to services overall met the MHP's standard less than 85% of the time. No Shows were not tracked similarly and consistently by contract providers. In contrast to the findings on the self-assessment of timely access, the pervasive feedback from multiple stakeholders was that currently, the MHP is challenged with providing timely access to psychiatry.

Quality

Quality of services appears to occur on two levels within Mendocino County Behavioral Health and Recovery Services. There is formal quality improvement that is headed by the MHP itself and has multiple branches (e.g., the Quality Improvement Committee, the Quality Improvement/Quality Management Committee, and others). There is functional quality improvement that involves RQMC and is reflected in their communication with staff and transparency and targeted services. Those who are involved with the formal quality improvement appear to be removed from those who actually do the work. One aspect of quality that the MHP does well in is engaging consumers as stakeholders.

Outcomes

The MHP made a number of changes that enable reliable and continual assessment of consumer progress, outcomes, and recovery, chiefly, the incorporation of CANS and ANSA into the EHR and .xml transfer that facilitate automation and data exchange between the MHP and ASO's electronic systems

INTRODUCTION

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

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

This report presents the fiscal year 2016-2017 (FY 16-17) findings of an external quality review of the Mendocino MHP by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES¹

This report contains the results of the EQRO's validation of **eight (8) Mandatory Performance Measures** (PM) as defined by DHCS. The eight performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Re-hospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

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.

- High Cost Beneficiaries (\$30,000 or higher)

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS²

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES³

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

- Fully addressed—
 - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
 - made clear plans and is in the early stages of initiating activities to address the recommendation
 - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Initiate a committee and create a written Information Systems (IS) strategic plan with organizational provider involvement adhering to dedicated implementation timelines for immediate action.
 - Fully addressed
 - Partially addressed
 - Not addressed
- The MHP did not provide a written strategic plan; however, the MHP has an operational sense of the steps needed to make its information systems functional. The MHP has engaged with a variety of consultants and vendors and made some changes to meet its needs systems integration.
- Much of this effort was then rendered moot by the change to the one ASO.
- A written strategic plan is still needed; the lack of which calls into question whether the executive team is getting enough information on the fundamental requirements and systemic challenges that the MHP will face over the next few years, so that they could plan adequately.

- Recommendation #2: Prioritize resolution of inoperability issues in implementing the Practice Management /Electronic Health Record (EHR) system within OMG adult ASO to enhance functionality of the IS system and full integration of EHR.

Fully addressed Partially addressed Not addressed

- The MHP allocated significant time during the reporting period engaged in these activities but they were ultimately rendered moot when the contract with OMG ended. The MHP extended the contract to its remaining ASO, RQMC, to cover service delivery requirements to serve adult population until a final solution can be worked out.

- Recommendation #3: Examine protocols and establish a formal system of progressive job skills and responsibilities for consumer employees.

Fully addressed Partially addressed Not addressed

- Most consumer employees are employed at the Wellness Centers, as peer navigators and peer/parent partners, for example.
- The Wellness Center has a system for progressive job skills and responsibilities for general employment, but not specifically for consumer employees. There is no formal system specifically for consumer employees. Consumers in these positions are able to, and do, move through the ranks just as other employees do.
- Consumers are also employed by BHRS and by contract providers, but in positions that are not specifically designated as peer positions. The positions are open to all, but happen to be filled by consumers or peers with lived experience.

- Recommendation #4: Evaluate the methodology for collection of co-occurring disorder data and standardize data collection.

Fully addressed Partially addressed Not addressed

- The MHP conducted appropriate analyses which identified data collection issues. The MHP is in the process of remedying these issues and expects better data and analysis to be available shortly.
- The Substance Use Disorder system of care utilizes WITS electronic medical record, the vendor is FEI Systems. Currently, the MHP does not have adequate access to the demographic and diagnostic information in this system to enhance its understanding of its co-occurring disorder population.

- Recommendation #5: Continue to track timeliness indicators for adherence to the established standards, emphasizing the impact of the anticipated tele-psychiatry appointments.

Fully addressed Partially addressed Not addressed

- The MHP has tracked timeliness indicators for psychiatry, including time to first appointment and No Shows for psychiatry.
 - The contribution of tele-psychiatry services on timelines was not delineated, but the MHP meets (and often exceeds) their timeliness standards.
 - Recommendation #6: Enroll organizational providers into Medicare through Noridian, the Medicare plan administrator. Consider outsourcing this as a feasible option.
- Fully addressed Partially addressed Not addressed
- The MHP began this process but this work was interrupted by the departure of OMG. The MHP has shifted their efforts to the new ASO and are in the preliminary stages of this process.

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

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

- Access to Care
 - Access for adults has been slowed by the transition of adult services to the remaining ASO, RQMC, and the transition of medication management to the MHP itself.
 - Eventually, access to services for adults stands to improve and be on par with children’s services once the transition is stabilized. The service model for RQMC gives more autonomy to contract providers to meet the needs of consumers, an approach that ostensibly was lacking with the other ASO.
- Timeliness of Services
 - Transition of adult services to RQMC and medication management to the MHP, as of late, has affected timely access to services adversely, especially for adult consumers.
- Quality of Care
 - The MHP seems to be in a better position to hold the current ASO accountable and maintain and enforce quality of services across the systems of care.
 - In January 2016, the MHP got a new director and new interim deputy director.
 - With RQMC as the one ASO, there is a perception among staff of increased transparency and greater focus on quality of services, which can be a motivating force.

- The MHP implemented .xml transfers between the ASO and their own EHR system, enabling automation and expedited practical data exchange, which can facilitate coordinated care.
- Consumer Outcomes
 - The MHP has integrated the CANS and ANSA into the EHR.
 - The MHP implemented .xml transfers between the ASO and the MHP's system, enabling automation and expedited practical data exchange, which has the potential to facilitate coordinated care.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Re-hospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (\$30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Mendocino MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	15,113	1,028
Hispanic	10,122	295
African-American	273	32
Asian/Pacific Islander	476	18
Native American	1,897	96
Other	2,789	153
Total	30,670	1,622

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

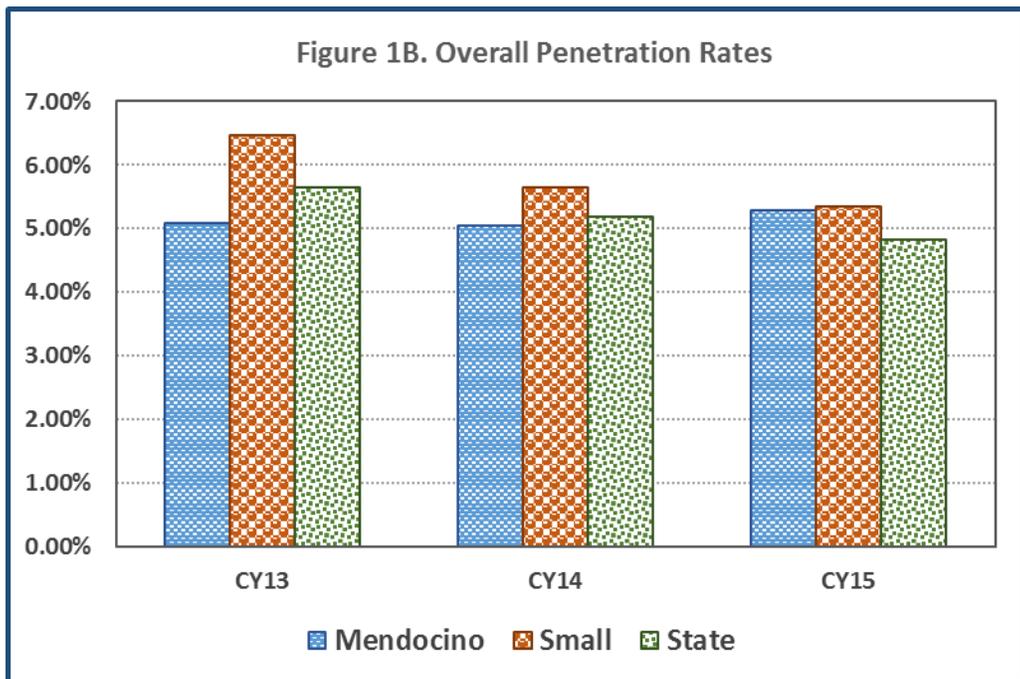
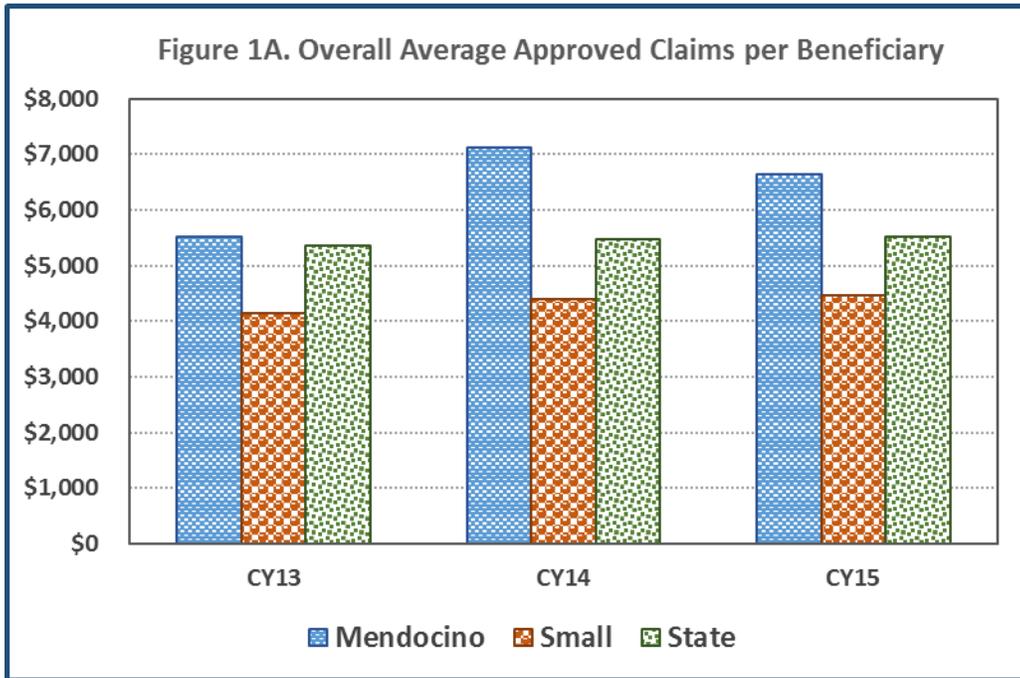
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

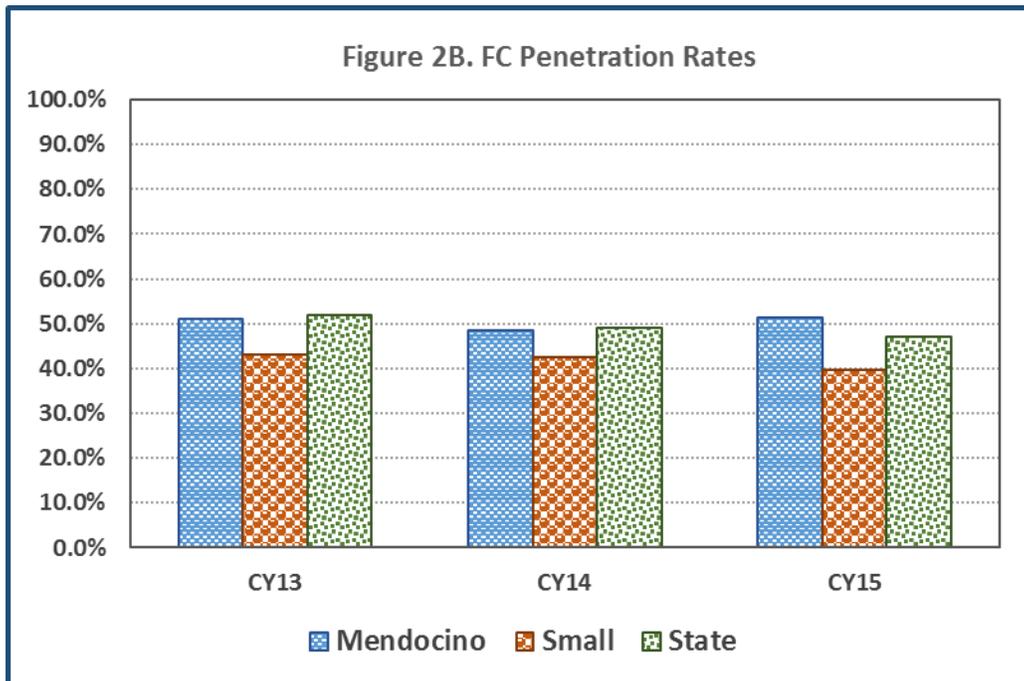
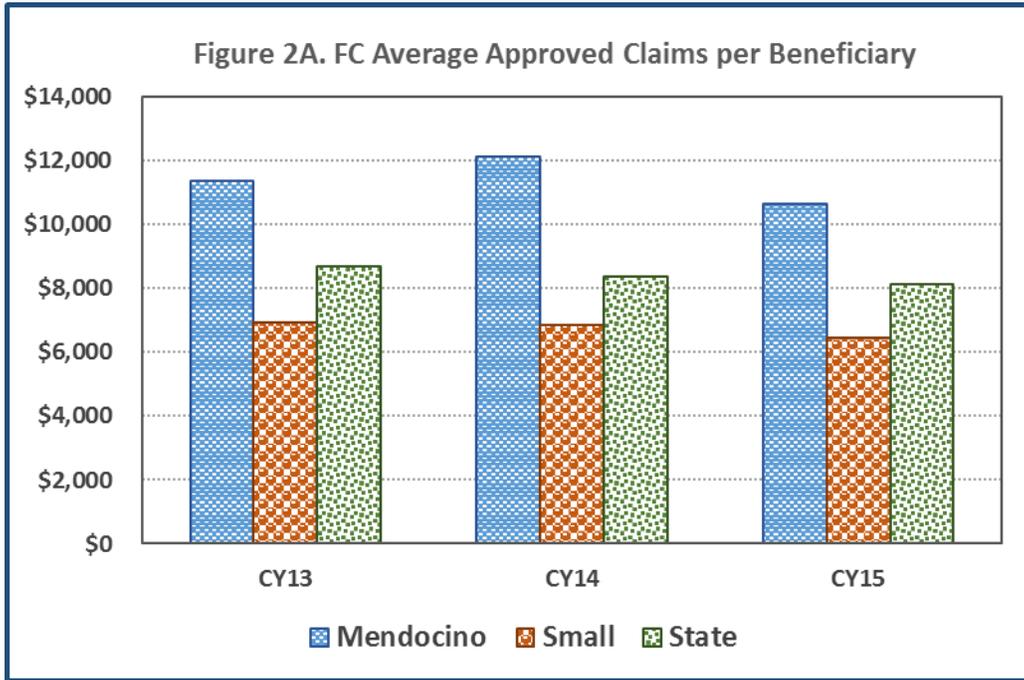
Regarding calculation of penetration rates, the Mendocino MHP:

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

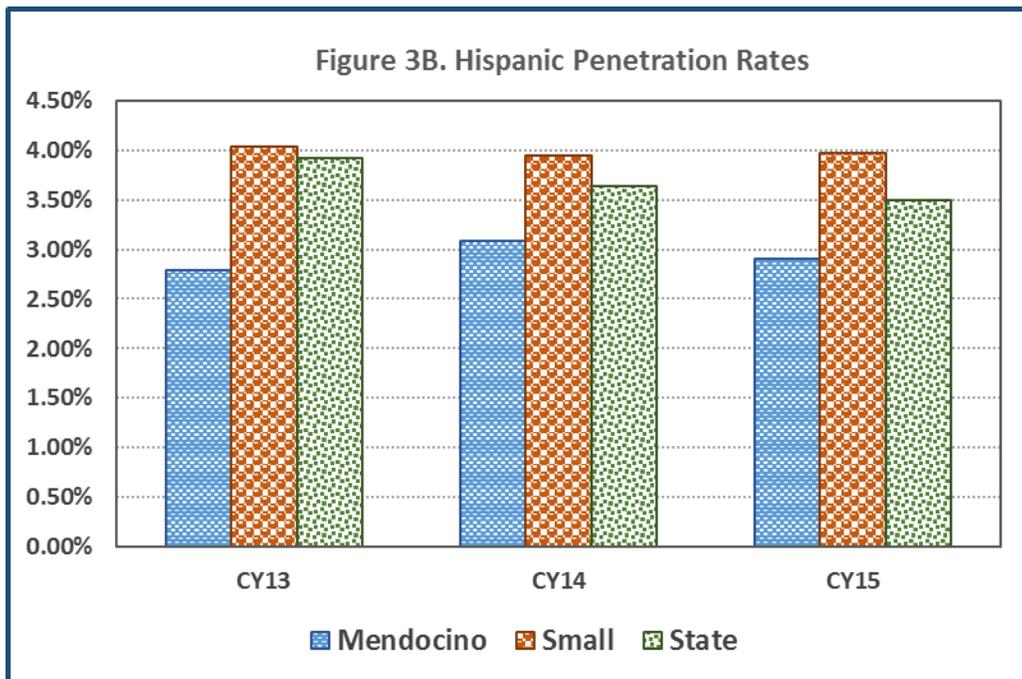
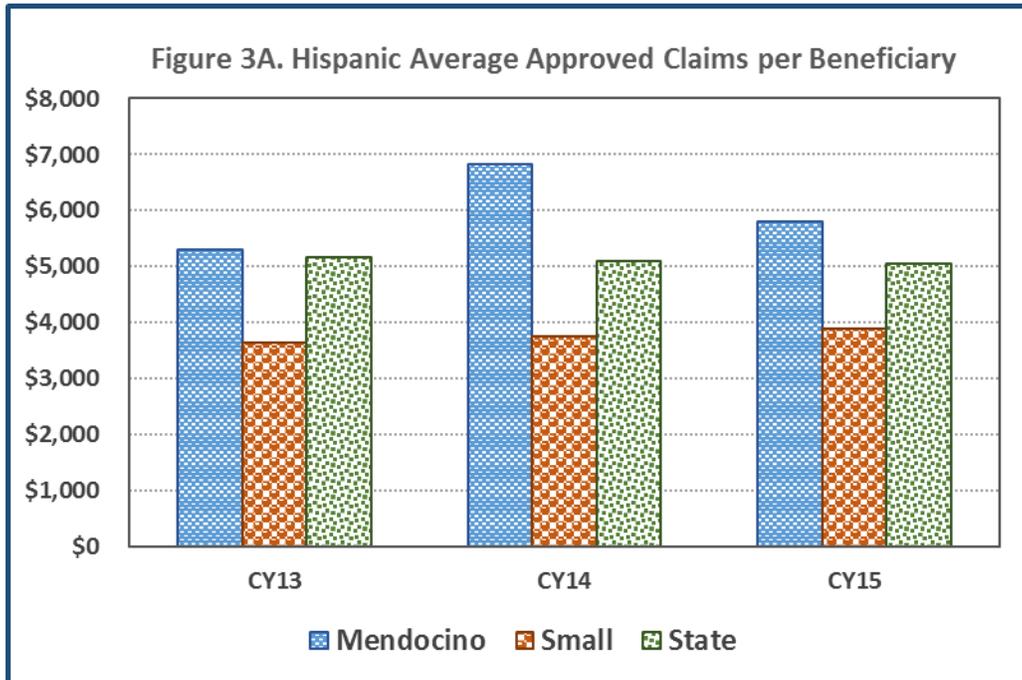
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



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



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



HIGH-COST BENEFICIARIES

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

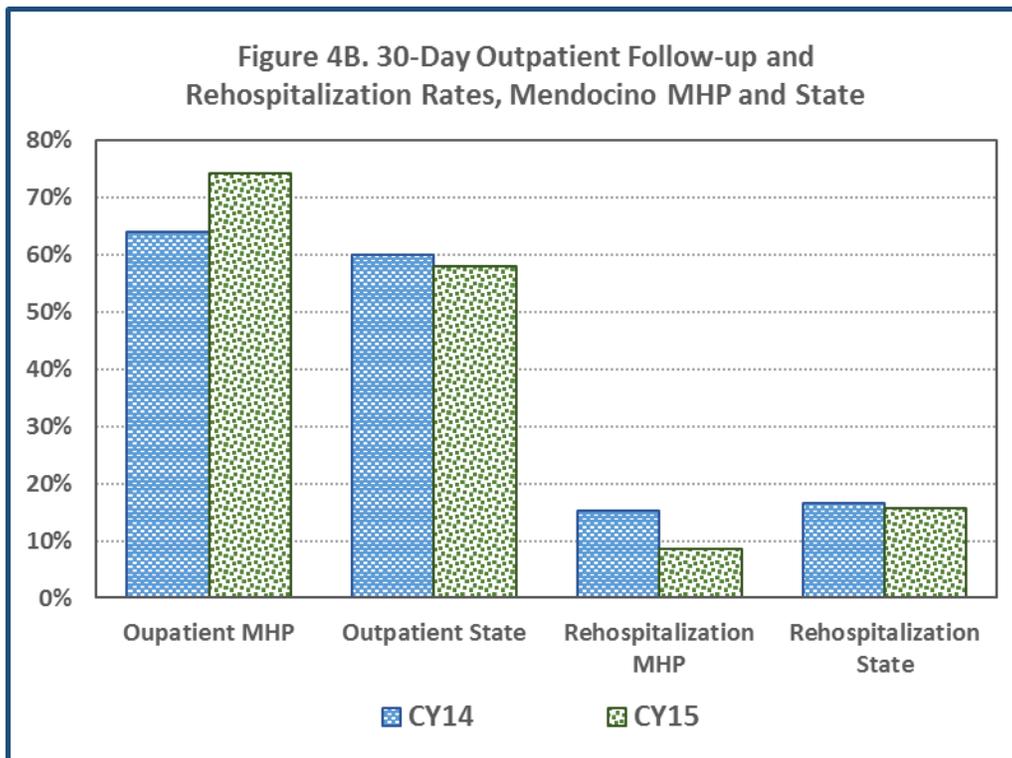
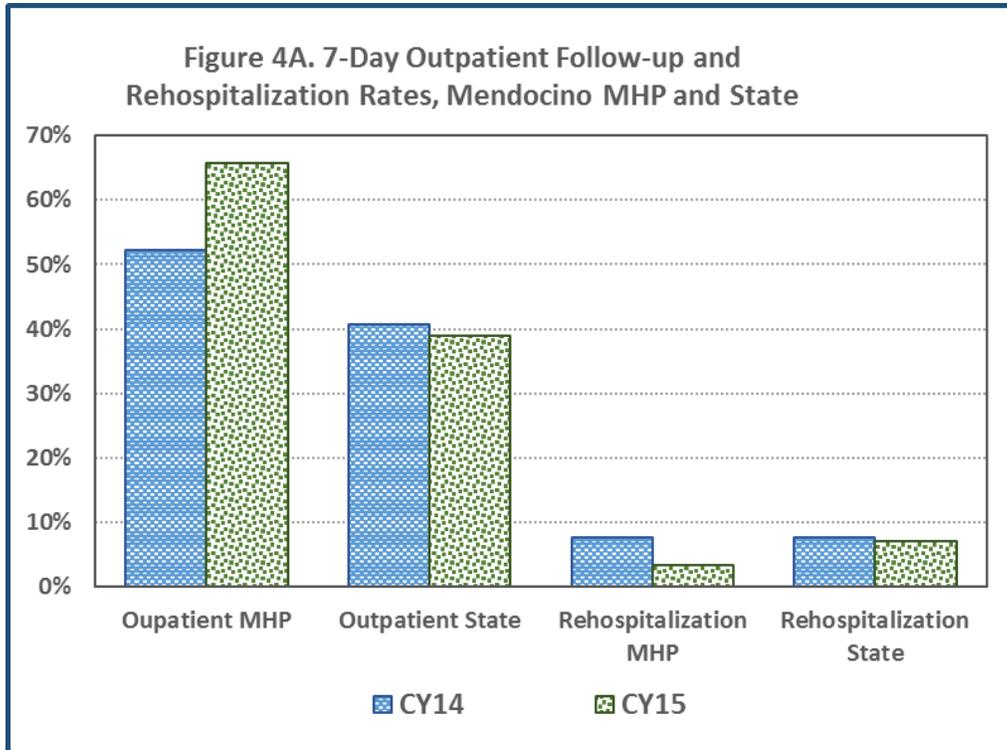
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	\$51,635	\$715,196,184	26.96%
Mendocino	CY15	71	1,622	4.38%	\$44,729	\$3,175,757	29.54%
	CY14	64	1,462	4.38%	\$40,744	\$2,607,602	26.83%
	CY13	43	1,332	3.23%	\$39,536	\$1,700,029	23.09%

Table C1 (Attachment C) shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (Affordable Care Act [ACA]) Penetration Rate and Approved Claims per Beneficiary.

Table C2 (Attachment C) show the distribution of the MHP CY15 Distribution of Beneficiaries by Approved Claims per Beneficiary (ACB) Range for the various categories; under \$20,000; \$20,000 to \$30,000, and those above \$30,000.

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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



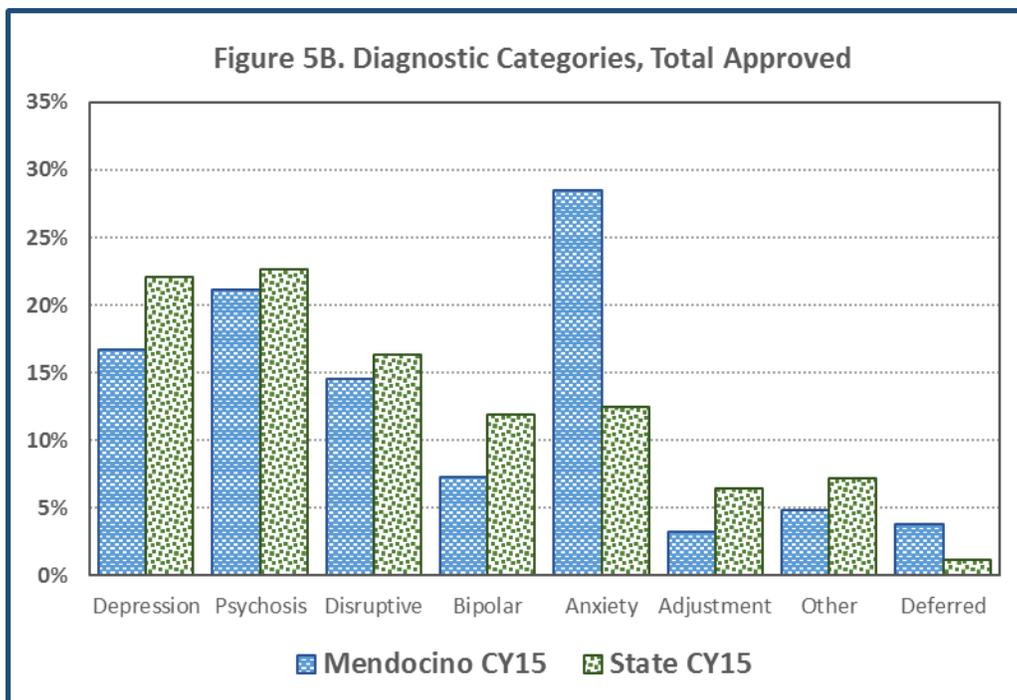
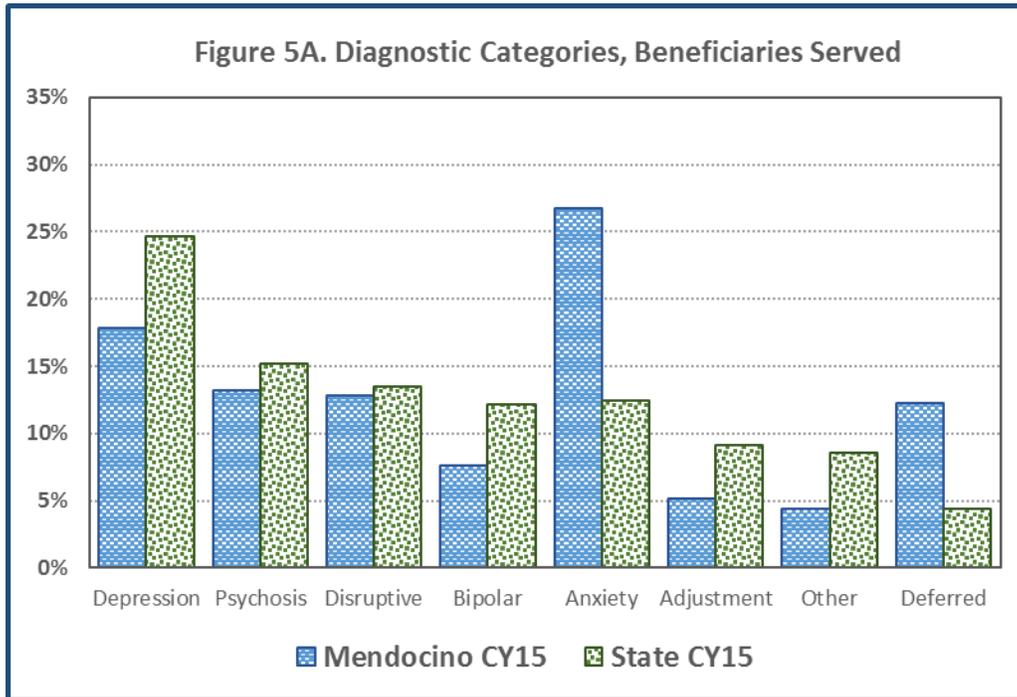
DIAGNOSTIC CATEGORIES

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

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

8.32%

occurring



PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP's penetration rate increased slightly in CY15, compared to rates in Small MHPs and the State that showed continued decline.
 - The MHP's FC penetration rates have been approximately the same over the past three years. The FC rate is comparable to the State overall rate.
 - The MHP's Hispanic penetration rate decreased slightly in CY15 and continues to be well below the rate of State and Small MHPs.
- Timeliness of Services
 - The MHP's 7-and 30-Day follow-up rates in CY15, at approximately 65% and 74% respectively, are well above the follow-up rates statewide.
 - The MHP's 7-Day and 30 Re-hospitalization rates have decreased considerably over the past year and both rates are below the rates statewide.
- Quality of Care
 - The number of HCBs has continued to increase, with a 10% increase from CY14. The MHP has a greater proportion of HCBs than that seen across the State.
 - Average Approved Claims per HCB is still rising, but remains below State spending.
 - Anxiety Disorders are the predominate diagnoses in the MHP, followed by Depression, Psychotic, and Disruptive Disorders. The MHP has a much higher prevalence of Deferred Diagnosis at approximately three times that of the State.
 - Approved Claims for Anxiety and Deferred diagnoses the most discrepant from the State, at nearly twice the proportion.
- Consumer Outcomes
 - Timely 7-Day and 30-Day follow-up rates have contributed to lower rates of re-hospitalization for consumers.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

MENDOCINO MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	ANSA Assessment Improvement Tool
Non-Clinical PIP	1	Latino Access

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.⁴

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

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

Table 3B—PIP Validation Review

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

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	UTD	-
		9.4	Statistical evidence of true improvement	NM	-
		9.5	Sustained improvement demonstrated through repeated measures.	NA	-

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

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

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	4	
Number Partially Met	8	
Number Not Met	11	
Number Applicable (AP) (Maximum = 28 <u>with</u> Sampling; 25 <u>without</u> Sampling)	27	
Overall PIP Rating $((\#Met*2)+(\#Partially\ Met))/(\#AP*2)$	30%	0%

CLINICAL PIP—ANSA ASSESSMENT IMPROVEMENT TOOL

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

- “Can we improve the quality of care and get improved client outcomes by having clinicians use the ANSA ‘sub score’ and ‘urgent needs’ score to inform treatment?”
- Date PIP began: 07/01/2015
- Status of PIP:
 - Active and ongoing
 - Completed

- Inactive, developed in a prior year
- Concept only, not yet active
- Submission determined not to be a PIP
- No PIP submitted

The purpose of this clinical PIP was to incorporate the ANSA into routine clinical practice. This PIP is part of a larger effort in the MHP to “treat to target”, whereby clinicians regularly review progress and focus care on target symptoms. The MHP believes that by increasing utilization and review of ANSA, as well as review of urgent needs and treatment progress, that clients will have improved outcomes and functioning. In order to facilitate ready access to ANSA, the MHP developed an EHR-based ANSA report that lists client’s initial and most recent ANSA scores. The MHP also revised their electronic progress note to include a check box for ANSA review. The MHP used an experimental design; there was a study group, whose clinicians reviewed the ANSA, and a retrospective control group, where clinicians had not reviewed ANSA. The interventions consisted of supervisory review of ANSA sub scores with clinicians, followed by clinician review of ANSA, urgent needs, and treatment progress with clients. The MHP compared the percent change in ANSA (i.e., from initial to most recently completed) between the control group and the study group.

The MHP succeeds in developing a report and incorporating a check box indicating ANSA review. The MHP is less successful in making the link between regular review of and subsequent improvements in ANSA. There were some methodological and analytical challenges in the study that prevent this link. A critical analytical issue was that the results were based on the original number of ‘study’ group participants (i.e., 46) although only 28 received the intervention. It is not possible for 35 participants to have improved, if again, only 28 received the intervention. One methodological challenge was the departure of some PIP team members/service providers and consequently the MHP’s access to participants aged 25 years and older. While the MHP attempted to address some issues (e.g., limiting the study and control groups to adults aged 18-24 years old), other issues were not addressed or were not even considered to be problematic. Overall, this PIP raised more questions than answered.

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

The technical assistance provided to the MHP by CaleQRO consisted of brief discussion on their efforts to control for other factors in the study (e.g., variability in clinician’s expertise in conducting ANSA) and whether their indicators effectively measured the variables in question. The EQRO offered ways in which some of these issues with the PIP could have been addressed.

NON-CLINICAL PIP—LATINO ACCESS

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

- “Can Mendocino County Behavioral Health & Recovery Services identify and begin to address barriers to accessing services as evidenced by low penetration rates?”
- Date PIP began: 03/01/2016
- Status of PIP:
 - Active and ongoing
 - Completed
 - Inactive, developed in a prior year
 - Concept only, not yet active
 - Submission determined not to be a PIP
 - No PIP submitted

The purpose of this non-clinical PIP was to increase access and engage Latino consumers who are eligible but are not receiving services through the MHP. The MHP has a two-pronged approach for this project: (1) identification of the barriers for Latinos and (2) implementation of targeted strategies. The MHP will use penetration rate as their measure of access and anticipates a rate greater than 2.7% (i.e., their current penetration rate). After six months, the MHP is still in the first phase of the project. The PIP team intends to continue by conducting another survey; the initial survey had a low response rate and did not provide enough information about barriers to access. . Additionally, the PIP team plans to revise their survey methodology/data collection approach to include Spanish-speaking surveyors and other means to engage Latino communities.

Relevant details of these issues and recommendations are included within the comments found in the PIP Validation Tool (Attachment D).

The technical assistance provided to the MHP by CaleQRO consisted of recommendations to target their outreach activities/events and to consider those events where the return on investment is greater.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

- Once implemented, the non-clinical PIP has the potential to increase access for Latino consumers, as determined by an increase in the Hispanic penetration rate.
- Timeliness of Services
 - Neither the clinical nor the non-clinical PIP has direct implications for timeliness of services.
- Quality of Care
 - At the heart of the clinical PIP and the focus on “treating to target” is improving the quality of care for consumers. Through this project, clinicians can enhance their ability to identify and hone in on consumer needs and then engage consumers in treatment.
 - The clinical PIP rests on the ability of clinicians to incorporate the ANSA review in their clinical practice. The PIP does not assess ANSA review as documented in clinician’s notes. Rather, the PIP measures the procedural use of the check box, which is a proxy for incorporation into clinical practice.
 - The clinical PIP was meant to empower clinicians to provide the level of service that meets each consumer’s needs. However, this part of the project was either not realized or not well documented. Thus, there is a missed opportunity to affect quality of the clinical PIP.
 - The non-clinical PIP relates to the larger issue of culturally-responsive services, which is a part of providing quality care to consumers. This PIP has the potential to improve the quality of care for both prospective and existing Latino consumers.
- Consumer Outcomes
 - Consumer outcomes are an essential component of the clinical PIP. The PIP uses the ANSA to objectively assess consumer outcomes. However, the conclusion that there was a 66% improvement is misleading.
 - The clinical and non-clinical PIPs incorporate consumer input through surveys, but there are methodological issues with both of them (e.g., response bias, incentives, and surveyor-respondent mismatch). The PIPs highlight the need for certain considerations in conducting a survey that accurately and reliably gauges consumer outcomes and input.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP solicits, assesses, implements, and evaluates the needs of diverse populations in their system of care and in the community, who are not yet served by the system of care. They staff knew who the underserved populations were (e.g., homeless, Native American, remotely located, Latino) and described various outreach activities to engage them.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	After the departure of OMG, RQMC increased staffing, but mostly of case managers. Staff indicated that this was beneficial and demonstrated the MHP’s intent to meet the demand for services. The MHP needs to continue examining and addressing their current capacity shortfalls (e.g., psychiatry) and the impact this has on consumers.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP’s structure (i.e., the ASO model) lends itself well to numerous opportunities for community based integration and collaboration. RQMC is already connected to a number of community organizations and providers, to which the MHP in turn has access. The MHP is integrated with SUD.

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

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide

timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The standard time to 1st appointment is 14 days and the MHP averages 7.5 days for adults and children. The MHP investigates outliers and identifies the reason(s) for the protracted assessments. The MHP should consider a standard that is better aligned to their capabilities and actual performance.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The standard time to 1st psychiatric appointment is 30 days and the MHP averages 15 days for adults and children. While the standard is reasonable, the MHP seems to have the ability to and consistently exceeds this timeframe. A more reasonable timeframe for the MHP might be 21 days. Given the transition to one ASO, staffing changes, and reshuffling of medication management, the MHP may now benefit from the additional time, but should revisit this standard once services stabilize.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The standard for response to crisis is 1 hour during the days and 2 hours at night. The MHP meets this standard 92% and 98% of the time respectively. The MHP has a dedicated crisis response unit that conducts crisis primarily at hospitals or at clinics. The start of the clock is when the crisis team receives the call.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The standard for discharge follow-up is 7 days and the MHP meets this 93% of the time. The follow-up is with a staff of the crisis team, not a psychiatric provider. The MHP utilizes their crisis response team to facilitate and coordinate discharge and post hospitalization services, including pick up from hospital, filling and picking up scripts, scheduling follow-up appointments. This system seems to work well for them and their consumers.
2E	Tracks and trends data on re-hospitalizations	FC	The standard for re-hospitalization is 10% in 30 days. The MHP has an average rate of 9.4% for adults and children. It was mentioned on-site that hospitalizations are an area for future utilization review. The post-discharge crisis stabilization process was implemented as a means to address re-hospitalizations. The MHP collects, reports, and evaluates performance.
2F	Tracks and trends No Shows	PC	The MHP provided No Show data for the children’s and adult system of care. However, they were more confident of the children’s No Show data, as it was tracked consistently and uniformly by providers. Thus, the MHP did not demonstrate broad systemic tracking

Table 5—Timeliness of Services		
Component	Compliant (FC/PC/NC)*	Comments
		and analysis of No Shows. They believe they will achieve uniform and systemic tracking now that there is only one ASO.

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

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, 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 6—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3A	PC	What the MHP calls their QIC is more akin to a community forum. In the QIC meetings, priority is given to stakeholders/consumers who attend and what their issues are. System-level decision-making that affects programs and policies appear to occur at QI/QM. The MHP produces an annual evaluation, but only certain activities included outcomes and efficacy. The MHP would do well to include in their annual evaluation a summative review, plans for continuation, improvement, etc. of activities performed. The official QI Manager position is currently vacant. The duties are assumed mostly by the Program Administrator and partially by the Director.
3B	PC	The MHP collects and reports on a number of data, including productivity, timeliness, and, per the PIP, clinical outcomes. The data are collected by contract providers and given to the ASO who then gives it, in aggregate, to the MHP. The MHP can also directly access individual data through EHR and other mechanisms for authorization of services. But, there was little evidence of how these data are used for decision-making, policy change, or other means of memorializing data review and utilization.

Table 6—Quality of Care

Table 6—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
3C	PC	The MHP seems to primarily communicate with the ASO, who then communicates with staff (line and supervisory), contract providers, and community providers. Consumer cited interaction with their case managers as their means of communication with the MHP. But, consumers also have an opportunity for bi-directional communication with MHP administration through QIC and Mental Health Services Act programs.
3D	PC	Stakeholder input was most evident with contract providers, through the multi-agency committee, and with consumers, at the QIC. Line staff and supervisors did not appear to be involved in meetings/forums that are facilitated by the MHP where system planning and implementation would take place (e.g., QA/QM, CDC, UR, and PIP).
3E	FC	The ASO model lends itself well to partnerships with other agencies and community providers. But, the ASO, not the MHP is at the center of this collaboration.
3F	PC	The MHP tracks and trends consumers over time and guides them through the systems of care. The MHP is furthering continuum of care by establishing relationships with providers who can fill identified gaps in service provision (e.g., inpatient hospitalization; TAY services). At present, the relationships are operationalized verbally. While the ability to monitor medication management and evaluate prescription practice is in the EHR, the review does not appear to be part of QI/QM or UR. Managers of various contracts were able to direct consumers to available services outside of their agencies, but line staff expressed difficulty in facilitating continuity of care for consumers who were not eligible for their services in their own agencies but were purportedly eligible at other providers.
3G	FC	The MHP incorporates Wellness and Recovery Action Plan (WRAP) at the Wellness Center. Consumers are informally and formally engaged in treatment planning. There are classes and programs for consumers and (presumably) family members—dual dx, anger mgmt., WRAP, life skills. From the focus group, a number of consumers were not aware of the Wellness Center.
3H	FC	Consumer/family member employment occurs at the Wellness Centers; there is a natural synergy where peers and former consumers seek employment at the center, though no formal peer positions exist. Peers

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			have the opportunity to advance, as they would in any profession/position.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	Consumer/family member employment occurs at the Wellness Centers. QIC also appears to be primarily consumer/family member driven.
3J	Measures clinical and/or functional outcomes of consumers served	PC	The MHP is moving toward broad use of Level of Service/ Care tools, including the ANSA and CANS, at present, use is at individual level and not systemic. As part of the PIPs, the MHP has developed an ability to track ANSA longitudinally. The MHP should re-analyze the results of their PIP and related training of staff to ensure consistency and reliability in utilization of ANSA.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP has conducted consumer satisfaction surveys during the year, but findings do not appear to be distributed or disseminated. When asked about the results of a March 2016 survey, which the MHP specifically cited as an example of a survey, relevant stakeholders (i.e., MHP leadership, QI, ASO leadership) were unable to report on any findings or outcomes. Per the FY15-16 EQRO report, the MHP was supposed to have conducted a staff and consumer survey in October 2015 on satisfaction with delivery of care through ASOs. When the MHP was asked about the outcome of this survey, the relevant stakeholders were unaware of the survey, if it had happened, and what the results were.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP’s structure with the ASO model enables access to care at various levels of care. The ASO leverages the strengths of each provider and also facilitates identification and access to diverse consumers, including those that are under-served.
 - While managers of the contract providers know how and are able to facilitate coordination/continuum of care with other contract providers, the line staff and supervisors who more directly interface with the consumes expressed difficulty

and an inability to connect consumers to other contract providers within the ASO.

- Since the transition to one ASO, the MHP has had challenges in providing stable access to psychiatric providers.
- The system of care might benefit substantially by improving the speed of analysis of the impact of a 23-hour crisis stabilization unit. Implementing a crisis stabilization unit could potentially be faster than additional inpatient capacity and would relieve current stress on the system.
- Timeliness of Services
 - Related to access to psychiatry, the MHP is not able to provide timely access to psychiatric services. Consumers and staff alike described long wait times for initial and routine psychiatric appointments.
 - Over the past year, the MHP met or surpassed their standards for timeliness to services, suggesting that the MHP has the capacity to better align their standards with actual performance.
- Quality of Care
 - The MHP's quality improvement program does not have broad input and participation by staff. Those who are involved with the formal quality improvement activities are removed from those who actually do the work. No supervisory or line staff were involved in QI in any substantive way.
 - Communication happens primarily at the executive and managerial level of the MHP and contract providers. Staff indicated little bi-directional communication or involvement in policy, meetings, or other opportunities for broad and program-wide impact. Very little communication was between staff and the MHP.
 - The MHP has a forum for regular stakeholder and consumer input. By holding the meetings in rotating and different towns, the MHP makes a concerted effort to obtain input from beneficiaries across the county.
 - The MHP has multiple quality improvement structures in place; there appears to be overlap in their committees and the need (and staff time) for these separate committees is unclear. As evidence, the MHP has a QI committee that does not address program-wide issues; the MHP has a QI/QM that functions mostly as a repository of data collection and reporting; and, the MHP has separate Compliance and UR committees that seem more involved in policy and data collection. Consumer Outcomes
 - The MHP has incorporated the CANS and ANSA into the EHR. The MHP has revised progress notes to reflect or trigger clinicians to incorporate these tools as a routine part of their clinical practice and interaction with consumers.

- The MHP recognizes the value of consumer input via surveys, but the MHP's recent efforts to conduct, analyze, or use survey results have met with some challenges.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

The MHP was requested to convene: a culturally diverse group of adult beneficiaries, including parents/caregivers of child/youth beneficiaries, with a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held on-site at the MHP main office.

Number of participants – 8

Focus group participants represented a diverse range of age, gender, ethnicity, and access to the MHP. As well, the participants had different years of engagement with the MHP.

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

- Participants indicated that the time to an assessment was between one to two months. They described much effort and frequent phone calls prior to receiving services, suggesting that without their persistence the time to the assessment would have been much longer than the 1-2 months that they waited.
- Participants had variable wait times for accessing therapy and psychiatric services. The time to a therapist or psychiatric provider was anywhere between one week to two and half months.
- Participants described their experiences overall as positive.

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

- The majority of the participants received therapeutic services, case management, and many accessed group therapy. They described the frequency of these visits as sufficient, with much more frequent (e.g., weekly) case management.
- For those who saw a psychiatric provider, participants described long waits of up to two or more months and also rapid turnover of psychiatric providers.
- Participants were all aware of crisis services and how to access them. But they had mixed feelings and experiences with crisis services. Contacting crisis services unduly lead to interaction with law enforcement and eventually jail. Participants indicated that the relationship between crisis and law enforcement made them reluctant to access crisis in the future.
- Participants had varying degrees of involvement in their treatment plan, WRAP, and services. They expressed having a ‘say’ in their treatment, but not necessarily tied to WRAP. Parents/caregivers of foster youth were more likely than the other consumers to have a written and formal plan. Also, participants expressed a desire for more input regarding selection of their clinicians rather than assignment of their clinician.

Recommendations for improving care included the following:

- Increase the number of options for clinicians/therapists from which consumers can choose to receive services;
- Relocate or provide services in larger facility that accommodates the growth in the clinic; and,
- Better publicize and inform consumers of available services, including transportation and programming at the Wellness Center.

Interpreter used for focus group 1: No Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
 - Consumers/family members avail themselves of a variety of mental health services, but are not as familiar with the Wellness Center and its role in services.
 - Consumers/family members do not have reliable access to psychiatric providers, increasing the risk of medication shortages.
- Timeliness of Services

- The MHP is challenged presently in providing timely services—from initial assessments, therapeutic appointments, to psychiatric appointments—to their consumers. This may be a result of the transition to one ASO and the MHP.
- Quality of Care
 - The MHP's relationship with law enforcement—and the perceived ease of their involvement--minimizes the trust that some consumers have of the MHP. Overtime, consumers may put themselves at risk by trying to avoid crisis and ER visits all together.
 - Consumers do not feel that that they have a choice in their selection of therapists. They do not have a voice in expressing their concern about or need to change therapists.
- Consumer Outcomes
 - The MHP's mechanism for involving consumers in treatment planning is not perceived as formal or uniformly applied. Consumer input in treatment planning was more apparent for services for foster youth.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 8—Distribution of Services by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	5.16%
Contract providers	94.8%
Network providers	0.04%
Total	100%

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

3.28%

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

Yes In Test/Pilot Phase No

- MHP currently provide services to consumers using an tele-psychiatry application:

Yes In Test/Pilot Phase No

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

3

- Tele-psychiatry services are available with English speaking practitioners.

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

Table 9 – Summary of Technology Staff Changes			
Number IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
7	0	0	0

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

Table 10 – Summary of Data Analytical Staff Changes			
Number Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
15	0	0	0

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

- The MHP has approximately a 50/50 mix of data analytical staff spread between Fiscal reporting and quality management support.

CURRENT OPERATIONS

- The MHP continues to utilize the Avatar and EXYM Electronic Health Records as their primary management information systems. Currently about 352 FTEs utilize this hybrid record across clinical, medical, and administrative functions.
- The MHP currently utilizes the services of XPIO Consulting to model Avatar data collection forms and write reports.
- Service data is currently being moved from EXYM into MyAvatar via an .xml data transfer process utilizing a secure site set up for the activity by County IT.

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 (SD/MC) 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
Avatar PM	Practice Management	Netsmart Technologies	13	Netsmart
Avatar CWS	Clinical	Netsmart Technologies	3	Netsmart
EXYM	EHR	EXYM	8	EXYM
Dimension Reports	Claims Reconciliation	Dimension	1	Dimension

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace the current system, which has been in place for over five years.
- The MHP continues to work with their IS/IT consultants, Netsmart, and XPIO, to craft interoperability solutions. The MHP worked diligently to implement .xml transfers between the ASO and the MHP's system this year to automate and expedite practical data exchange mechanisms.
- The MHP has a number of system enhancements in the queue. Of particular interest will be the establishment of a Consumer Portal, which will facilitate consumer engagement.

ELECTRONIC HEALTH RECORD STATUS

Table 12 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 12—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Netsmart/EXYM	X			
Assessments	Netsmart/EXYM		X		
Document imaging/storage	Netsmart/EXYM			X	

Table 12—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Electronic signature—consumer	Netsmart/EXYM			X	
Laboratory results (eLab)	EXYM	X			
Level of Care/Level of Service				X	
Outcomes	Netsmart/EXYM		X		
Prescriptions (eRx)	Netsmart/EXYM		X		
Progress notes	Netsmart/EXYM	X			
Treatment plans	Netsmart/EXYM		X		
Summary Totals for EHR Functionality		3	4	3	0

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

- The MHP plans to have Assessments, Outcomes tools, and Treatment Plans out of testing this month.
- The MHP has scheduled go live dates for document imaging, eRx, and electronic signatures for consumers later this year.
- While the MHP has modeled Level of Service/Level of Care tools into the EHR it is still in the process of rolling these out system-wide. Secondary longitudinal analysis of this data for quality improvement initiatives has not yet begun.
- Consumer’s Chart of Record for county-operated programs (self-reported by MHP):

Paper
 Electronic
 Combination

MAJOR CHANGES SINCE LAST YEAR

- The .xml upload of services provided by the subcontractors of Redwood Quality Management Company into the county’s Avatar system.
- The MHP implemented the Scheduler with their in-house clinical staff.
- The CANS and ANSA have been modeled into Avatar and are being tested.
- A Medication Consent Form has been modeled into Avatar and is being tested.
- A new Progress Note has been modeled into Avatar and is being tested.

- The Audit Tool and Outpatient Chart Audit tool have been modeled into Avatar.
- The assessments (BPSA, GAD7) have been modeled into Avatar and are being tested.
- The Client Treatment Plan is being tested.

PRIORITIES FOR THE COMING YEAR

- The training and use of the Assessments, Client Plan, CANS/ANSA, and the Audit Tools.
- “MModal”, a dictation application, will be integrated into Avatar for the physicians.
- Implementation of Perceptive, a document scanning application, into the Avatar system.
- Uploading of the Assessment data via .xml export from the ASO’s EXYM system into Avatar.
- Medication consent training for physicians.
- Research OrderConnect module (eRx) for future implementation.
- Start a pilot program for sharing client information with the local Rural Health clinic.

OTHER SIGNIFICANT ISSUES

- The MHP, while having some data analysts dedicated to quality management, would benefit from more staff in this area due to the nature of the current data stores. These repositories, held by the ASO, are at a distance from access by MHP analysts and require extra time to obtain and process. Items like analysis of Level of Service/Level of Care tools still appear to be handled manually rather than automated reports.
- The MHP made a serious attempt to apply for Medicare authorization but was stalled by the exit of OMG. The process has been restarted but is in the preliminary stages.
- While the MHP appears to be expanding use of tele-psychiatry services (32 hours/week to be added soon), tele-psychiatry has yet to make an impact on current wait times for psychiatric providers and services.
- The MHP worked diligently with its vendor and consultant to extend EHR functionality to OMG during the year. This activity was rendered moot when the contract with OMG ended. However, the enhancements that were made may enable the MHP to have greater and more frequent data exchange between the principal EHR systems.
- The MHP is engaged in a commendable effort to create HIPAA compliant Business Associate agreements with service partners (e.g. FQHCs, hospitals, etc.) to enhance data sharing. It is

unclear if the MHP and County Counsel are leveraging State-level efforts, like CAHIE’s protocols, which would make this endeavor easier.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:
 - Monthly More than 1x month Weekly More than 1x weekly
- MHP performs end-to-end (837/835) claim transaction reconciliations:
 - Yes No

If yes, product or application:

Dimensions Reports

- Method used to submit Medicare Part B claims:
 - Clearinghouse Electronic Paper N/A
 - The MHP is currently unable to bill for Medicare reimbursement. They are in the process to become recertified.

Table 13 - Mendocino MHP Summary of CY15 Processed SDMC Claims

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
56,739	\$9,651,079	\$177,613	1.84%	920	\$9,473,466	\$22,921	\$9,450,545

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

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
 - The MHP is evaluating the need for more tele-psychiatry services and is adding hours to provide adequate access.

- The MHP is calculating its own penetration rates to provide for adequate review of data to ensure ethnic and underserved beneficiaries have access to services.
- Timeliness of Services
 - With more tele-psychiatry, the MHP may also improve timeliness for psychiatric services.
- Quality of Care
 - The MHP is working to integrate new assessments and outcomes tools within the EHRs to provide a firm basis for objective analysis of consumer quality of care.
 - The MHP has not yet fully automated the process of longitudinal Level of Service/Level of Care analysis. This process could give the QI/QM a solid foundation for extending its current work around right-sizing services.
- Consumer Outcomes
 - Staff regularly reviews Level of Service/Level of Care data to ensure that service provision matches consumer level of function.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers to the site review.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
 - The MHP's ASO, RQMC, has fostered an environment and service model that enables contract providers to provide services that has improved consumer's access to care and empowers staff to meet consumer's needs.
 - The MHP engages in activities that facilitate access for under-served populations, including the cultural competency/diversity committee and the roving QI committee.
- Opportunities:
 - The MHP must address insufficient and unstable staffing for psychiatry and medication services.
 - The MHP and RQMC leadership should share with line staff the mechanisms to facilitate coordinated care or a continuum of care among/with other contract providers when the staff person's own agency cannot serve the consumer.
 - The MHP should consider an examination of the factors that are contributing to escalating high cost beneficiary rates.
 - As the MHP prepares for Drug Medi-Cal, the MHP may wish to consider cross platform data analysis of its co-occurring disorder population to identify program needs for their MH/SUD population.

Timeliness of Services

- Strengths:
 - The MHP is actively monitoring the use of and protocols for tele-psychiatry. The MHP intends to bolster psychiatry services by increasing utilization of tele-psychiatry in areas of need.
- Opportunities:

- The MHP should continue their efforts to track No Shows consistently across the systems of care.
- Once services have stabilized (i.e., with the transition to one ASO), the MHP should evaluate their timeliness standards. The MHP should set standards that (1) better reflect their capability and (2) motivate continuous improvement in timeliness.

Quality of Care

- Strengths:
 - The MHP makes a concerted effort to obtain feedback from beneficiaries. Through the QIC, the MHP has a forum for regular input from stakeholders spread across the county.
 - The MHP has a commitment to the use of data in its clinical quality improvement efforts.
 - The MHP and RQMC have implemented a number of initiatives that affect quality of care—increasing opportunities for staff supervision, deliberately engaging consumers in treatment, and incorporating culturally-responsive services.
- Opportunities:
 - The MHP should examine their crisis protocols for contacting law enforcement.
 - The MHP would benefit from engaging staff as stakeholders. There were few opportunities for supervisory or line staff to engage in system planning, program/project implementation, or decision-making in a substantive way. This effort would also facilitate bi-directional communication among contract provider staff and the MHP.
 - The MHP would benefit from an examination of their quality improvement program, including all the committees that relate to quality, staffing to support data analysis, and current projects/initiatives. The MHP appears to be stretched thin, with limited staffing to supervise and see projects to completion, and manage data-rich reporting.
 - The MHP should examine diagnosing practices, particularly related to the use of Deferred Diagnoses and Anxiety Disorders, both of which are high.

Consumer Outcomes

- Strengths:
 - The MHP's crisis program coordinates care and a variety of services for consumers following hospital discharge. The intense follow-up has had a positive impact on re-hospitalization rates; the MHP's 7- and 30-Day re-hospitalization rates are both well below that of the State.

- The MHP has incorporated ANSA and CANS into the EHR, developed a formal Level of Service Measurement Tool, and modified progress notes to trigger ANSA review. All of these enable reliable and continual assessment of consumer progress, outcomes, and recovery.
- Opportunities:
 - Before implementing future consumer surveys, the MHP should address reliability, validity, potential biases, and barriers.
 - The MHP should consider broad or system-wide use of Level of Care/Level of Outcome tools, which would promote right-sizing of service delivery to a greater proportion of beneficiaries.

RECOMMENDATIONS

- Track access and timeliness to psychiatry in both adult and children's system of care for at least one full quarter to determine actual wait times and then, if needed, implement improvement activities to reduce wait times followed by subsequent monitoring.
- Include line and/or supervisory staff as standing members in programmatic committees, with evidence of regular attendance by these staff members.
- Track occurrence/frequency of crisis contacts that result in detention and examine crisis protocols and the parameters for contacting law enforcement.
- Complete Medicare Part B certification process in order to submit claims.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA



Mendocino County MHP CalEQRO Agenda

Tuesday, September 13, 2016

All sessions will be held at **1120 S. Dora Street, Ukiah, CA 95482** unless otherwise noted.

Time	Activity		
8:30 am – 9:30 am	<p>Opening Session w/ MHP Leadership, Quality Management Staff & Key Stakeholders</p> <ul style="list-style-type: none"> • Introduction to BHC • MHP Introductions <p>Review of Past Year</p> <ul style="list-style-type: none"> • Responses to Last Year’s Recommendations • Significant Changes and Key Initiatives • Surveys (State and others) • Use of Data in the Past Year <p>EQRO: All Location: Conference Room #1</p>		
9:30 am – 10:30 am	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>MHP Clinical Line Staff Group Interview</p> <p>6-8 Clinical staff, representing various geographical regions and aspects of service delivery, including crisis, with no supervisory level staff included.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Billing/IT & Fiscal Key Staff/Group Interview</p> <ul style="list-style-type: none"> • Review FY16-17 ISCA • Review FY15-16 Recommendations • EHR Implementation • IS & Data Analytical Staff Changes • Tele-psychiatry • Primary Care Collaboration • Claims Processing – denied & replaced transactions & reconciliation • HIE and/or two-way exchange of clients healthcare data <p>EQRO: Henderson Location: Conference Room #1</p> </td> </tr> </table>	<p>MHP Clinical Line Staff Group Interview</p> <p>6-8 Clinical staff, representing various geographical regions and aspects of service delivery, including crisis, with no supervisory level staff included.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p>	<p>Billing/IT & Fiscal Key Staff/Group Interview</p> <ul style="list-style-type: none"> • Review FY16-17 ISCA • Review FY15-16 Recommendations • EHR Implementation • IS & Data Analytical Staff Changes • Tele-psychiatry • Primary Care Collaboration • Claims Processing – denied & replaced transactions & reconciliation • HIE and/or two-way exchange of clients healthcare data <p>EQRO: Henderson Location: Conference Room #1</p>
<p>MHP Clinical Line Staff Group Interview</p> <p>6-8 Clinical staff, representing various geographical regions and aspects of service delivery, including crisis, with no supervisory level staff included.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p>	<p>Billing/IT & Fiscal Key Staff/Group Interview</p> <ul style="list-style-type: none"> • Review FY16-17 ISCA • Review FY15-16 Recommendations • EHR Implementation • IS & Data Analytical Staff Changes • Tele-psychiatry • Primary Care Collaboration • Claims Processing – denied & replaced transactions & reconciliation • HIE and/or two-way exchange of clients healthcare data <p>EQRO: Henderson Location: Conference Room #1</p>		
10:30 am – 11:15 am	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>MHP Clinical Supervisors Group Interview</p> <p>6-8 Clinical supervisors, representing various geographical regions and various aspects of service delivery.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p> </td> <td style="width: 50%; vertical-align: top;"> <p>EQRO: Henderson Location: Conference Room #1</p> </td> </tr> </table>	<p>MHP Clinical Supervisors Group Interview</p> <p>6-8 Clinical supervisors, representing various geographical regions and various aspects of service delivery.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p>	<p>EQRO: Henderson Location: Conference Room #1</p>
<p>MHP Clinical Supervisors Group Interview</p> <p>6-8 Clinical supervisors, representing various geographical regions and various aspects of service delivery.</p> <p>EQRO: Shaw-Taylor & Marrin Location: Conference Room #251</p>	<p>EQRO: Henderson Location: Conference Room #1</p>		
11:15 am – 12:20 pm	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>MHP & Administrative Service Org. (& Contract Providers) Discussion</p> <ul style="list-style-type: none"> • Integration, collaboration, and communication: MHP and RQMC • Acute to follow-up care/transition • Outpatient program capacity to serve consumers timely • Staff hiring and retention <p>EQRO: Henderson & Shaw-Taylor Location: Conference Room #1</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Katie A. Implementation</p> <ul style="list-style-type: none"> • Collaboration & Service Provision • Monitoring/Tracking • Training & CPM <p>EQRO: Marrin Location: Conference Room #251</p> </td> </tr> </table>	<p>MHP & Administrative Service Org. (& Contract Providers) Discussion</p> <ul style="list-style-type: none"> • Integration, collaboration, and communication: MHP and RQMC • Acute to follow-up care/transition • Outpatient program capacity to serve consumers timely • Staff hiring and retention <p>EQRO: Henderson & Shaw-Taylor Location: Conference Room #1</p>	<p>Katie A. Implementation</p> <ul style="list-style-type: none"> • Collaboration & Service Provision • Monitoring/Tracking • Training & CPM <p>EQRO: Marrin Location: Conference Room #251</p>
<p>MHP & Administrative Service Org. (& Contract Providers) Discussion</p> <ul style="list-style-type: none"> • Integration, collaboration, and communication: MHP and RQMC • Acute to follow-up care/transition • Outpatient program capacity to serve consumers timely • Staff hiring and retention <p>EQRO: Henderson & Shaw-Taylor Location: Conference Room #1</p>	<p>Katie A. Implementation</p> <ul style="list-style-type: none"> • Collaboration & Service Provision • Monitoring/Tracking • Training & CPM <p>EQRO: Marrin Location: Conference Room #251</p>		
12:20 pm – 1:00pm	EQRO Working Lunch		

Time	Activity	
1:00 pm – 2:15 pm	Performance Improvement Projects <ul style="list-style-type: none"> Review Clinical PIP Review Non-Clinical PIP Technical Assistance <p>EQRO: Shaw-Taylor Location: Conference Room #251</p>	Consumer/Family Member Focus Group 10+ culturally diverse adult beneficiaries and parents/caregivers of youth beneficiaries representing both high and low utilizers of service.
2:15 pm – 3:15 pm	Quality Management & Cultural Competence Activities <ul style="list-style-type: none"> QI Plan & Goals Data utilization Evaluation Cultural Competence Committee/Plan <p>EQRO: Shaw-Taylor Location: Conference Room #251</p>	<p>EQRO: Marrin & Henderson Location: Conference Room #1</p> <p>2:40 pm – 3:15 pm Tour of Manzanita Wellness Center 410 Jones St., C-1, Ukiah, CA 95482</p> <p>EQRO: Marrin & Henderson</p>
3:30 pm - 4:45 pm	Access, Timeliness, Outcomes, and Quality <ul style="list-style-type: none"> Timeliness Self-Assessment Document MHP Timeliness Metrics and Procedures Access Medi-Cal Penetration Rates <p>EQRO: All Location: Conference Room #1</p>	
4:45 pm -5:05 pm BHC Staff Meeting		
5:05 pm – 5:20 pm	Exit Interview <ul style="list-style-type: none"> Questions Summary of Findings Collection of Requested Documentation Next Steps <p>Participants: MHP Leadership, Quality Management Staff, Key Stakeholders Location: Conference Room #1</p>	
Wednesday 9/14/2016 10:30 am BHC Tour of Hospitality House (Corner of E. Oak/N. Franklin) 101 N. Franklin St Ft. Bragg, CA 95437		

CalEQRO Review Team:

Ewurama Shaw – Taylor, PhD – Lead Quality Reviewer ewurama.shawtaylor@bhceqro.com
 Duane Henderson – Information Systems Reviewer duane.henderson@bhceqro.com
 Gloria Marrin – Consumer/Family Member Consultant
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ATTACHMENT B—REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Ewurama Shaw - Taylor, Quality Reviewer
Duane Henderson, Information Systems Reviewer
Gloria Marrin, Consumer/Family Member Consultant

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

SITES OF MHP REVIEW

MHP SITES

Mendocino County Behavioral Health & Recovery Services
1120 S. Dora Street
Ukiah, CA 95482

CONTRACT PROVIDER SITES

Manzanita Services
Manzanita Wellness Center
410 Jones Street, C-1
Ukiah, CA 95482

Mendocino County Hospitality Center
Hospitality House
101 N. Franklin Street
Ft. Bragg, CA 95437

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
Alicia Logan	Business Administrator	Redwood Quality Management Company
Amanda Pantaleren	Clinician, LMFT	Tapestry Family Services
Andrea Turchin	Senior Department Analyst	Behavioral Health & Recovery Services
Anna Shaw	Executive Director	Mendocino County Hospitality Center
Annette Simmons	Clinician, MFTI	Mendocino County Hospitality Center
Arthur R. Davidson	Deputy Director, SUDT	Behavioral Health & Recovery Services
Barbie Svendsen	Program Administrator	Behavioral Health & Recovery Services

Name	Position	Agency
C. Joy Kinion	Mental Health Outreach	Behavioral Health & Recovery Services
Camille Schraeder	Systems Officer	Redwood Quality Management Company
Carol Vokoun	Data Application Specialist	Behavioral Health & Recovery Services
Chandra Gonsales	Director, Crisis Services	Redwood Community Services
Christina Offill	ACSW	Redwood Community Services
Dan Anderson (telephone)	Operations Officer	Redwood Quality Management Company
Danielle Lower	Operations Manager	Redwood Community Services
David Delgado	Clinician, LCSW	Mendocino County Youth Project
Deborah Lovett	Senior Program Manager	Family & Children's Services
Heather Fine	Executive Director	Tapestry Family Services
Iris Padgett	Clinician, MFTI	Manzanita Services
Jackie Mullis-Echeverin	Clinician, MFTI	Manzanita Services
Jena Conner	Deputy Director	Family & Children's Services
Jenine Miller	Director, Behavioral Health	Behavioral Health & Recovery Services
Karen Lovato	Acting Deputy Director/ Program Manager	Behavioral Health & Recovery Services
Katherine White	Clinical Supervisor	Mendocino County Hospitality Center
Libby Guthrie	Executive Director	MCAVHN
Lisa Larumer Burtis	Clinical Supervisor	Behavioral Health & Recovery Services
Lois LaDelle-Daly	QA/Compliance	Redwood Quality Management Company
Mary Alice Willeford	Acting Administrative Service Manager	Behavioral Health & Recovery Services
Mary Anna Ashurst	Clinical Supervisor	Manzanita Services
Mary Yovino	POA Administrator	Redwood Quality Management Company
Michael Dodge	Department Analyst	Behavioral Health & Recovery Services
Mimine Ambrois	Clinical Director	Mendocino County Youth Project
Nicole Johns	Clinical Director	Tapestry Family Services
Patricia Messer	Mental Health Clinician I	Behavioral Health & Recovery Services
Richard Muenzer	Clinical Supervisor	Redwood Community Services
Sarah Shems	Clinician, MFTI	Redwood Community Services
Sarah Walsh	Contract/Data Analyst	Redwood Quality Management Company
Scott Abbott	Compliance Manager	Behavioral Health & Recovery Services
Susan "Wynd" Novotny	Executive Director	Manzanita Services
Terri Rathbun	Clinician, LMFT	Mendocino County Youth Project

Name	Position	Agency
Tim Schraeder	Chief Executive Officer	Redwood Quality Management Company
Venus Hoaglen	Staff Service Administrator	Behavioral Health & Recovery Services
Zoy Kazan	Clinical Supervisor	Redwood Community Services

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands.

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

Table C1 - CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary					
Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	\$533,318,886	\$4,060
Small	93,417	6,478	6.93%	\$21,306,066	\$3,289
Mendocino	6,936	341	4.92%	\$2,052,681	\$6,020

Table C2 shows the distribution of the MHP CY15 Distribution of Beneficiaries by Approved Claims per Beneficiary (ACB) Range for the various categories; under \$20,000; \$20,000 to \$30,000, and those above \$30,000.

Table C2 - Mendocino MHP CY15 Distribution of Beneficiaries by ACB Range								
Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
\$0K - \$20K	1,472	90.75%	94.46%	\$5,619,886	\$3,818	\$3,553	52.27%	61.20%
>\$20K - \$30K	79	4.87%	2.67%	\$1,956,227	\$24,762	\$24,306	18.19%	11.85%
>\$30K	71	4.38%	2.86%	\$3,175,757	\$44,729	\$51,635	29.54%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL



PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Mendocino County <input checked="" type="checkbox"/> Clinical PIP <input type="checkbox"/> Non-Clinical PIP	
PIP Title: ANSA Assessment Improvement Tool	
Start Date (MM/DD/YY): 07/01/2015 Completion Date (MM/DD/YY): 08/12/2016 Projected Study Period (#of Months): Completed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date(s) of On-Site Review (MM/DD/YY): 09/13/2016 Name of Reviewer: Ewurama Shaw - Taylor	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started)
	<input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
<input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP	
Brief Description of PIP (including goal and what PIP is attempting to accomplish): <p>This PIP is about utilization of ANSA to inform treatment and improve client outcomes. The goal of the PIP was to improve ANSA score. The premise is that if clinicians routinely review ANSA scores, as well as urgent needs and treatment progress with clients, then they will be “treating to target” and clients will have improved outcomes and functioning. In order to facilitate ready access to ANSA scores, the MHP developed an electronic health record (EHR)-based ANSA Data report that lists client’s initial and most recent ANSA scores, by clinician. Clinicians (and supervisors) then reviewed the report monthly to determine client progress. Additionally, to facilitate verification of ANSA review, the MHP created a new progress note in their EHR that ascertains if the ANSA review was conducted.</p>	



ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP is about clinician-consumer utilization and review of the ANSA. Yet, the PIP team did not include either of these two key stakeholders. Clinicians (line staff) or consumers were only involved in applying the intervention. Otherwise, the PIP team consisted primarily of management-level staff of the MHP and the ASO.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP was designed to improve data collection of ANSA to then facilitate its use as a regular part of clinical practice. The PIP was part of a larger endeavor to facilitate utilization of Level of Outcome tools systemically. That said, the PIP team did not actually audit or review records to determine if clinicians were already in the practice of reviewing ANSA and documenting it in their notes. There was no data to support the claim that clinicians “were not regularly reviewing the ANSA sub scores, urgent needs or progress in treatment”.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP has the potential to address at least four aspects of enrollee care and services. The PIP addressed consumer outcomes via ANSA score and quality of care via response/feedback on the ANSA review. The PIP did not adequately address client engagement, which was purported to be a benefit of the ANSA review. The PIP also did not address adequately the impact on/for consumers who were identified as having or needing “higher level concern/services”.



<p>1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?</p> <p><i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP was meant to include adults (≥ 18 years). Due to departure of some PIP team members/service providers and access to their consumers, the sample was limited to adults aged 18-24 years.</p> <p>N.B. the PIP Implementation & Submission Tool did not indicate the age range of the study group. But it was confirmed during the onsite discussion that the study group was also between 18-24 years of age. Other demographic information of the participants were not provided/indicated.</p>
Totals		<p>0 Met 1 Partially Met 3 Not Met 0 UTD</p>



STEP 2: Review the Study Question(s)									
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> Can we improve the quality of care and get improved client outcomes by having clinicians use the ANSA ‘sub score’ and ‘urgent needs’ score to inform treatment?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP clearly stated the study question. The question has two parts (1) improving the quality of care and (2) improving client outcomes. The MHP can objectively measure (or assess) outcomes through a change in ANSA score. The MHP did not explicitly state/indicate their measure for quality of care. They incorporated a consumer satisfaction survey, which can function as a proxy for quality of care.</p>							
Totals		1	Met	0	Partially Met	0	Not Met	0	UTD
STEP 3: Review the Identified Study Population									
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other </p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study question is relevant to all adult Medi-Cal enrollees. There was an attempt to include all adults in the study, but access to adults 25 was precluded with the departure of some of the PIP team members/service providers.</p>							
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: Text if checked </p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The data collection approach had the potential to capture all enrollees, albeit the study participants were then limited to 18-24 year olds.</p>							
Totals		0	Met	2	Partially Met	1	Not Met	0	UTD



STEP 4: Review Selected Study Indicators

<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p>List indicators:</p> <ol style="list-style-type: none"> Improved functioning: # participants with increase ANSA/total participants Clinician review of ANSA: # participants who participated in ANSA reviews/total participants Client satisfaction: # responses 'Helpful'/total number of reviews 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study has three indicators. All are ostensibly measurable and objective. However, with the exception of the first indicator, indicator 2 and 3 do not actually <i>indicate</i> or relate to the variables in question. The selected numerator and denominators do not fit with what is being measured. To “monitor” ANSA review (2), the measure should have been the # of times the clinician conducted the ANSA review/# of times that clinician met with their client. To determine consumer satisfaction (3), the measure should have been the # of <u>clients</u> who rated it beneficial/the # of clients in the study group (i.e., 28).</p>
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<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input checked="" type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The only indicator of <i>change</i> in status is the first indicator, the ANSA score (the initial vs. the one conducted during the project).</p> <p>The long-term outcome for this project is to expand usage of this ANSA review progress note template to (all) other clinicians and providers.</p>
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Totals	0	Met	2	Partially Met	0	Not Met	0	UTD
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STEP 5: Review Sampling Methods

<p>5.1 Did the sampling technique consider and specify the:</p> <ol style="list-style-type: none"> True (or estimated) frequency of occurrence of the event? Confidence interval to be used? Margin of error that will be acceptable? 	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team did not estimate the frequency of review of ANSA prior to the development of this PIP. They speculated that “clinicians did not regularly review ANSA sub scores...with clients.</p> <p>The PIP team did not measure the true frequency of ANSA review after the intervention. Rather, they measured the use of the check box indicating review. And, as they stated themselves, it is possible for clinicians to do the review and “forget to document the review”. So, the check box is not a true measure of frequency of review.</p> <p>Confidence intervals and margins of error were not included.</p>
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<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> Sampling methodology was not indicated.</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Unable to Determine	<p>The sampling technique was neither documented nor discussed onsite. Concerns regarding sampling were focused on whether the control and study groups were appropriately matched and why the study was limited to only 18-24 year olds.</p>
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Unable to Determine	<p>The PIP team unnecessarily reduced their study sample (to 28 from 46) by basing their measure on clients who participated in reviews rather than on the number of <i>clinicians</i> who were trained to do the reviews.</p>
Totals		<p>0 Met 0 Partially Met 1 Not Met 2 UTD</p>



STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The sources of data were the ANSA and the consumer perception of the ANSA review.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider</p> <p><input checked="" type="checkbox"/> Other: ANSA assessment tool and consumer perception survey</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Yes. Same as above.</p>
<p>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?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The method for collecting the second ANSA was not articulated—only that the ANSA took place sometime during the six-month study period. The PIP team did not articulate how/if they controlled for variability in the timing of the ANSA, that is if it was completed at the beginning of the study versus at the end of the study, when both the clinician and consumer have had months of benefiting from the ANSA review. The PIP team did not provide a clear and convincing explanation for why the initial ANSA was used as a comparison (i.e., baseline) rather than the most recent ANSA. If consumers complete an ANSA every 6 months, then there was a ready comparison of ANSA just prior to the intervention and ANSA after the intervention. Going back many months (or perhaps years) for a baseline measure introduces other factors into the study (e.g., time in treatment, different clinicians) for which the PIP team does not control.</p> <p>The method for collecting the survey has the potential for response bias of consumers. By being asked immediately (and repeatedly) after the clinical session by the very clinician who conducted the review if the review was helpful puts pressure on consumers to answer affirmatively.</p>



<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input checked="" type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input checked="" type="checkbox"/> Level of Care tools, ANSA</p> <p><input type="checkbox"/> Other: Text if checked</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP team used the ANSA and the consumer survey to collect data. These instruments have the potential to provide consistent and accurate data; however, the PIP team does not address variability inherent in their collection methods. The team does not address clinician variability in the use of ANSA assessment. That each clinician at some point (in the past) scored ≥ 70 suggests a wide range of proficiency in ANSA administration. As stated above, the repeated questioning about helpfulness of the review by the very clinician conducting the review introduces consumer bias in response.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The data analysis presented is a restatement of the study indicators and restatement of the data collection sections.</p> <p>A key part of the study rests on “regular review” of ANSA. The PIP team neither provided a definition of “regular” nor an objective measure of “regular”. In effect, the very intervention that was implemented was not assessed. The PIP team also did not analyze the effect of more frequent reviews. There is also no actual analysis of the content of the review, only whether the clinician indicates (or checks) that the review was conducted. Just as it is possible for a clinician to do the review and “forget to document the review” (see 5.1), it may also be possible for the clinician to check the box and not do a review.</p> <p>In effect, the PIP focuses on the use of the check box. So, when the check box was not used or was not operational in the EHR, the PIP team opted to eliminate those reviews and <i>participants</i> from the study. Rather, the PIP team could have implemented an alternate verification process, auditing or reviewing the actual clinical notes. The PIP team was not adequately prepared to address untoward events and implement appropriate contingencies.</p>



<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Dan Anderson Title: Chief Operating Officer, RQMC Role: Project Lead <i>Other team members:</i> Names: Text</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection was automated through the EHR and the production of the ANSA review reports. The survey was also part of the EHR and linked to the ANSA review template.</p> <p>The data collection process would have benefitted from input from either a clinician or a clinical supervisor. Their input would have helped address issues such as response bias, variability in frequency of ANSA review, and documentation of ANSA review.</p>
Totals		2 Met 2 Partially Met 2 Not Met 0 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> The PIP team listed 13 items as interventions. Of these 13, only three were actual interventions: 6. Provide higher level of services for clients who score 3 or above on certain items 7. Conduct supervisor and clinician review of ANSA sub scores 9. Use of the new progress note, which includes notation about ANSA review and client satisfaction question</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team conducted a cursory analysis of the findings. The intent of the analyses seem more to substantiate their hypothesis (i.e., ANSA review improves consumer functioning), rather than to examine the findings and their implications. Had the PIP team conducted a more rigorous analyses, they would have recognized the need to change the study sample (from 46 to 28) and accordingly those who benefitted from the intervention would have been changed from 35 to some other number ≤ 28. So, the proportion that benefitted from the intervention was not 76%. With a more thorough analysis, the PIP team could have looked more closely at the cases/participants who did not improve after the intervention and determine why.</p> <p>Of the three interventions (6, 7, and 9) that were actionable, only intervention 9 had corresponding monitoring and data collection.</p> <p>There were missed opportunities for analysis of the underlying issue, the project itself, and the findings. As a consequence there were also missed opportunities to address causes/barriers or to implement alternate solutions.</p>
Totals		0 Met 0 Partially Met 1 Not Met 0 NA 0 UTD



STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>As above, there was only a cursory analysis of the findings and there was analysis plan (see 6.5)</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Based on the information that the PIP team provided, especially regarding who had the intervention, it does not appear that the results are accurately presented. See 7.1.</p>



<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: <u>Undetermined</u></p> <p>Indicate the statistical analysis used: <u>Not indicated</u></p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>See previous comments for 6.4, 6.5, and 7.1, which address repeated measures and threats to validity.</p> <p>The time period for measurement is variable. The PIP team chose to use the initial ANSA as baseline rather than the most recent which would only go back six months.</p> <p>The PIP team presented a p values of 0.03. However, the analysis was conducted with an incorrect number of participants. An accurate analysis of difference between the control group and study was not provided.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> "...[60%] of the study group clients reviewed the ANSA sub score and/or progress in treatment..." "It is curious as to why clinicians did not provide the review for all [of] their study group clients." "The statistical evidence has been based on relatively small samples." <i>Conclusions regarding the success of the interpretation: None</i> <i>Recommendations for follow-up: None</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP included an interpretation of the success of the PIP; the team believes that they succeeded in improving outcomes for participants.</p> <p>There was an attempt to acknowledge some of the limitations and missed opportunities for controlling variability. But, instead of addressing the underlying issues, the PIP team reframed the limitations and put positive perspective on the issues. For example, that 60% in the study group received the intervention is presented as a positive outcome, because this was greater than the 50% goal. By definition, 100% of those in a study group receives the intervention.</p> <p>The team does not provide recommendations per se for follow-up. The PIP team presented their plans to expand the use of the template and corresponding review protocol with other clinicians.</p>
Totals		0 Met 1 Partially Met 3 Not Met 0 NA 0 UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The primary measurement was the ANSA score. The project compares ANSA scores for a control group versus a study group. The interval for ANSA scoring was variable as the initial ANSA score was used, not the most recent.</p>



<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The results were based on the total sample, all of whom did not receive the intervention. Re-analysis, of the results, using outcomes for only those who received the intervention, was warranted in order to determine actual improvement.</p>
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input checked="" type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>It is difficult to state conclusively if the improvements were due to the intervention because 1) the conclusions were not based on the correct study sample and 2) the control group also showed considerable improvement in ANSA score, at 66%.</p>
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input checked="" type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>While the results of statistical analyses are presented, it cannot be concluded that the improvement is based on true improvement. To bolster ‘real’ improvement, the MHP might have considered actual chart review/audit to determine if there is actual correlation between use of the check box and the review of ANSA, and similarly if review was conducted, despite use of the check box.</p>
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Repeated measures were not part of this study. The only repeated measure was for consumer perception/satisfaction, for which the PIP team did not present results for repeated, successive measures.</p>
Totals		<p>1 Met 0 Partially Met 1 Not Met 1 NA 2 UTD</p>



ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

Conclusions:
Text

Recommendations:
Text

Check one:

<input type="checkbox"/> High confidence in reported Plan PIP results	<input type="checkbox"/> Low confidence in reported Plan PIP results
<input type="checkbox"/> Confidence in reported Plan PIP results	<input type="checkbox"/> Reported Plan PIP results not credible
<input type="checkbox"/> Confidence in PIP results cannot be determined at this time	



PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION	
MHP: Mendocino County <input type="checkbox"/> Clinical PIP <input checked="" type="checkbox"/> Non-Clinical PIP	
PIP Title: Latino Access	
Start Date (MM/DD/YY): 03/01/2016	Status of PIP (Only Active and ongoing, and completed PIPs are rated): Rated <input type="checkbox"/> Active and ongoing (baseline established and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR) Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only. <input checked="" type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP
Completion Date (MM/DD/YY): in progress	
Projected Study Period (# of Months): 6 months	
Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Date(s) of On-Site Review (MM/DD/YY): 09/13/2016	
Name of Reviewer: Ewurama Shaw - Taylor	
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The purpose of this PIP is to increase access to Mental Health and specialty Mental Health Services for Latinos in Mendocino County. The MHP recognizes low penetration rates for Latinos in their communities. In its present state, this project is not a PIP. It is more of an exploratory project to then develop a PIP. The key elements of a PIP are not in place, including a measurable study question, data collection methods, identification of the study sample, and others. The MHP should intensely focus its effort on identifying barriers germane to their program and population and then develop the PIP.	



ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team includes participation by the MHP, ASO, and other community partners. The community partners are linked to the Latino community. The representatives of the community partners were Latino, bi-cultural, and bi-lingual.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team referred to data from EQRO, county demographic data, MHSA data, and cultural competency committee to determine their penetration within/access to Latinos, at 2.7%. They set 2.11% as their benchmark for Latino penetration, based on penetration report in their cultural competency plan.
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input checked="" type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP has the potential to address a broad spectrum of aspects of care and services in the Latino community. Once, the PIP team can glean the various barriers to access, they can begin to address them.
1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP is focused on improving access for Latinos. Within this population of potential consumers, the PIP does not exclude participants or enrollees.
Totals		4 Met 0 Partially Met 0 Not Met 0 UTD



STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> Can Mendocino County Behavioral Health & Recovery Services identify and begin to address barriers to Latinos accessing services as evidenced by low penetration rates?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study question was stated clearly, but it is not measurable. The response to the question would be either 'Yes' or 'No'. An alternate question might be: Will addressing barrier to Latino access in Mendocino County BHRS increase the Hispanic penetration rate?</p> <p>The MHP is cautioned to use the same data source for measuring penetration rate at the beginning and end of the study. If the MHP calculates their own penetration rate, this may be a more reliable (and available) measure than an EQRO penetration rate which is only provided annually and is retrospective.</p>
Totals		0 Met 0 Partially Met 1 Not Met 0 UTD
STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>The PIP is meant to increase access for Medi-Cal eligibles and enrollees. The team's plan is to target events and activities where Latinos attend.</p>
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>The PIP team is still in the process of data collection, related to identifying barriers. At present, the PIP team has 43 survey responses related to barriers. The team should determine the minim number of survey responses needed in order to make general claims about the Latino population in the community or county.</p>
Totals		0 Met 0 Partially Met 0 Not Met 2 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>



<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status</p> <p><input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The PIP team is not at this stage of the study.</p>
Totals		<p>0 Met 0 Partially Met 0 Not Met 2 UTD</p>
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>At present, the PIP team needs to collect more surveys to determine potential barriers. The stated goal for this sampling is that 50% be completed by Latinos. If the PIP is meant to survey Latinos, 100% of the surveys should be completed by Latinos. The goal of 50% seems arbitrary, ineffective, and somewhat short-sighted. Rather the goal for the survey should be some number of surveys (necessarily completed by Latinos) that is representative of the Latinos in the community/county.</p> <p>Using their only example of sampling, the PIP team is not on track to achieve true and representative sampling.</p>
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p> <p>Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The PIP team is not at this stage of the study.</p>



<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame</p> <p>_____ N of sample</p> <p>_____ N of participants (i.e. – return rate)</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input checked="" type="checkbox"/> Unable to Determine</p>	<p>The PIP team is not at this stage of the study.</p>
Totals		<p>0 Met 0 Partially Met 1 Not Met 2 UTD</p>



STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team has yet to design the study. They have some preliminary data on potential barriers but not enough to develop interventions around. The PIP team has not laid out plans for other data collection or implementation, based on the information that they currently have.
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i> <input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input type="checkbox"/> Other: Text if checked	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team is not at this stage of the study.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team is not at this stage of the study.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other: Text if checked	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team is not at this stage of the study.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The PIP team is not at this stage of the study.



<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Barbie Svendsen Title: Program Administrator Role: Project Leader <i>Other team members:</i> Names: See Team Members</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP team indicated that they had numerous challenges in obtaining surveys from Latino consumers. One deficit was not having Spanish-speaking surveyors at events where many mono-lingual Latinos would be present. Apparently one surveyor was informed “We see you there and we walk the other way. We will never fill out your survey”. This statement points to the PIP not having the qualified staff and personnel to collect the relevant data at the time.</p>
Totals		0 Met 0 Partially Met 1 Not Met 5 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>
Totals		0 Met 0 Partially Met 0 Not Met 0 NA 1 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is “Not Met” if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>



<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> Text</p> <p><i>Conclusions regarding the success of the interpretation:</i> Text</p> <p><i>Recommendations for follow-up:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>
Totals		<p>0 Met 0 Partially Met 0 Not Met 4 NA 0 UTD</p>
STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The PIP team is not at this stage of the study.</p>



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



ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

Conclusions:
Text

Recommendations:
Text

- Check one:
- High confidence in reported Plan PIP results
 - Confidence in reported Plan PIP results
 - Confidence in PIP results cannot be determined at this time
 - Low confidence in reported Plan PIP results
 - Reported Plan PIP results not credible