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

info@bhceqro.com
www.caleqro.com

FY 17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

MENDOCINO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 12-13, 2017

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

MENDOCINO MHP SUMMARY OF FINDINGS

Beneficiaries served in CY16 — 1,827

MHP Threshold Language — Spanish

MHP Size — Small

MHP Region — Superior

MHP Location — Ukiah

MHP County Seat — Ukiah

Introduction

Mendocino County is located on the north coast of California. The county seat is located in the city of Ukiah. It is located north of the San Francisco Bay Area and west of the Central Valley.

The county is noted for its distinctive Pacific Ocean coastline, Redwood forests, and massive vineyards over rolling hills. Tourism is the primary industry due to its location. The average number of the Medi-Cal eligible population in calendar year (CY) 2016 was 42,187 serving an average of 1,827 eligibles and an estimated overall county population of 87,650.

The mission statement of Mendocino County's mental health plan is to deliver services in the least restrictive, most accessible environment within a coordinated system of care that is respectful of family, language, heritage and culture.

During the fiscal year (FY) 2017-2018 review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The MHP expanded access with the concept of the "no wrong door" approach. Prior to this, the MHP used the central access line for all beneficiaries to initiate service. Now, all clinic sites are equipped to schedule an intake assessment for a beneficiary who may call-in or walk-in.

The MHP continued the transition of adult services, to beneficiaries aged 25 and older, to Redwood Quality Management Company (RQMC) that has been their Administrative Service Organization (ASO) for the children's system of care. RQMC has contracts with several other agencies to deliver mental health services. Currently, RQMC provides most of the MHP's services to beneficiaries; this arrangement is considered unique among MHPs. The MHP assumed service delivery for the adult medications support services.

Timeliness

The MHP has strived to consistently track and monitor its timeliness metrics. This fiscal year, the MHP has established standards in line with best practices. This will require the MHP to adjust for improvements as it monitors to a higher standard through the year.

Quality

Given the unique position with the ASO mentioned above, the MHP has fully embraced its partners in all service delivery endeavors. The ASO and its contract providers attend all meetings structured to meet the mental health needs of the community.

Outcomes

RQMC's contract providers use both the Child and Adolescent Needs and Strengths (CANS) tool and the Adult Needs and Strengths Assessment (ANSA) tool to monitor consumer progress. Trending reports are reviewed in committees for treatment transitions if indicated. RQMC's contract providers maintain services for all consumers for a minimum of sixty days following any initial session to ensure consumer stability prior to closure of a chart.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care 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 State Medicaid 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 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year 2017-2018 (FY17-18) findings of an EQR 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:

Validation of Performance Measures[1]

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

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;

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

- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

Each MHP is required to conduct two performance improvement projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO 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 a review of the MHP's reporting systems and methodologies for calculating PMs.

Validation of State and County Consumer Satisfaction Surveys

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

---

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

[3] 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.

[4] 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.

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, Valero and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY16-17

Recommendation #1: 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.

Status: **Met**

- The MHP tracked access and timeliness to psychiatry in both adult and children's services throughout FY16-17. The results were reviewed in the Quality Improvement/Quality Management Committee meetings.
- The MHP standard was 30 days. Overall, the average length of time from first request for services to first psychiatric appointment was 23 days. The percent of appointments that met the standard was 77%.

- For adults, the average length of time from first request for services to first psychiatric appointment was 12 days. The percent of appointments that met the standard was 87%.
- For youth, the average length of time from first request for services to first psychiatric appointment was 33 days. The percent of appointments that met the standard was 66%.
- The children's system of care has found it difficult to find qualified providers to meet the increased caseloads. The psychiatrist was only available one day a week until February 2017, after which the doctor added extra days to meet the additional demand for psychiatry appointments. In May 2017, a physician assistant was hired part-time.
- The MHP reported adult services wait times meeting its standard of 30 days or far below it. The MHP indicated that going forward, for FY17-18, it has revised the standard to 15 days to first psychiatric appointment for both adults and children. The MHP also plans to track the length of time between determination of need for psychiatric evaluation to first psychiatric appointment offered. The MHP has plans underway to hire medical extenders such as a nurse practitioner.
- The new standards align with best practice and will require the MHP to continue to conduct activities to meet the higher standard for timeliness, especially for children's services. Since the MHP provided its data collection for the 30-day standard, and implemented few improvements as recommended, time to psychiatry will benefit from increased monitoring and subsequent activities to reduce wait times.

Recommendation #2: Include line and/or supervisory staff as standing members in programmatic committees, with evidence of regular attendance by these staff members.

Status: **Met**

- The MHP policy is to extend an invitation to the entire behavioral health system of care to attend committee meetings and includes line staff as well as supervisory staff. Attendance is evidenced by sign-in sheets at meetings.
- The MHP and its contracted providers include line staff in the following programmatic committee meetings: Quality Improvement Committee, Mental Health Service Act Forums, Cultural Diversity Committee, and Quality Improvement/Quality Management Meetings.
- The ASO, the oversight agency for most of the services delivered, conducts a monthly multi-agency coalition meeting with line staff and conducts meetings

with its partner agencies such as child welfare services (CWS) and law enforcement. Twice monthly, both the adult and children's system of care staff conduct meetings. Attendance at meetings are documented with sign-in sheets and minutes.

- The rural and mountainous nature of the geography of the county impacts travel and can take from one to two hours to reach a destination. The committees rotate meetings throughout the county to allow more stakeholder involvement and provider participation and, typically, the attendees are those working in that location.
- To increase broader stakeholder attendance, the MHP has introduced a video-conferencing system to reduce travel time.

Recommendation #3: Track occurrence/frequency of crisis contacts that result in detention and examine crisis protocols and the parameters for contacting law enforcement.

Status: **Met**

- The contract agency for the MHP tracked the frequency of crisis contacts that resulted in detentions. There were no reported crisis contacts that resulted in an individual being detained by law enforcement from crisis services. There were three incidents where an individual placed on a psychiatric hold status was arrested for committing a crime at the emergency room hospital while awaiting placement.
- Crisis protocols and parameters for contacting law enforcement were reviewed. Crisis service staff contacts law enforcement when there is a need for a welfare check. They also contact law enforcement if an individual is threatening violence or becomes violent with an on-site worker.
- The MHP expanded mobile outreach and prevention services in partnership with the Mendocino County sheriff's office using a team response. The MHP engaged the sheriff's office in meetings focused on collaborative strategies to address mutual concerns resulting in enhanced working partnerships.
- The ASO leadership, the crisis services manager, and law enforcement staff meet monthly, **are in the process of finalizing** a Memorandum of Understanding (MOU), and eliminated many cultural barriers with collaborative efforts. This has led to increased relationships built on mutual trust.
- While the MHP has made obvious strides in creating these partnerships, some consumers perceive that law enforcement may continue to disrespect and

stigmatize them. This may apply to a smaller cohort of consumers, yet it may be worth exploring with consumer focus groups.

Recommendation #4: Complete Medicare Part B certification process in order to submit claims.

Status: **Met**

- The MHP and the ASO were both certified for Medicare Part B billing during the reporting period.
- The MHP notes that while overall claims volumes for Medicare Part B are a small fraction of total claim lines processed, the revenue has exceeded initial expectations.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- The MHP expanded access with an open door philosophy that allows consumers to request initial service at all clinics, eliminating the need to call into the central access line.
- The MHP implemented MOUs with community partners to enhance working relationships with hospitals, courts, substance use disorders (SUD) services, and Federally Qualified Health Clinics (FQHCs) for collaborative care and is in the process with law enforcement.

Timeliness of Services

- The MHP consistently tracked its timeliness metrics and adapted new standards for timeliness aligned with best practices. The standard for the initial psychiatry evaluation is now set at 15 days, improved from the prior standard of 30 days.

Quality of Care

- The MHP successfully transitioned the adult services under RQMC, consisting of approximately 400 consumers, to new providers.
- Funds have been awarded for a local housing project to increase permanent housing. The project includes plans for 26 single-room occupancy units, 11 one-bedroom apartments, and one three-bedroom manager's apartment.

Consumer Outcomes

- The MHP purchased property for a crisis residential treatment center to expand the continuum of care in this rural area.
- The funding recently awarded for the Round Valley Innovation Project from the Mental Health Services Oversight and Accountability Commission will provide services in remote regions to consumers.

PERFORMANCE MEASUREMENT

As noted above, 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 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 LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Mendocino MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	22,455	53.2%	1,162	63.6%
Latino/Hispanic	12,483	29.6%	338	18.5%
African-American	413	1.0%	30	1.6%
Asian/Pacific Islander	869	2.1%	16	0.9%
Native American	2,405	5.7%	114	6.2%
Other	3,564	8.4%	167	9.1%
Total	**42,187**	**100%**	**1,827**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

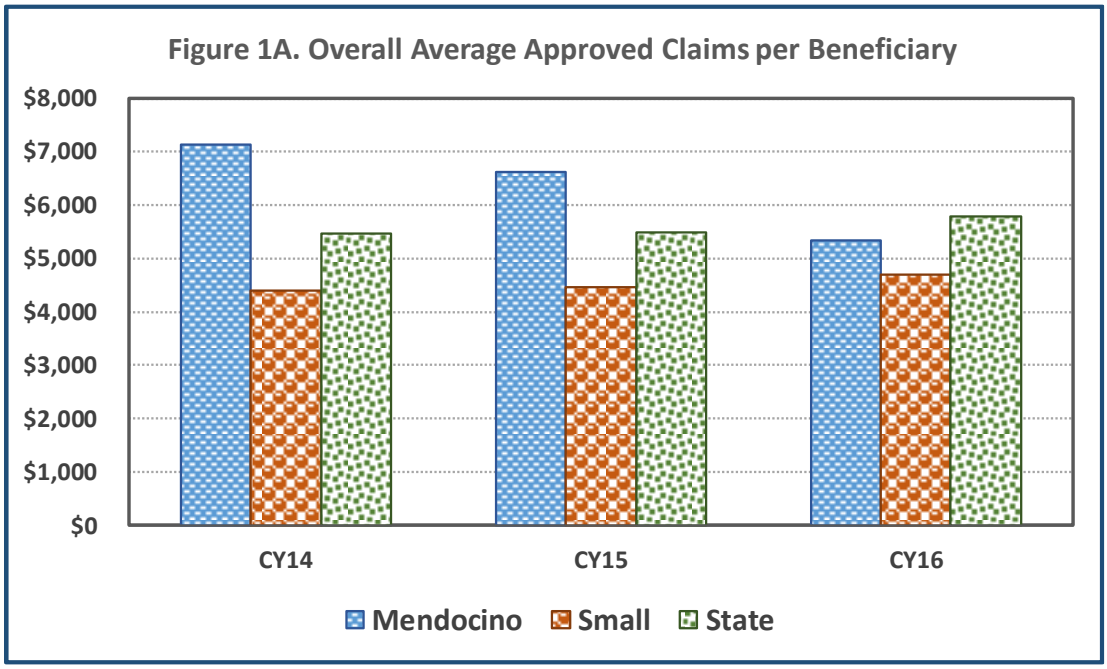
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

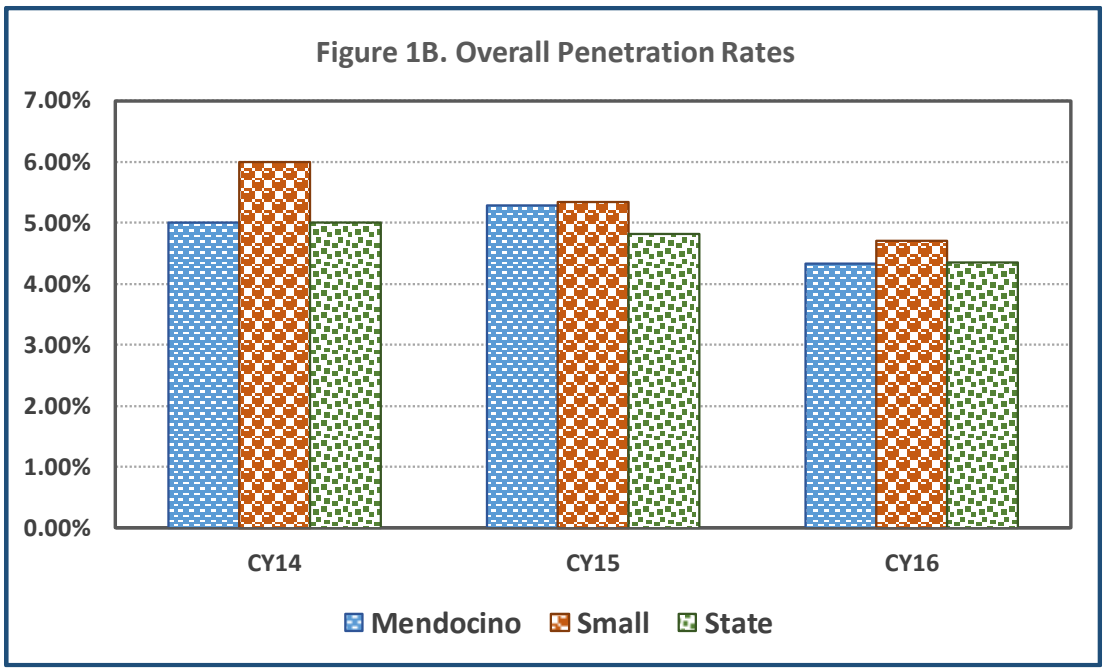
Penetration Rates and Approved Claim Dollars per Beneficiary

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.

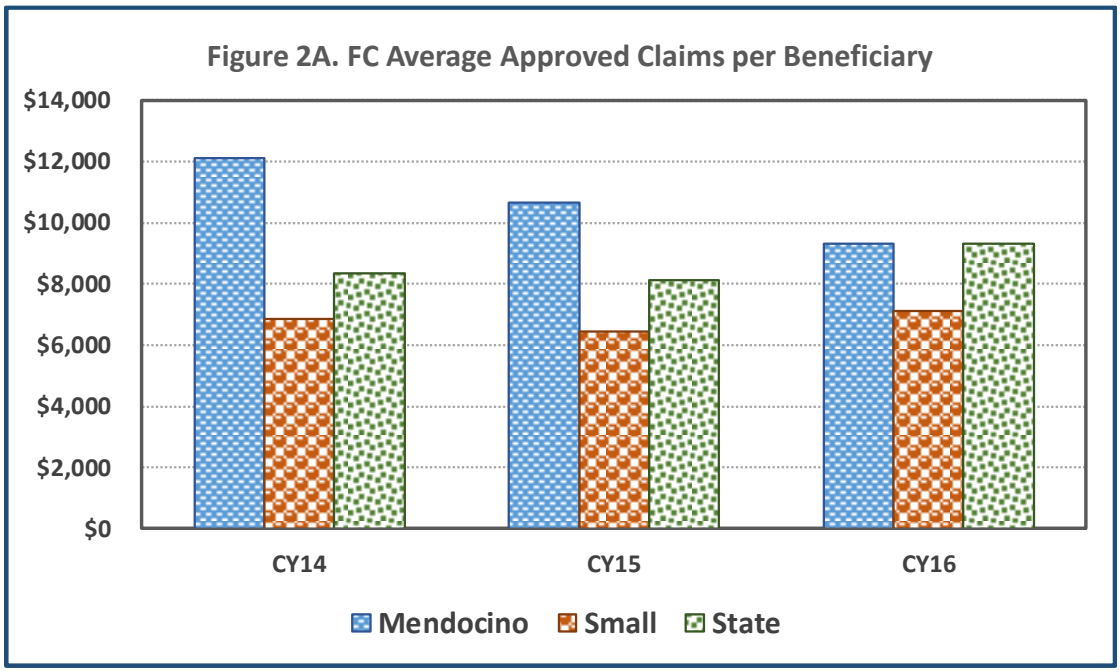
Regarding calculation of penetration rates, the Mendocino MHP uses a different method.

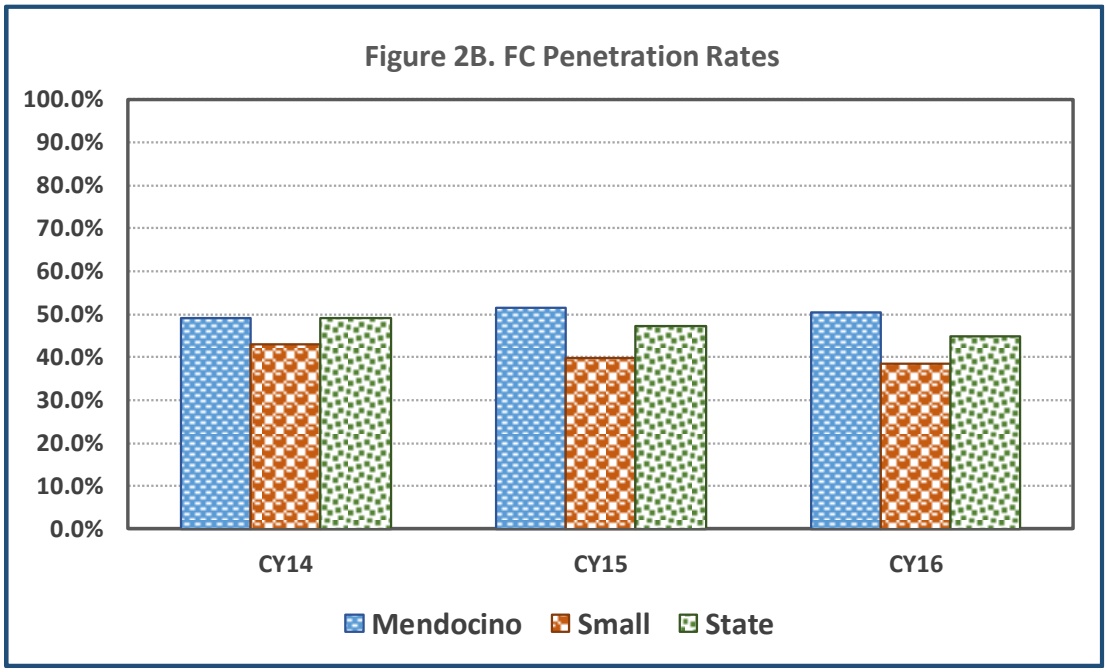
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.



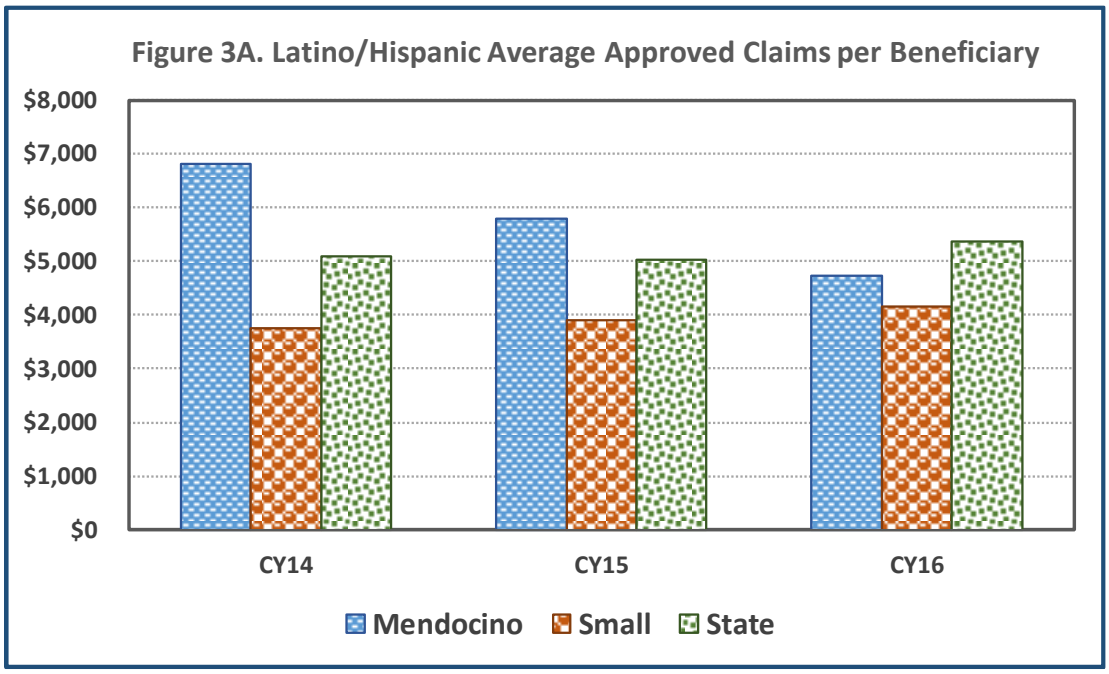


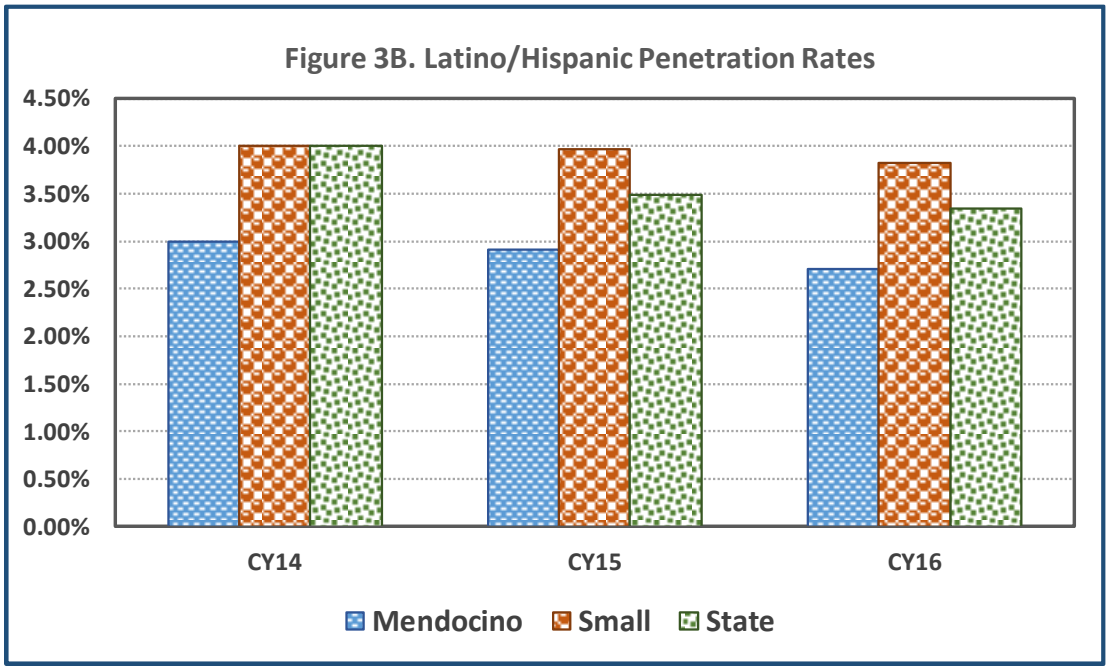
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/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 (HCBs) for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

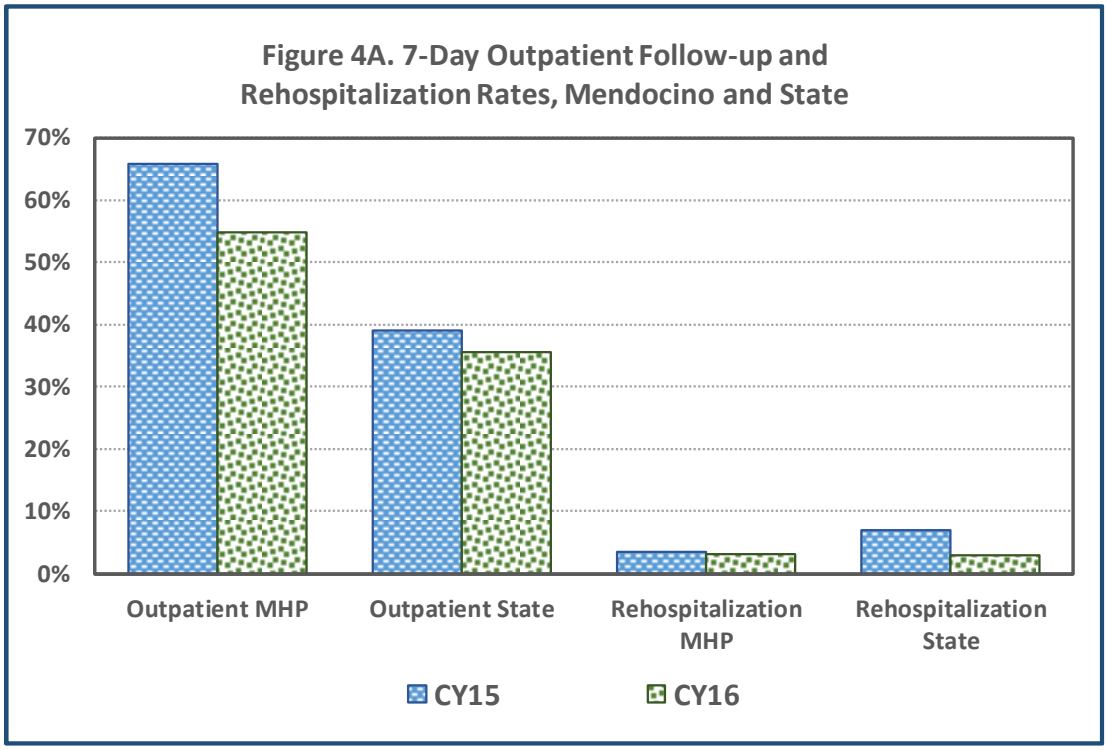
Table 2: Mendocino MHP High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	18,909	598,296	3.16%	$53,219	$1,006,318,438	29.02%
Mendocino	CY16	42	1,827	2.30%	$46,837	$1,967,173	20.15%
	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%

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

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.



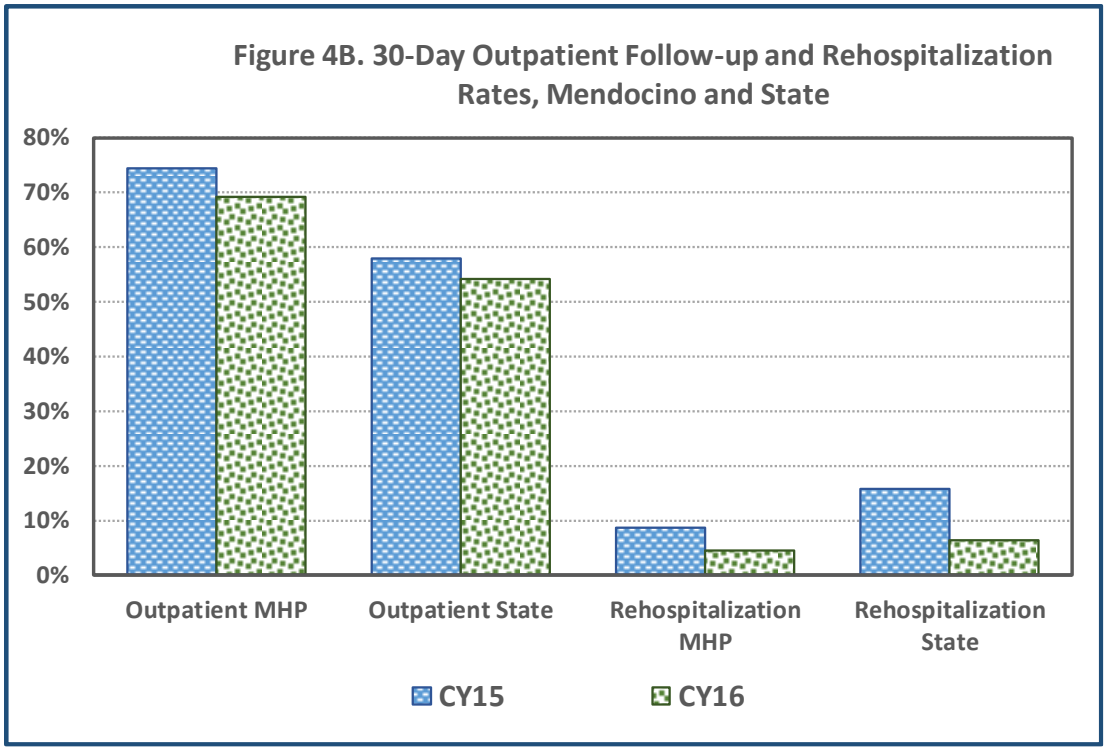
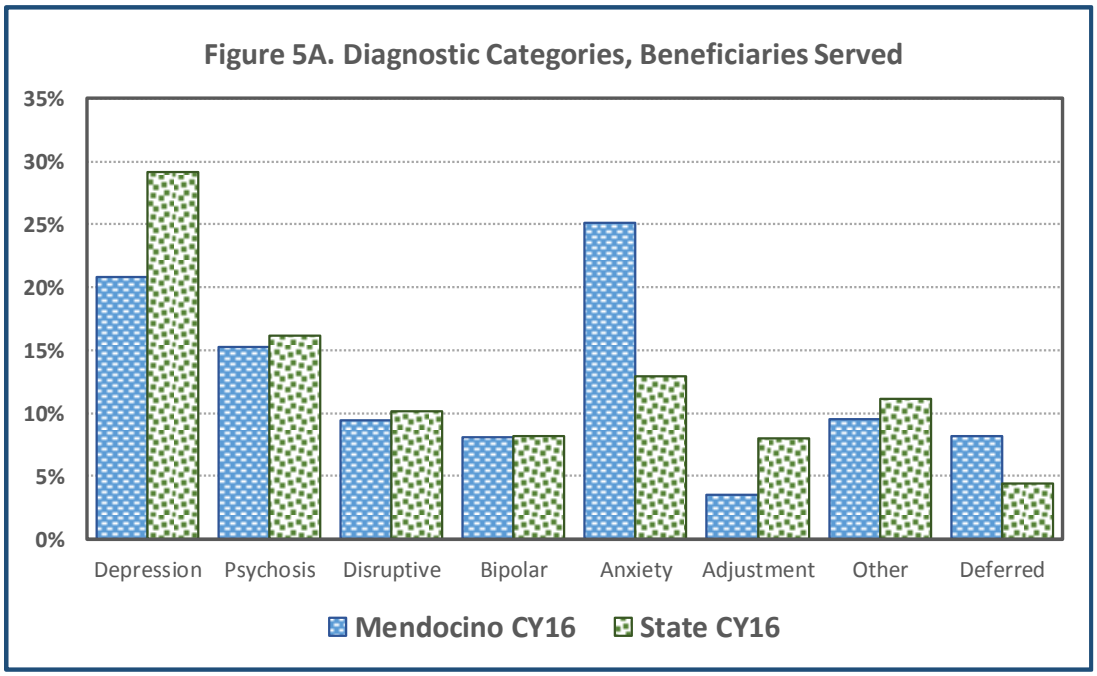


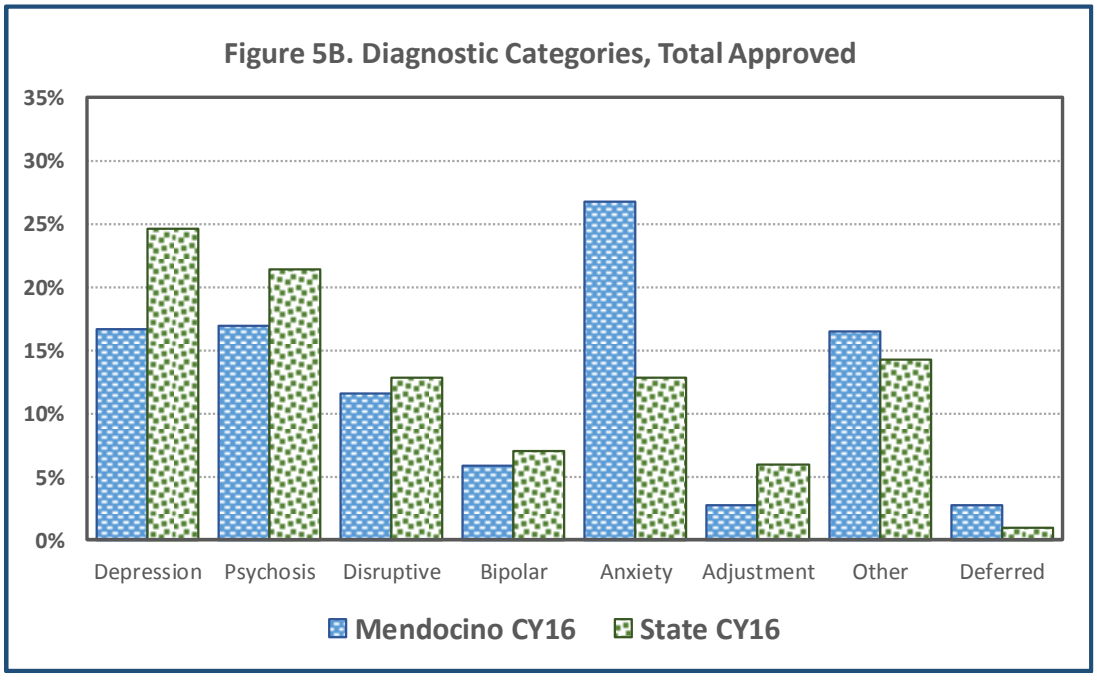
Figure 4B. 30-Day Outpatient Follow-up and Rehospitalization Rates, Mendocino and State
80%
70%
60%
50%
40%
30%
20%
10%
0%
Outpatient MHP
Outpatient State
Rehospitalization MHP
Rehospitalization State
CY15
CY16

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 CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 22.79%.





Performance Measures Findings—Impact and Implications

Access to Care

- The number of eligibles, including the Affordable Care Act (ACA) beneficiaries, rose slightly from CY15 to CY16 while the number of beneficiaries served decreased from CY15 to CY16.
- The number of eligible foster care beneficiaries rose slightly from CY15 to CY16 and the number of foster care beneficiaries served rose minimally from CY15 to CY16.
- Both, the number of eligible Latino/Hispanic beneficiaries and the number of Latino/Hispanic beneficiaries served rose from CY15 to CY16.

Timeliness of Services

- The MHP's 7-day and 30-day follow-up rates are higher than the statewide averages.

Quality of Care

- The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are both lower than statewide.
- The MHP has a much higher percentage of anxiety and deferred diagnoses than statewide and a much lower percentage of depression and adjustment diagnoses than statewide.

Consumer Outcomes

- The MHP experienced higher 7-day and lower 30-day psychiatric rehospitalization rates in CY16 compared to CY15.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (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.

Mendocino MHP PIPs Identified for Validation

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

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Mendocino MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Diagnosis and Treatment of Co-Occurring Disorders (COD)
Non-clinical PIP	1	Improving No-show Rates for Medication Support Services

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

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

Table 4: PIP Validation Review					
Step		**PIP Section**	**Validation Item**	**Item Rating**	
				Clinical	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	M
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	M
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	M
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NA
		5.2	Valid sampling techniques that protected against bias were employed	NR	NA
		5.3	Sample contained sufficient number of enrollees	NR	NA
6	Data Collection Procedures	6.1	Clear specification of data	NR	PM
		6.2	Clear specification of sources of data	NR	M
		6.3	Systematic collection of reliable and valid data for the study population	NR	M
		6.4	Plan for consistent and accurate data collection	NR	M
		6.5	Prospective data analysis plan including contingencies	NR	M
		6.6	Qualified data collection personnel	NR	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	M
		8.2	PIP results and findings presented clearly and accurately	NR	M
		8.3	Threats to comparability, internal and external validity	NR	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	M
		9.3	Improvement in performance linked to the PIP	NR	PM
		9.4	Statistical evidence of true improvement	NR	M
		9.5	Sustained improvement demonstrated through repeated measures.	NR	M

Table 5 provides a summary of the PIP validation review

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	NR	20
Number Partially Met	NR	5
Number Not Met	NR	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	NR	25
Overall PIP Rating ((#Met*2) + (#Partially Met))/(AP*2)	**0%**	**90%**

Clinical PIP—Diagnosis and Treatment of Co-occurring Disorders (COD)

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

"Will the increase of awareness, co-occurring knowledge, and capacity building in the Mental Health system to identify and coordinate co-occurring disorders treatment with Mendocino County Substance Use Disorders Treatment services improve treatment outcomes and quality of life for individuals accessing specialty mental health services and bring the rates of co-occurring diagnosis closer to epidemiological rates?"

Date PIP began: July 2017

Status of PIP: Concept only, not yet active (not rated)

The on-site review was an opportunity to provide technical assistance (TA) to help the MHP move this project towards an active PIP. Baseline data have been collected, but interventions have not been started. This will not be rated as this is not an active PIP. The PIP validation tool has been completed and comments in the PIP validation tool are provided for technical assistance only.

The PIP intends to evaluate the current diagnosing standards, rates of occurrence, and clinical training so that providers will diagnose co-occurring mental health and substance use disorders in the target population and coordinate treatment services.

The MHP reported its FY15-16 rate of co-occurring disorders (COD) as 12.31% for adults 18 years and older. The MHP indicated this was reflective of under-diagnosing substance use

disorders in their mental health population, leading to fewer referrals and less treatment than actual co-morbid incidence rates would indicate. Additional research was provided by the MHP in the PIP submission document.

Often co-occurring disorders can be difficult to diagnose due to the complexity of presenting symptoms. The overarching goal of the PIP is to increase awareness and knowledge and build capacity in the mental health system to identify and coordinate mental health treatment with substance use disorders treatment. Early detection and treatment improves treatment outcomes and quality of life for individuals who are accessing services.

The MHP is in the early stages of the PIP. The MHP has conducted a staff focus group and a survey regarding staff confidence in diagnosing the COD, which is considered the groundwork for the clinical interventions. The MHP will need to develop this PIP to include measurable clinical outcomes. Information regarding methods to improve the PIP study question, the indicators, and interventions are outlined in the PIP validation tool with comments. Methods to improve the PIP were also discussed on-site at the review time.

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

The TA provided to the MHP by CalEQRO informed them of the need to: expand interventions to include consumer outcomes; review its goals for success; consider the treatment implications for better identifying this population; and, plan next steps to this effort. The PIP requires a method or tool to measure the progress noted in the study question (i.e., to "improve treatment outcomes and quality of life for individuals").

The MHP was referred to the PIP validation tool and the PIP guidance tools as well as encouraged to request ongoing TA during the implementation of this PIP.

Non-clinical PIP—Improving No-show Rates for Medication Support Services

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

"Will a new appointment reminder system for adults 25 years and older, that provides a specific set of reminder practices for the system of care, improve the no-show rate for specialty mental health service adults receiving medication support services toward meeting the MCBHRS standard of 10% or less?"

Date PIP began: July 2016

Status of PIP: Completed

The MHP's standard for no-show rates for all services provided within the MHP is 10% or less. With the transition of adult services to the remaining ASO, medication support services for adults 25 years and older have seen a significant increase in no-show rates, up to 24%. The MHP will be implementing a new appointment reminder system whose goals is to reduce the number of medication support no-shows to 10% or less for adults 25 years and older.

The no-show indicator rate was selected because reducing no-shows potentially increases engagement with medication services for clients. Measuring the no-show rate relates to engagement, which can lead to symptom reduction. The MHP made reminder calls, created a more welcoming environment, and incentivized attendance to decrease the no-show rate. The MHP intends to continue the reminder calls at this time. To show correlation between these calls and the decreased no-show, the MHP needs to standardize the calls.

The MHP will need to detail how reduced wait times has an impact on attendance. How long is the wait time decreased? Will this be measured? The discussion does not appear to include this aspect in the submission tool.

The MHP presented monthly data that indicated an improved no-show rate to an overall average of 11%. This was impressive since the MHP simultaneously increased the number of consumers served. With this result, the MHP has concluded the formal PIP.

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

The TA provided to the MHP by CalEQRO consisted of discussion of the impact of this PIP and new PIP ideas for submission in the next review cycle. The discussion included the benefits of kept appointments. CalEQRO made suggestions including reviewing whether this project assists consumers with early engagement and whether subsequent visits are kept. Does the consumer's functioning improve, if so, how is this measured? Information regarding standardizing the interventions, obtaining consumer feedback regarding the effectiveness of the call, and measuring decreased wait times could be considered.

The MHP was referred to the PIP validation tool and the PIP guidance tools as well as encouraged to request on-going TA during the implementation of its next PIP.

PIP Findings—Impact and Implications

Access to Care

- By decreasing the no-show rate, availability of appointments would increase, leading to improved access to service.
- Initial identification of COD can assist consumers with access to additional recovery services.

Timeliness of Services

- Accurate diagnoses of COD at the onset can lead to earlier engagement to timely treatment.
- Decreased no-shows may indirectly decrease wait time to services.

Quality of Care

- With the clinical PIP focused on increased COD diagnoses, accurate diagnostics can assist consumers with right-matched treatment leading to improved symptoms.
- Productive use of clinical time through decreased no-show rates promotes system-wide improvements with increased provider time for clinical care.
- Coordination between mental health and substance use disorders proves optimal for the COD cohort.

Consumer Outcomes

- Consumer recovery can occur with appropriate treatment for COD.
- As the MHP provides increased available slots for clinical appointments, consumer engagement potentially increases wellness.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 6: Access to Care Components

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

The Cultural Diversity Committee (CDC) continues to meet quarterly with a broad representation and produces minutes of its activities. A teleconference meeting is being considered to increase attendance by remote stakeholders.

CDC also provided four cultural trainings during the year. The trainings were provided in Point Arena, Redwood Valley, and Willits. There was a total of 146 individuals that attended the trainings. Trainings focused on Latino Culture, Native American Cultural Responsiveness, and promotores.

A Latino responsiveness training was held with improved attendance. The MHP readily acknowledges it has limited bilingual providers although telepsychiatry has bilingual staff. The MHP has strengthened its relationships with local family resource centers at the Nuestra Allianza de Willets, the ARC Family Resource Center, Safe Passages, and the Action Network. It works closely with the Consolidated Tribal Health Project, Inc., which is an ambulatory community health clinic governed by a consortium of eight federally recognized tribes serving Native Americans incorporating traditional values.

During Fiscal Year 16-17, the MHP offered three SafeTALK trainings. The trainings were provided in Fort Bragg and Ukiah. SafeTALK trains individuals to recognize the signs of suicidal ideation and how to connect people to resources.

The MHP has the capacity to serve all identified Katie A. subclass members. All of the services are provided by community providers. The MHP serves an average of 20-36 youth through Katie A. services.		
1B	Manages and adapts its capacity to meet consumer service needs	M
The MHP continues to assess the use of telepsychiatry to meet consumer needs and expects to identify new venues where this service can be beneficial. The MHP has out of county subclass members. Services are delivered by the community provider near where the youth are living. RQMC subcontractors are available in other counties and are able to provide those services, so transfer is not an issue. Based on a trauma focused assessment, all clients that meet medical necessity receive Intensive Care Coordination (ICC) and/or Intensive Home Based Services (IHBS) and the CANS assessment is used to determine consumer progress. The MHP produces monthly consumer utilization reports and tabulates age, gender, residency, ethnicity, diagnosis, and services provided to consumers. The MHP has revised its MHSA and Quality Improvement Committee (QIC) meeting and holds these consecutively to increase stakeholder involvement for the mutual attendees. Discussions are developing for the feasibility to use video-conferencing for future meetings. Rotating meetings geographically and opening meetings to the public lends itself to transparent leadership style. The revised access process, wherein all sites take walk-ins or call-ins, has improved availability to service with a "no wrong door" philosophy.		
1C	Integration and/or collaboration with community-based services to improve access	M
With improved partnerships comes improved referral processes between agencies. A MHP quality management staff is available to assist consumers with the transition process from clinic to clinic. This is a result of continuous meetings and demonstrating care for mutual consumers. The linkages with primary care providers requires work to further bi-directional processes for step-down care. At times, primary care providers have been resistant to accept seriously mentally ill (SMI) adults secondary to treatment concerns for this group. The ASO continues to meet with the primary care clinics to pave a path to lower levels of care for stable consumers. A goal in the Quality Improvement (QI) work plan indicated 90% of charts will have a signed release of information for the beneficiary's health care providers. This year, Mobile Outreach and Preventions Services expanded to two teams. The mental health rehabilitation specialists have established working relationships with law enforcement and local clinics. The mental health rehabilitation specialist works in partnership with a Sheriff's Office technician. These efforts are commendable and the MHP will need to continue as stakeholder groups voiced a negative view of law enforcement's commitment to serve consumers. The MHP leadership has acted on its values of wellness and recovery to create hope, to build trust, and to bridge the gap among its partners.		

Timeliness of Services

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

Table 7: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first appointment	M
The MHP standard is 14 days with an overall average of nine days and the MHP met this at 83%. The average for adult services was ten days and the MHP met this at 73%. The average for children's services was seven days and the MHP met this at 93%.		
2B	Tracks and trends access data from initial contact to first psychiatric appointment	M
The MHP standard is 30 days with an overall average of 23 days and the MHP met this at 77%. The average for adult services was 12 days and the MHP met this at 87%. The average for children's services was 33 days and the MHP met this at 66%. The MHP indicated on-site that it intends to change this standard to a 15-day goal beginning with FY17-18. It will need to consistently review this to comply with its goals. Although attempts were made to hire more psychiatrists, the region cannot generate interest for many professionals. The MHP shared the difficulty in acquiring a child psychiatrist and plans are underway to hire a nurse practitioner. Discussions occurred with the MHP on-site which urged them to consider telepsychiatry. Telepsychiatry is currently being explored by the Children's System of Care. In February 2017, the MHP added extra days to meet the additional demand for psychiatry appointments. In May 2017, a physician assistant was hired part-time. The MHP may want to consider further improvements to meet its goals, especially for children. It may want to consider options such as a call list to fill-in for cancelled appointments.		
2C	Tracks and trends access data for timely appointments for urgent conditions	M
The MHP standard is set at a one-hour response during business hours and a two-hour response after-hours. The MHP met this at 98% and 99%, respectively, with an overall average of 17 minutes. The average for adult services was 18 minutes and the MHP met this at 97% and 99%. The average for children's services was 16 minutes and the MHP met this at 98% and 99%. The crisis services broadened its outreach with a mobile team that is deployed to the hospitals to perform evaluations. The crisis issues in this community have been controversial because of long-standing questions about jurisdiction for response between mental health and law enforcement. Since there is no local in-patient hospital, the sheriff's officers find themselves as the		

default responders after hours. The substantial improvements in crisis response are acknowledged and these will need to continue to eliminate past concerns.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
The MHP standard is seven days to timely access to follow-up appointments after hospital discharge. A total of 551 hospitalizations were reported for 374 adults and 177 youth. Actual performance for the MHP on this metric was one day to follow-up, which suggests the MHP has this process in place.		
2E	Tracks and trends data on rehospitalizations	M
The MHP has a goal of 10% or less for rehospitalizations. The overall 30-day rehospitalization rate for 52 beneficiaries was 9.4%. For the adult services, 38 beneficiaries or 10.1% were rehospitalized. For the children's services, 14 beneficiaries or 7.9% were rehospitalized. It appears this metric overall is met.		
2F	Tracks and trends no-shows	M
The MHP has set a 10% goal for its no-show rate. Overall for clinicians, it met this at 10.91%, with adult services at 11.31%, and children's services at 10.50%. Overall for psychiatrists it met this at 13.87%, with adult services at 15.10%, and children's services at 12.63%. The MHP underwent a system-wide transfer of service delivery for adult medications support at the onset of this fiscal year. The MHP also initiated a PIP to decrease the no-show rate for psychiatry. With the new standard for psychiatric evaluations, it will benefit them to review and implement on-going improvements for capacity reasons.		

Quality of Care

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

Table 8: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP has assigned staffing resources to the QIC and three committees, with stakeholders responsible for key functions of the QI Program, the QIC, the CDC, and the Mental Health Service Act. In the spirit of transparency, the MHP provides a brochure with scheduled meetings, which covers the focus of QIC, and posts this online. Minutes from these committee meetings are used to identify and monitor goals and objectives related to the QI program. While the MHP has improved its QI plan during the past year, it is encouraged to review its benchmarks to ensure that measurable goals for all indicators are included. The MHP has provided executive team leadership training to build competency for succession planning efforts. To augment resources for the SMI population, the MHP has received funds under the Whole Person Care grant. The MHP has initiated discussions with its partners for a shared assessment to serve the mild to moderate.		
3B	Data are used to inform management and guide decisions	PM
The MHP made significant progress in defining a concrete level of service/level of care protocol standard. With continued efforts, the MHP is on track to automate analysis of its outcomes tools for determining consumer wellness and recovery longitudinally. This could assist with capacity needs and treatment planning. Data is collected and reviewed monthly on consumer utilization and the MHP could extend this activity with analysis of its capacity to serve, especially given anticipated growth in the COD population. All the QI work plan goals need to be measurable, reviewed, and monitored for improvements. Data could be expanded to include line staff and other stakeholders for input, and eventual improvements.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM
The QIC, MHSA, and CDC meetings were held in different locations throughout the county to provide more options for stakeholder involvement. Tracking was conducted on the number of individuals who attended the meetings. Various stakeholder groups noted that while the MHP executive team communicates, the communication is predominately top-down. Bi-directional discussions occur at community meetings, which the MHP has formalized regionally to be more inclusive. Limited venues for staff input were recognized. This was most evident among line staff who work for various agencies and rarely have occasion to meet as a group.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Consumers are encouraged to attend Client Council Meetings, held bi-weekly at the Manzanita Wellness Center, and consumers have an opportunity to give input to MHP administration on services and activities through QIC and MHSA meetings. Some efforts with Consumer/Family Member (CFM) stakeholders appear limited regarding the MHP's vision as some focus group participants were not aware of the warm-line and expressed the need for one. The MHP made concerted efforts to embrace its ASO as a viable partner which was evident in the rapport displayed on-site. The MHP indicated that communication occurs through a variety of methods including newspapers, radio talk shows, National Alliance for Mentally Ill (NAMI), emails, community forums, and the media to keep stakeholders up-to-date. All MHP agencies have suggestion boxes available for stakeholders which are checked monthly**.** The MHP could consider implementing a consumer portal for care, the community-wide newsletter, and monthly or quarterly staff meetings among similar groups.		
3D	Evidence of a systematic clinical continuum of care	M
While the MHP has formalized its level of service/level of care protocols, operationalizing this at the line staff level to facilitate transition of care discussions across the entire system of care has not occurred. Discussions appear to occur at the leadership level, yet it was not clear that staff use these level of service instruments for treatment. This could afford the MHP the benefit of a formalized transition of care plan. Consumers report that they participate in treatment planning and that with their clinical provider, they set treatment goals for themselves. They report these goals are reviewed with them and updated at least annually, with updates as needed. Consumers also report that they have a Wellness Recovery Action Plan (WRAP) or a similar plan for recovery and use them regularly, giving them another option to participate in their own treatment planning and care. The MHP has standard services, such as groups, medication support, crisis stabilization, and drug treatment, already in place. Given the rural and geographic spread, the MHP may consider additional services such as housing, a crisis residential center, or in-patient hospitalization services.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The director of Manzanita Wellness Center is a family member and is part of the management team. Consumer employees reported that they get support from team leaders to take care of their own mental health issues, including time off for medical appointments. They also reported they receive support and encouragement to expand their roles and responsibilities in their positions.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
Consumer/family member staff at the wellness centers report they can be promoted to team lead positions; others stated their promotional opportunities are limited by their lack of education; others reported they are given additional responsibilities, but are not given formal promotions. Consumer employees can work up to 40 hours weekly and positions offer benefits.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
The consumer run program at Manzanita Wellness Center is open to all adults (age 25 and older) regardless of whether they are receiving mental health services or transitioning out of services from the MHP. The Manzanita Wellness Center operates Monday to Friday from 8am-5:30pm. The drop-in center is open Monday to Friday from 10am-3pm. There are additional consumer run wellness centers: Manzanita offers centers in both Ukiah and Willits; Hospitality House is located on the coast; and the Arbor Youth Resource Center in Ukiah. Consumers and family members are given information at their intake appointments about the wellness center, including information about the services, activities, and contact information. The Manzanita Wellness Center maintains a website, monthly calendar of activities, a newsletter, and has flyers available in English and Spanish. The center staff also does outreach to the Latino/Hispanic community through the local churches and markets frequented by Spanish speakers.		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP uses the CANS and the Adult Needs and Strengths Assessment (ANSA) for consumer outcome tools. Protocols are in place with extensive scoring reports provided to leadership. The CANS/ANSA assessment tool is a component of the MHP assessment protocol. The CANS/ANSA is done at intake and then at 6 months intervals and integrates this within the EHR via a digital assessment tool and calculates the CANS/ANSA scores. These scores are collated into a Crystal Report with the sub- scores automatically calculated and stored within each medical record. The Crystal report retrieves these measures and formats them in ways that clinicians can use on a regular basis as they develop treatment plans.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The Consumer Perception Survey was provided bi-annually to clients and family members to determine their perception of services. In May 2017, a total of 478 surveys were collected: 20 older adults, 141 adults, 216 families, and 101 youth. Survey results are shared with MHP and contracted providers.		

Table 8: Quality of Care Components	
Component	**Quality Rating**
The MHP has a QI goal to increase the number of surveys received and overall satisfaction. It also uses the feedback from the surveys, for example to upgrades to the lobby based on consumer perception. The MHP solicited consumer feedback following treatment sessions through a consumer questionnaire on Survey Monkey. Substance Use Disorders Treatment completed one client satisfaction survey this year. A total of 33 people completed the survey.	

Key Components Findings—Impact and Implications

Access to Care

- The advent of the "no wrong door" approach has facilitated improved accessibility especially in this rural region with limited transportation options for consumers.

Timeliness of Services

- The MHP has revised its timeliness metric for first psychiatric appointment, which will require consistent monitoring for adherence.

Quality of Care

- The MHP transitioned successfully its adult consumers to one ASO in a short timeframe.
- The MHP and ASO have created a model partnership, which serves mutual consumers.

Consumer Outcomes

- The ASO provides regular comprehensive reports on consumer outcomes, which are captured through tools to measure progress and consumer needs.
- The MHP has improved its working relationships with law enforcement, which benefits consumer outcomes. The MHP recognizes this as a building block which requires consistent maintenance for on-going de-stigmatization.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

Consumer/Family Member Focus Group 1

A culturally diverse group of parents/caregivers of child/youth beneficiaries, including a mix of existing and new clients who have initiated/utilized services within the past 12 months was held at the MHP Administrative office at 1120 S. Dora Street, Ukiah.

Number of participants: 6

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

- Participants indicated initial access to service was readily available. Some were seen on-site at their children's school.
- Staff were perceived to be responsive, kind, understanding and accessible. Cell phone contact was available when staff were in the field.
- Each participant knew how to contact the crisis services if needed.
- Some stated that the staff answering the telephones appeared to have limited knowledge of processes and resources, which felt to be unwelcoming. Some participants wondered if these might be new staff.

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

- When staff left a position, a warm-hand off was provided, ensuring a smooth transition for families.

- Several participants had children/youth who were involved with school plans and found this to be a collaborative effort with the mental health provider.
- Parents were involved in the treatment planning and felt included in decisions regarding their child.

Recommendations for improving care included the following:

- Consider a support group for parents and a separate support group for youth.
- Revisit welcoming strategies for the new front desk staff who have limited knowledge of the system.
- Increase displays and information about available services at sites in the community that parents frequent.
- Facilitate coordination of children's needs with comprehensive treatment plans that includes schools and medical providers.

Interpreter used for focus group 1: No

Consumer/Family Member Focus Group 2

A culturally diverse group of adult beneficiaries, including a mix of existing and new clients who have initiated/utilized services within the past 12 months was held at the MHP Administrative office at 1120 S. Dora Street, Ukiah.

Number of participants: 11

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

- Access to the initial service was perceived to be timely and varied from within one week to one month of the request.
- Follow-up counseling and case management services were adequately provided for each consumer's needs.
- Several participants noted group therapy was readily available and they participated at both the wellness center and at crisis services as needed.
- Most of the participants had long term chronic physical health issues and were the SMI population.

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

- Most of the participants were involved in treatment planning and some used the WRAP plan.
- The consumers who used the Manzanita Wellness Center indicated it was a supportive, respectful, and healing outlet for them.
- The primary concern voiced by multiple participants involved the perceived inconsistencies at the crisis center. This particular group found criteria for services to be subjective. For instance, consumers indicated at times they met criteria to stay and at other times they were provided referrals to outpatient service. This may be a result of consumer perceptions.
- Many of the SMI participants had experienced homelessness or unpleasant encounters with law enforcement and felt stigmatized by law enforcement.

Recommendations for improving care included the following:

- Implement a warm-line to diffuse a crisis. None were aware of a warm-line operating locally and expressed a critical need for one.
- Minimize staff turnovers or consider transition sessions.

Interpreter used for focus group 1: No

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Overall, access was perceived to be efficient and appropriate to consumer needs.
- The MHP should consider holding bridge sessions between the outgoing staff and the new staff.

Timeliness of Services

- Consumers expressed long times waiting on the phone for a response, which could impact dropped calls.

Quality of Care

- Crisis care was experienced differently among informants.
- Overall, participants noted they were involved in their care.

Consumer Outcomes

- Improved working relationships with law enforcement could contribute to positive consumer perceptions.
- Housing appears to be a high priority for the SMI group.

INFORMATION SYSTEMS REVIEW

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

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

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

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	8.48%
Contract providers	91.51%
Network providers	0.002%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): **2.2**%

The budget determination process for information system operations is:

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

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: **3**

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

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve consumers temporarily residing outside the county
☒ Reduce travel time for healthcare professional staff
☐ Reduce travel time for consumers

Telepsychiatry services are available with English and Spanish speaking practitioners not including the use of interpreters or language line.

Approximately 14telepsychiatry sessions were conducted in other languages.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
7	0	0	0

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
15	0	0	2

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

- The MHP commits significant resources to its data analytics staffing but the above table does not reflect all the FTEs, some are fractional and are currently allocated to clinical quality improvement analytics.
- The MHP does not currently track information to provide sufficient knowledge to gauge how often the quality analytics resources are being used.

Current Operations

- The MHP continues to use the Netsmart Avatar EHR as its primary management information system. The MHP is maintaining and upgrading the EHR as warranted.
- The ASO continues to use the EXYM EHR as its primary management information system and EXYM is the EHR for the children's and adult system of care.
- The MHP has worked diligently with its vendors to create .xml data transfers from the EXYM system to Avatar to improve reliability.

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

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar PM	Practice Management	Netsmart	14	MHP/ Vendor
Avatar CWS	Clinical	Netsmart	4	MHP/ Vendor
EXYM	All	EXYM	9	EXYM

Priorities for the Coming Year

The MHP has determined the following priorities:

- Testing and implementation of the 2017 Perceptive software that scans client documentation within the Avatar system.
- Medication consent training for the physicians. Research OrderConnect module (e-prescribing) for future implementation.
- Starting a pilot program of sharing client information with the local rural health clinic.
- Care Connect, Order Entry, and patient portal implementations.
- Conversion project for the SUD treatment program from current software program to Avatar.

Major Changes Since Prior Year

- Training and implementation of the assessment, client plan, the CANS, and audit tools.
- Implemented Modal Fluency Direct for physician and clinical staff so staff can dictate progress notes and other documents into Avatar.
- Installed 2016 Perceptive and 2017 Perceptive in TEST system.
- Electronic signature software and pads installed and functioning for consumer signature.
- Medications management staff are utilizing Avatar.

Other Significant Issues

- Stakeholders reported that the capabilities and utilization of the EHRs in place within the MHP/ASO context were varied. Some areas were doing small amounts of collaborative documentation and some areas had access to supplemental reporting.
-
- The level of service/care starts at the level of line staff and moves up to management level.
- The MHP also have bi-directional conversations around level of care, and discussions are imbedded in multiple types of meetings (supervision, team meetings, etc.).
- The MHP has not yet engaged in practical health information exchange (HIE). Secure physician to physician encrypted email have not yet been piloted although encrypted email products exist within the county.
- The MHP also has not engaged with broad statewide initiatives, like California Association of Health Information Exchanges, to leverage the vast amount of work already done to create a practical and secure framework for HIE. This effort might greatly simplify data exchange among the MHP, ASO, and various service partners like the local hospitals.
- The MHP/ASO have engaged in the practical exchange of operations data via custom .xml data extracts and uploads. Stakeholders report this has been very successful on the operations level.
- .. The MHP is currently utilizing telepsychiatry and will continue to do so, including expansion of it. The ASO has also increased psychiatry services by increasing days, with an available psychiatrist and has hired a nurse practitioner to provide services.
-
- The MHP reported low co-occurring diagnosis (COD) rates (22.79%) within their integrated MH/SUD environment. The QI team has been tasked to investigate the rate of COD to better inform the system of care.

Plans for Information Systems Change

- The MHP has no plans to replace the current system which has been in place more than five years.

Current Electronic Health Record Status

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

Table 13: EHR Functionality					
Function	**System/ Application**	**Rating**			
		Present	**Partially Present**	**Not Present**	**Not Rated**
Alerts	Netsmart/EXYM	x			
Assessments	Netsmart/EXYM	x			
Care Coordination	Netsmart / EXYM	x			
Document imaging/storage	Netsmart/EXYM	x			
Electronic signature—consumer	Netsmart/EXYM	x			
Laboratory results (Elba)	EXYM			x	
Level of Care/Level of Service	EXYM	x			
Outcomes	Netsmart/EXYM	x			
Prescriptions (era)	Netsmart/EXYM	x			
Progress notes	Netsmart/EXYM	x			
Referral Management	EXYM	x			
Treatment plans	Netsmart/EXYM	x			
Summary Totals for EHR Functionality		11	0	1	0

Table 13: EHR Functionality

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

- The MHP continues to work with the ASO to bring additional functionality to the Avatar/EXYM pairing. The ASO expects the EXYM product to have Care Coordination/Referral Management capability within the next six to nine months.
- The MHP is exploring the implementation of Avatar CareConnect for data transfer and accuracy capabilities.

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

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

The MHP uses Excel/Access, Dimension Reports and an outside consultant.

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☒ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Mendocino MHP Summary of CY16 Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
44,660	$8,316,658	**417**	$92,046	1.11%	$8,224,612	$67,730	$8,156,882

Note: Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Mendocino MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	255	$54,434	59%
Missing, incomplete, invalid ICD-10 diagnosis or condition	36	$10,143	11%
Invalid procedure code and modfier combination	15	$5,961	6%
Total Denied Claims	417	$92,046	100%

Information Systems Review Findings—Implications

Access to Care

- Continue to evaluate access to psychiatry service including specialty, telepsychiatry, and linguistically competent services.

Timeliness of Services

- Evaluate and improve timeliness to service for psychiatry across the entire system of care.

Quality of Care

- Continue its work in integrating outcomes information, particularly relevant reporting for line staff, into the EHR for the entire system of care.
- The MHP is in the early stages of pursuing HIE projects with its service partners.

Consumer Outcomes

- The MHP has made considerable progress in creating a level of service/level of care analysis protocol that will allow for the automation of longitudinal level of care analysis.
- The MHP provides dashboard reporting from the EXYM EHR, to the Mental Health Board on a monthly basis.

SITE REVIEW PROCESS BARRIERS

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

- No barriers were encountered during this review.

CONCLUSIONS

During the FY17-18 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:

- Increased access to service was facilitated with the change to an open door policy whereby all clinic sites can provide assessments.
- The ASO continues to follow-up for consumer care at a minimum of 60 days after the initial contact for all services.
- The MHP efficiently transitioned hundreds of adult consumers into service following a change in the ASO contract.

Opportunities:

- The MHP would benefit in reviewing the need for adequate psychiatry services, perhaps using more telepsychiatry to provide reasonable access to service across the entire system of care.
- The MHP has an opportunity to review its rate of co-occurring disorders, which may then identify protocols, stigma reduction activities, and training that could be conducted for this population.

Timeliness of Services

Strengths:

- The MHP transitioned numerous adults in a timely manner to new providers.
- To enhance timely service, the MHP focused efforts on decreasing no-show rates in adult medications support services.

Opportunities:

- The MHP may consider formalizing its intention to adopt new timeliness standards for the first psychiatric appointment in the QI work plan.
- The MHP should continue their efforts to track no-show rates consistently across the systems of care for standardized improvements.

Quality of Care

Strengths:

- In its efforts to show transparency, the MHP created a QIC brochure to inform stakeholders of its mission and calendar of meetings.
- More advanced than many of its constituents, the ASO has developed protocols for the use of outcome tools.
- The ASO which operates over 90% of the MHP services has, overall, attended to consumer needs.

Opportunities:

- The MHP should continue to expand its partnerships to improve consumer engagement and seamless bi-directional transitions, especially with primary care providers.
- The MHP may consider a health information exchange (HIE) pilot project with one of its existing service partners.

Consumer Outcomes

Strengths:

- The MHP has worked diligently to formulate concrete written level of service/level of care analysis protocols for the system of care.

Opportunities:

- The MHP should continue and expand its use of level of service/level of care protocols to facilitate secondary analysis of outcomes data related to longitudinal analysis of capacity.

Recommendations

- Track, monitor, and implement activities to improve timeliness between request for psychiatric services and initial appointment to meet the new established standards.
- Continue building linkages for coordination of care with primary care providers for bi-directional transitions.
- Investigate the feasibility and use of dashboard software and incorporate products to automate data for clinical quality improvement projects across the system of care.
- Identify a service partner and explore a health information exchange (HIE) pilot project using statewide HIE standards that can be readily expanded across the system of care.
- Continue to expand current efforts to operationalize level of service/level of care protocols for clinical and executive levels to provide appropriate consumer treatment across a continuum of care.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Mendocino MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Groups
Contract Provider Group Interview – Administration and Operations
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.

Attachment B—Review Participants

CalEQRO Reviewers

Jovonne Price, Quality Reviewer Consultant
Duane Henderson, Information Systems Consultant
Margret Gerriets, 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 in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

Behavioral Health Services Administration
1120 South Dora Street
Ukiah, CA

Contract Provider Sites

Manzanita Wellness Center
410 Jones Street
Ukiah, CA

Redwood Quality Management Company
376 East Gobbi Street
Ukiah, CA

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Miller	Jenine	Mental Health Director	Behavioral Health & Recovery Services
Lovato	Karen	Acting Deputy Director	Behavioral Health & Recovery Services
Abbott	Scott	Compliance Officer	Behavioral Health & Recovery Services
Svendsen	Barbie	Acting QA/QI Manager	Behavioral Health & Recovery Services
Hoaglen	Venus	Acting Administrative Services Manager I	Behavioral Health & Recovery Services
Landis	Cliff	Mental Health QI Clinician	Behavioral Health & Recovery Services
Vokoun	Carol (CJ)	Department Application Specialist	Behavioral Health & Recovery Services
Turchin	Andrea	Senior Department Analyst	Behavioral Health & Recovery Services
Emery	Bekki	Assistant Health & Human Services Agency Director	Health & Human Services Agency (HHSA)
Griffith	John	Senior Program Manager	Child Welfare Services (HHSA)
Schraeder	Camille	Chief Financial Officer	Redwood Quality Management Company
Schraeder	Tim	Chief Executive Officer	Redwood Quality Management Company
Anderson	Dan	Chief Operations Officer	Redwood Quality Management Company
Logan	Alicia	Business Administrator	Redwood Quality Management Company

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Yovino	Mary	Point of Authorization (POA) Administrator	Redwood Quality Management Company
Palomo	Christy	Rehabilitation Specialist	Redwood Community Services
Glasscock	Jenna	Therapist	Mendocino County Health Care
Mullis	Jackie	Therapist	Manzanita Wellness Center
Rathbun	Terri	Therapist	Mendocino County Youth Program
Sakurada	Grace	Therapist	Tapestry Family Services
Wilson	Teresa	Therapist	Redwood Children's Services
Kiwion	Carla Joy	Mental Health Rehabilitation Specialist	Behavioral Health & Recovery Services

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Mendocino MHP CY16 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	3,674,069	137,620	3.75%	$599,045,852	$4,353
Small	169,682	6,634	3.91%	$23,428,744	$3,532
Mendocino	12,144	354	2.92%	$1,389,410	$3,925

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

Table C2: Mendocino MHP CY16 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
< $20K	1,718	94.03%	93.97%	$6,178,431	$3,596	$3,636	63.28%	58.96%
>$20K - $30K	67	3.67%	2.87%	$1,617,361	$24,140	$24,284	16.57%	12.02%
>$30K	42	2.30%	3.16%	$1,967,173	$46,837	$53,219	20.15%	29.02%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18	CLINICAL PIP

GENERAL INFORMATION	
MHP: Mendocino	
PIP Title: Diagnosis of and Coordination of Co-Occurring Disorders Services	
Start Date: 07/01/16 **Completion Date** (MM/DD/YY): anticipated 07/01/18 **Projected Study Period** (#of Months): 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 09/12-09/13/2017 **Name of Reviewer**: Jovonne Price	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): According to the Substance Abuse and Mental Health Services Administration, in 2014, 2.3 million people in the United States met the criteria for co-occurring disorders (COD), diagnosed with a serious mental health and substance use disorder. NAMI estimates that 37 percent of individuals with a mental health diagnosis also struggle with alcoholism and 53 percent	

struggle with drug addiction. The MHP's co-occurring disorders rate is 12.31 percent for adults 18 years and older. MCBHRS' overall percentage of individuals diagnosed as co-occurring indicates that the MHP is under-diagnosing substance use disorders in the mental health population being served, leading to fewer referrals and less treatment than national rates would indicate. Additional research was provided by the MHP in the PIP submission document.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The multi-functional team includes Mendocino County Behavioral Health and Recovery Services (MCBHRS), Redwood Quality Management Company (RQMC), and adult community-based organizations. These stakeholders were selected because they provide services to adults 18 years and older. Stakeholders include representatives from the MHP, contract providers, and consumer groups.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has been tracking co-occurring diagnosis rates for a couple of years with the expectation that all individuals assessed for specialty mental health services will received a co-occurring diagnosis if they meet criteria. The MHP reports yearly to EQRO the co-occurring data that is captured on active consumers. Below is the data for the last three years: Fiscal Year 15/16 Fiscal Year 14/15 Fiscal Year 13/14 12.31% 4.69% 16.53%

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

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP evaluates current diagnosing standards, rates of occurrence, and clinical training so providers will diagnose co-occurring disorders and coordinate treatment services. Often co-occurring disorders can be difficult to diagnose due to the complexity of symptoms being presented by the individual. The overarching goal of the PIP is to increase awareness of co-occurring disorders and build capacity in the mental health system to identify and coordinate substance use treatment. Early detection and treatment improves treatment outcomes and quality of life for individuals who are accessing services. The early stages of activity have included conducting a staff focus group and a survey on staff confidence in diagnosing COD. The groundwork for the clinical interventions will be on staff ability to diagnose. The MHP will need to develop this PIP to include clinical outcomes that will be measured. This was discussed on-site at the review time.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP will include all individuals 18 and over that access and receive specialty mental health services in Mendocino County from July 2, 2016 – June 30, 2018. Individuals that are assessed and determined to have a co-occurring diagnosis will be included in the overall co-occurring diagnosis percentage.
	Totals	Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the increase of awareness, co-occurring knowledge, and capacity building in the Mental Health system to identify and coordinate co-occurring disorders treatment with Mendocino County Substance Use Disorders Treatment services improve treatment outcomes and quality of life for individuals accessing specialty mental health services and bring the rates of co-occurring diagnosis closer to epidemiological rates?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP will need a method or tool to measure the progress noted in the study question to "improve treatment outcomes and quality of life for individuals". In other words, how will this be measured? Maybe the question might be "Will bringing the rates of co-occurring diagnosis to XX% improve treatment outcomes by XX% and quality of life (by some measurement) for individuals accessing specialty mental health services?
	Totals	Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP will include all individuals 18 and over that accessed and received specialty mental health services in Mendocino county from July 2, 2016 – June 30, 2018. Individuals that are assessed and determined to have a co-occurring diagnosis will be included in the overall co-occurring diagnosis percentage.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide data for this item.
	Totals	Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Percentage of clinicians that feel they have adequate training to identify co-occurring diagnosis – 2016 (goal-65%) • Percentage of individuals diagnosed as co-occurring 2016 (goal=50%) • Percentage of individuals diagnosed as co-occurring 2017 (goal=50%) • Coordination of Care with Substance Use Treatment Services 2017 (goal=100%) • Percentage of clinicians that feel they have adequate training to identify co-occurring diagnosis – 2017 (goal=100%)	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	These primarily represent staff improvements, while some could be an educational intervention, these do not show a benefit to consumers and are not applicable to consumers. The MHP will need to consider further indicators that measure consumer benefit. The MHP will need to measure the difference in the number of co-occurring disorders identified at baseline versus after clinical interventions take place. Also, the rate of diagnoses of co-occurring disorders be an indicator. It is recommended that the MHP review its goal of 50% of consumers diagnosed with COD in 2017. This is a considerable increase from the baseline of 22.79% in 2016. The MHP should consider if this a realistic goal? If yes, will the MHP have the capacity to serve this population? Perhaps include how the MHP will serve the increased population. Will a new practice be instituted or a new COD unit? To measure coordination, more than a referral should be measured. Ideas: engagement, completion of recovery program, or survey of recovery activities by those diagnosed as COD, etc.

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. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Ideas to measure consumer improvements: engagement, completion of recovery program, survey of recovery activities by those diagnosed with COD, etc.
	Totals	Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Sampling did not occur as all persons age 18 and older will be considered.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	Met Partially Met Not Met Not Applicable UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has not progressed beyond the initial concept of this PIP. The MHP did not outline a clear plan or a data source other than the survey of staff. Again, the survey provides information that benefits staff. The MHP should consider a consumer survey regarding recovery. The MHP identified that it conducted a staff focus group and a staff survey related to this PIP. If this the only intervention that occurred during 2016, the MHP must consider how would this account for any increase in identifying the pool of COD. Without measures and data, how does the MHP know if what is done will be effective? The MHP notes that this is a two-year PIP, which will be responded to in year two after all data is collected and analyzed. However, the MHP will need to have a current plan, and to define when, how often, and what method the data will be extracted, analyzed, and modified if needed. The MHP will need to pull data at least quarterly to determine if something is amiss or something is working well and modifying as indicated. To date, a clinician survey has been distributed and a staff focus group was conducted. No interventions have occurred for consumers. Consumer benefit will need to be included and measured.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider	☐ Met ☐ Partially Met ☐ Not Met	

☐ Other:	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Staff survey conducted.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Barbie Svendsen Title: QA/QI Acting Program Manager Role: Lead *Other team members:* Names: see comments section 6.6.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Michael Dodge QA/QI Analyst Venus Hoaglen Fiscal Services Administrator Navin Bhandari Cultural Competency Administrator Lois LaDelle-Daly Compliance Officer Pamela Dawson Patient Rights AdvocateContractor Susan Wynd Novotny Executive Director Nicole Sorace Adult Provider Analyst Chris Johnson Healthy Start VolunteerHealthy Start Kristina Harju Adult Provider Manager Ken Hanover Substance Abuse Counselor Otis Brotherton Substance Abuse Counselor Javier Chavez Family Advocate
	Totals	**Met** **Partially Met** **Not Met** **UTD**
STEP 7: Assess Improvement Strategies		

7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Meetings and discussion with Management and Supervisors regarding co-occurring and the lack of diagnosing. Administer clinician survey on co-occurring disorders Focus group with clinicians addressing perceived barriers to SUD diagnosis and ideas to improve this process. Training on diagnosing co-occurring disorders. Administer clinician survey on co-occurring disorders following training on co-occurring disorders	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The interventions appear to lead up to an improvement, which would benefit consumers. At present, these interventions benefit the staff and increase confidence in identifying and treating COD. This leads to improved confidence in staff assessments of consumer needs. The MHP will need to consider the consumer outcome to measure the effectiveness of the staff training. Overall, there will need to be interventions that apply to consumer outcomes.
	Totals	**Met Partially Met Not Met NA UTD**
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	This PIP is in concept only stage. The MHP has not progressed beyond the initial groundwork step of a staff survey and focus group.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

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

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

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: To date, after a one-year timeline, interventions consist of training staff and conducting a focus group with staff in which feedback was obtained. The interventions will need to be expanded to include the consumer outcomes. Secondary to lack of interventions geared towards consumers, the PIP is considered in the concept only phase and ratings are not applied. Comments provide feedback to the MHP for future consideration.		
Recommendations: The MHP is encouraged to seek ongoing TA for its PIP. Interventions applicable to consumer outcomes will require further identification.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18	NON- CLINICAL PIP

GENERAL INFORMATION	
MHP: Mendocino	
PIP Title: Improving No-show Rates for Medication Support Services	
Start Date: 07/01/16 **Completion Date:** 06/01/17 **Projected Study Period** (#of Months): 12 **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review:** 09/12-09/13/17 **Name of Reviewer**: Jovonne Price	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): MCBHRS set its standards for no-show rates for all services provided within the Mental Health Plan (MHP) as 10%. With the transition of adult services and medication support services for adults 25 years and older, there has been a significant increase in no-show rates, up to 24%. The MHP will be implementing a new appointment reminder system that will reduce the number of medication support no-shows to 10% or less for adults 25 years and older.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP input comprised of behavioral health practitioners, providers, as well as Medi-Cal beneficiaries, parents, spouses, relatives, legal representatives, and other persons similarly involved with beneficiaries who have accessed specialty mental health services through the MHP.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Medication support services have shifted service providers two times in the past three years, from county provided services, to a contractor provided services, and then back to county provided services again. This contributed to confusion among clients as to who the providers were and where medication services were being provided. The MHP indicated a no-show rate for medications support for an average of 183 monthly billable medication support services at 24.31%, for FY15-16. For future reference, the MHP will need to describe the baseline data that shows the problem in the narrative. This is described further in the report and this would need to be reported earlier for clear information about the problem. In other words, the MHP will need to state how this is a problem; what does their data tell them that leads to an improvement project?

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The no-show indicator rate was selected because reducing no-shows increases engagement with medication services for clients. Measuring no-show rates is central to the study question of how to increase client linkage to medication services through reduction of no- show rates to its 10% standard.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population includes specialty mental health clients, age 25 and over, who are receiving medication management services from the MHP.
	Totals	4 Met 0 Partially Met 0 Not Met 0 UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will a new appointment reminder system for adults 25 years and older, that provides a specific set of reminder practices for the system of care, improve the No-Show rate for specialty mental health service adults receiving medication support services toward meeting the MCBHRS standard of 10% or less?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Consider restating the question as follows: "Will a new appointment reminder system improve the no-show rate for specialty mental health beneficiaries 25 years and older receiving medication support services to 10% or less?"
	Totals	1 Met 0 Partially Met 0 Not Met 0 UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population includes adults, age 25 and over, who are receiving specialty mental health medication management services from MCBHRS.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data supporting the Indicator is available through the electronic health record (EHR) Avatar.
	Totals	2 Met 0 Partially Met 0 Not Met 0 UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* No-show rates to medications support services.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	There are other indicators that could be explored. Examples include: A survey of those who miss their appointment and the reason it was missed; Number who missed appointment and contact reschedule within in XX days; Number who missed appointment who received the reminder call; As is, more information is needed, not only to measure the success of the interventions, but to determine what could be an issue/barrier to attending the appointment. The MHP cannot successfully replicate this PIP in other venues unless it knows from the data what led to success.

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. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Measuring the no-show rate relates to engagement, which can lead to symptom reduction. It would benefit the MHP to know how this assists consumers. For instance, does early engagement ensure that subsequent visits are kept as well? Does the consumer functioning improve, if so, how is this measured?
	Totals	0 Met 2 Partially Met 0 Not Met 0 UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling as all aged 25 and older were included.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	0 Met 0 Partially Met 0 Not Met 3 NA UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The statistics will be reviewed on a bi-monthly basis and reported to the Quality Improvement Committee stakeholders. Data is derived in total from billable medication services. The MHP would benefit from tracking data from the consumer-focused interventions to provide information as to which interventions are most useful for replication.
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☒ Met ☐ Partially Met	

☐ Member ☒ Claims ☐ Provider ☒ Other: E HR	☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data collected monthly.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: claims	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Monthly data reports were completed and tracked for no-show rates and number of contacts.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Barbie Svendsen Title: Acting Program Manager Role: Facilitator *Other team members:* Names: Venus Hoaglen	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Venus Hoaglen, the Acting Administrator Services Manager I, will be responsible for collecting and reporting results on a monthly basis.
Totals		5 Met 1 Partially Met 0 Not Met 0 UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Reminder Calls to clients Improved welcoming environment for telepsychiatry Reduce wait times: Seek additional telepsychiatry providers, utilize FB telepsychiatry time slots for Ukiah waitlist. Reminder calls to care managers (In addition to clients) Dissemination of appointment schedule to contract provider Further attempt to address wait times through better utilization of cancellation schedule Incentivizing attendance: providing bus passes when care managers are not able to transport. Further reduce wait times with added telepsychiatry days (new provider) Improved collaboration with referral sources through accessing EXYM and more consistent communication regarding care managers Provide free cell phone program	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	A number of interventions were implemented. The MHP will need to detail how reduced wait times has an impact on attendance. How long is the wait time decreased? Will this be measured? The discussion does not appear to include this aspect or provide data for the timelines that the MHP drafted in the submission tool. To show correlation between calls and decreased no-show, they need to standardize the calls. The MHP must determine standardized processes for consistency and for measuring effectiveness, such as: when will the calls be made…two days before, one day before the appointment; what time of day; will the same staff call; will messages be left on the machine? A short survey at the time of the appointment may provide feedback as to consumer adherence to determine what had an impact? What will be useful for the MHP to replicate? The MHP outlined the challenges with the interventions in detail in the PIP submission document. Primarily, these centered on limited access to the free cell phone.
	Totals	0 Met 1 Partially Met 0 Not Met 0 NA **0**UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The confidence level of 95% will be used as it is an industry standard, with a margin of error of +/-2%.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The year to year data analysis indicates the interventions utilized in conducting this PIP reflected a substantial reduction in no-show rates, towards the target goal of 10%. It is the MHP's intent to continue the strategies from this project, as well as identifying new interventions and revisions as needed, to ensure meeting the target goal in the future. The MHP conducted appointment reminder phone calls to clients prior to their visit as well as sending a monthly list of client appointments to its ASO, RQMC, who then sends a list to their care managers. There are continued efforts to refine the flow of information, thus enabling care managers to make client contact prior to their actual appointment dates.
	Totals	2 Met 0 Partially Met 0 Not Met 0 NA 0 UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data for the number of reminder calls, appointments kept, and the no-show rate were collected and repeated monthly. The interventions regarding issued cell phones were not available.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The no-show rate decreased to an overall average of 11% with a 9.23 percentage point drop. The consumer-focused interventions of providing bus tickets and cell phones were limited due to external factors not considered or accounted for at the onset. The bus schedule was not aligned with appointment times and the cell phone company did not provide adequate coverage in the area. Revisions or adjustments for these were not available per the MHP.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Although there was monthly variation due to undetermined factors, the average no-show rate for the year, 11%, was greater than 9 percentage point decrease, a significant improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☒ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP utilized the same denominator (total number of medication services invoiced each month, via the EHR Avatar) for validity. The information provided was sufficient to analyze the progress in meeting the target goal. The decrease in no-show rate is amplified by the context of a 79% increase in total number of medication services rendered during this year. MCBHRS' medication management services has made important progress toward meeting its target average monthly no-show rate, while increasing the number of medication services provided each month.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The no-show rate improved over time.
	Totals	4 Met 1 Partially Met 0 **Not** Met 0 NA 0 UTD

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

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

Conclusions:

Documented monthly data indicated an improved no-show rate to an overall average of 11%. This was impressive since the MHP simultaneously increased the number of appointments scheduled. The MHP has stated this concluded the formal PIP. Discussion occurred on site to provide technical assistance for consideration of this PIP and methods to formulate a new PIP for submission in the next review cycle.

Recommendations:

It appears the reminder calls and the coordination efforts have led to an improved show rate. It will benefit the MHP to conduct a survey of consumer benefit to then replicate the effective interventions.

Check one:

☒ High confidence in reported Plan PIP results

☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time