FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

MHP FINAL Report

Mendocino

Conducted on

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INTRODUCTION

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

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

- MHP information:
  - Beneficiaries served in CY13—1,332
  - MHP Size—Small
  - MHP Region—Superior
  - MHP Threshold Languages—Spanish
  - MHP Location—Ukiah

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Mendocino County mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- 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 four percent (4%) Emily Q. Benchmark.
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

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

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

- Ratings for Key Components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 recommendations, which are summarized below.

Assignment of Ratings

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

Key Recommendations from FY13-14

- Recommendation #1: Enhance the QI Work Plan activities with increased measurable goals, timelines, routine data reports and timely, detailed documentation of the meeting activities.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP's QI Work Plan for FY14-15 calls for review of reports on the number of consumers served six times annually, with demographic breakdown semi-annually.
  - Productivity standards are stated in the Work Plan with semi-annual report review by the QIC.

- Timeliness standards are set in the QI Work Plan for initial assessment, initial psychiatric appointment and urgent conditions, with data reports reviewed six times annually.
- After-hours access line responsiveness standards are set, including six test calls each month, with results reported to QIC six times during the year.

- Recommendation #2: Routinely analyze results from identified outcome measures to assist in monitoring appropriate service utilization and consumer progress.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has implemented comprehensive use of the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) instruments for all consumers, including the point of authorization that utilizes this information for the medical necessity review.
- CANS/ANSA data is used at the point of intake and when care plan updates are updated. An algorithm is being developed by Redwood Quality Management Corporation (RQMC) to assist in the development of an aggregate CANS analysis process.
- The MHP's administrative and QI plan to use outcomes and service data in system management. Challenges exist in the different IS systems in use create yet unresolved problems in interoperability and report production, particularly on the adult services area, managed by Ortner Management Group (OMG).

- Recommendation #3: Establish work groups to conduct a needs analysis to determine adequate resources to support and maintain EHR and data access requirements and practice management functions. Prioritize resources to complete the EHR contract and include feasibility of a rollout to organizational providers.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- At the end of a Request for Qualifications (RFQ) process ending in July 2014, the MHP selected an IT consultancy (Expio) to lead a multi-faceted analysis of IS area needs including HIPAA, Meaningful Use, and State DHCS SD/MC claiming requirements, and others. The consultant will have the ability to meet with subcontracted organizational providers, Administrative Services Organization (ASO) staff, and MHP personnel in the pursuit of IS area responsibilities.
- From the information presented, it is not apparent that the MHP convened a multi-level and multi-agency work group in advance of and informing the RFQ process.
- During the review period, there is no evidence that the MHP has addressed the issue of staffing/support resources for current IS operations.

- During the review, the MHP discussed the possibility of implementing Netsmart/Avatar EHR use by the adult ASO (OMG), the decision will be deferred for later determination in the process lead by the consultant.

- Recommendation #4: Create an inter-agency line staff venue for sharing of service delivery practices to establish collaboration and eliminate access barrier.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP and its primary contract Administrative Services Organization (ASO) agencies, OMG and RQMC, meet on a monthly or more frequent basis to discuss issues and caseload management. The effectiveness of meetings between the MHP and its providers was also recognized by line staff who have experienced the improvement in operations.
- The Quality Improvement/Management/Leadership Committee meetings and Flash are the events in which service delivery practices are shared, with a focus on collaboration and access to care barriers being reduced.
- Both contract agency and MHP staff feel the referral process and access management has improved greatly.

- Recommendation #5: Establish routine reporting, analysis and subsequent improvements as warranted for medications support services timeliness standard.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The previous review found the MHP reporting a 21-day standard for initial psychiatry access, and met this goal 47% of the time for adults with an average of 44 days. During the current review, the MHP reports a 30-day standard for prescribing access, with adults accessing psychiatry services 100% of the time within 14 days and 100% of children within 12 days. The minimum standard has been lowered, while actual performance has improved.
- The MHP monitors data on timeliness usually on a monthly basis, and is also considered by QIC, as evidenced by QIC minutes.
- Medication Support services are delivered by an MHP psychiatrist and Nurse Practitioner, Integrated Care Management Solutions (ICMS) psychiatrist and a nurse practitioner.
- The MHP and its consumers report some consumers seek psychiatric services from outside providers such as the local FQHCs, which also have psychiatric prescribing capacity.

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

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

- Access to Care
    - Communication and coordination between providers has improved, and the roll-out of ASO contracted-out services has overcome the initial hurdles, as confirmed by both line staff and consumers.
- Timeliness of Services
    - The MHP's spreadsheet data indicates that actual time to first service and time to first psychiatry service for adult consumers has improved by 68%; the MHP's standard has been lowered from 21 to 30 days (43%).
    - Review participants indicated wide variations in actual timeliness of service experienced, with longer times occurring earlier on in the transition from county to contractor care, particularly noted by the adult service consumers.
- Quality of Care
    - The MHP's relatively new ASO model of service delivery has some unresolved issues relating to Information System (IS) areas. RQMC, the Children's ASO, utilizes Exym for both Electronic Health Record (EHR) and Practice Management (PM); however its services are manually entered into its Netsmart/Avatar system by MHP personnel. The Adult (OMG) Services system lacks a PM/EHR system, using pen and paper methodology, and does not currently possess an electronic system. Resolving these IS issues are important issues faced by the MHP.
    - The quality improvement process, committee function, and documentation have improved with an important addition of consumers, family and community members in the process.
    - The routine focus on data and within QIC is a strong area of improvement for the MHP.
    - The MHP's QIC process has the QIC meeting occurring on a rotating basis throughout the service regions of the county, providing regional stakeholders with opportunities to easily participate.
    - Efforts to improve the inclusion of consumers and identify both strength and challenge areas includes leading off the QIC with local community and consumer/family representatives, who are directly asked for feedback regarding

how the MHP is doing, with suggestions being brought forward for executive/management review.

- The MHP notes that it now has ICC Coordinators for all of its Katie A. beneficiaries and is monitoring fidelity and quality of service provision within the model. Strong communications between the MHP and CWS has provided significant comfort to family members as the team moves to improve beneficiary wellness and step them down to lower levels of care.

- Consumer Outcomes
  - CANS and ANSA instruments have become an active part of the intake and assessment, as well as on-going level of care determination process.
  - Under development is a process for analyzing CANS data in an aggregate manner for use in determining both level and locus of care.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2015.

TOTAL BENEFICIARIES SERVED

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

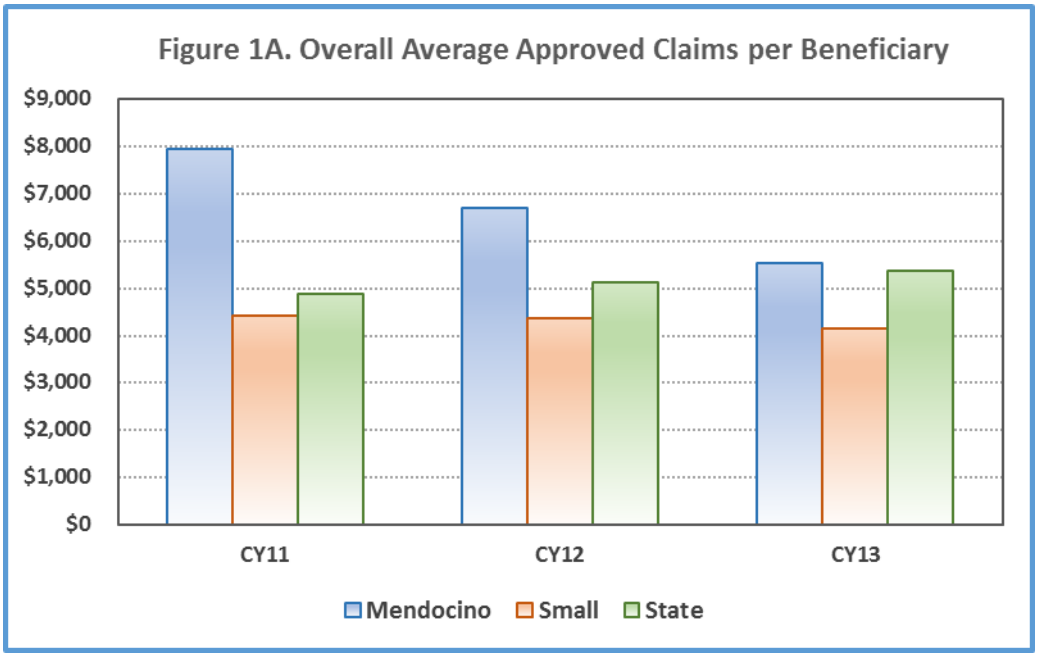
Table 1—Mendocino MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

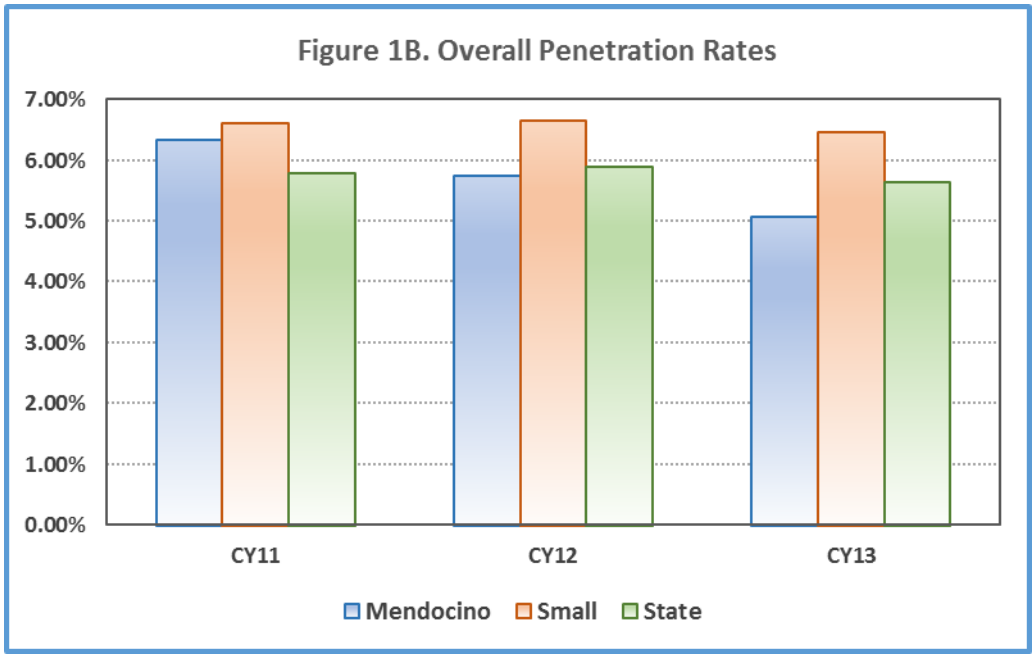
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	13,368	867
Hispanic	8,580	239
African-American	253	30
Asian/Pacific Islander	308	16
Native American	1,774	98
Other	1,917	82
Total	26,197	1,332

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

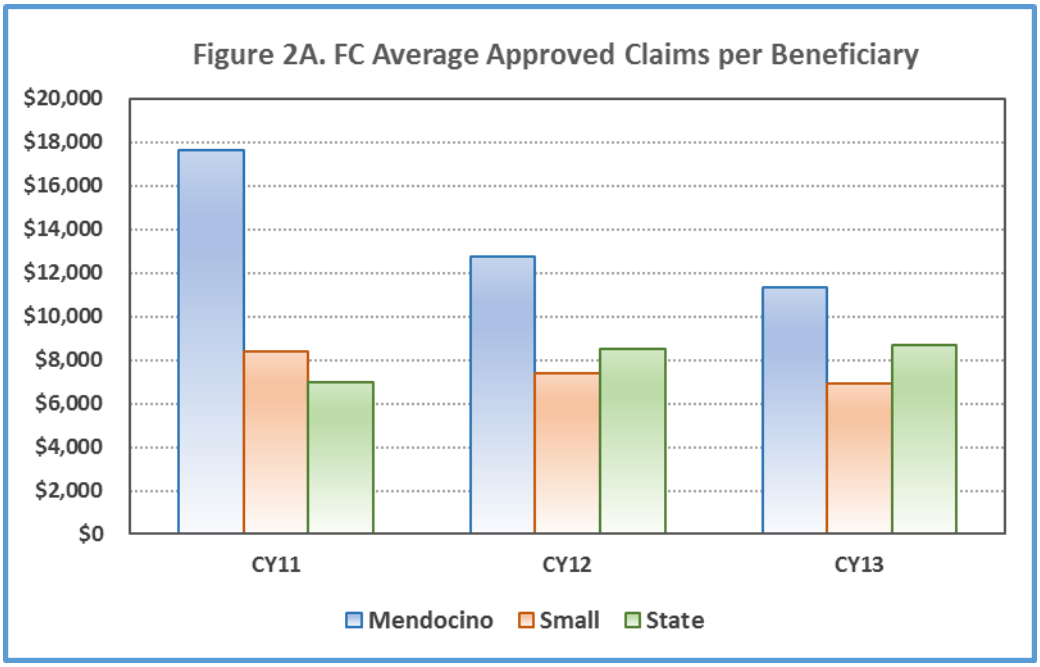
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

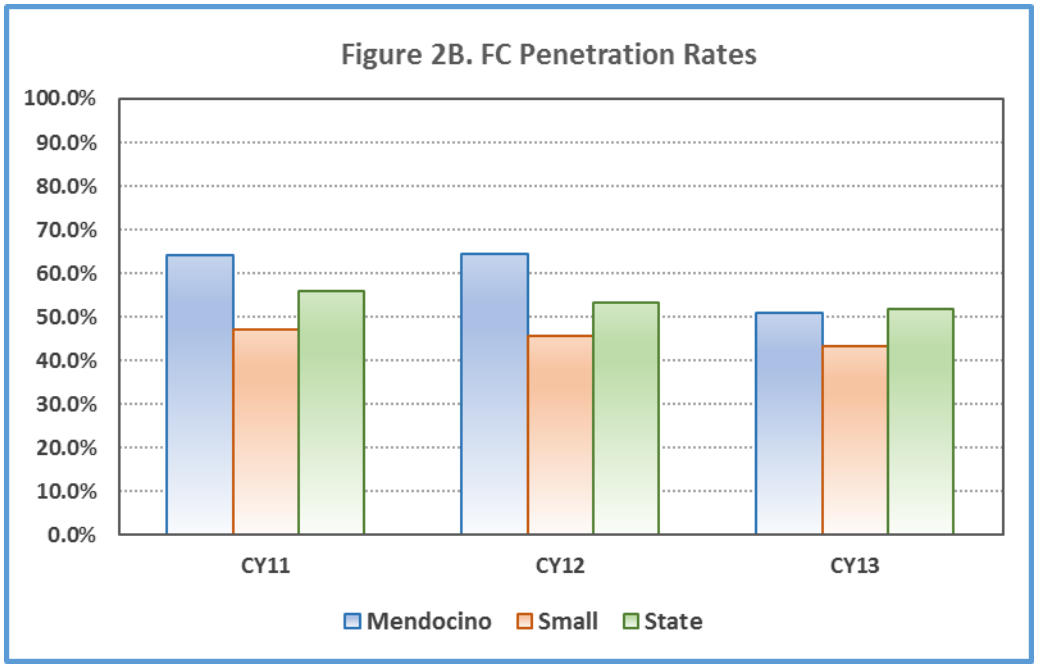
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for **Small** MHPs.



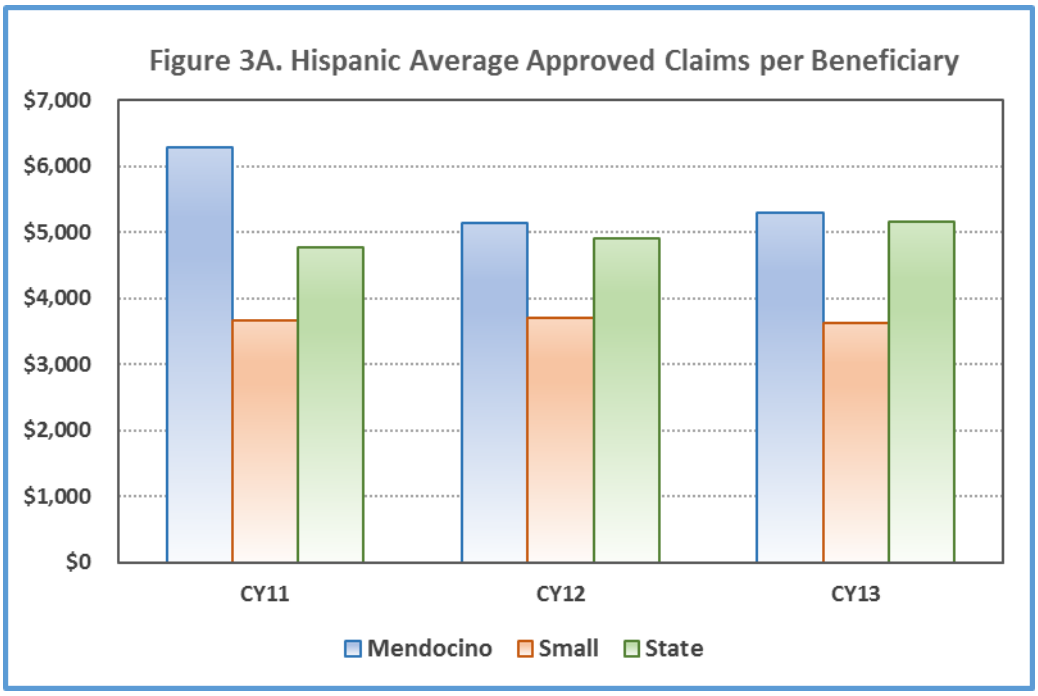


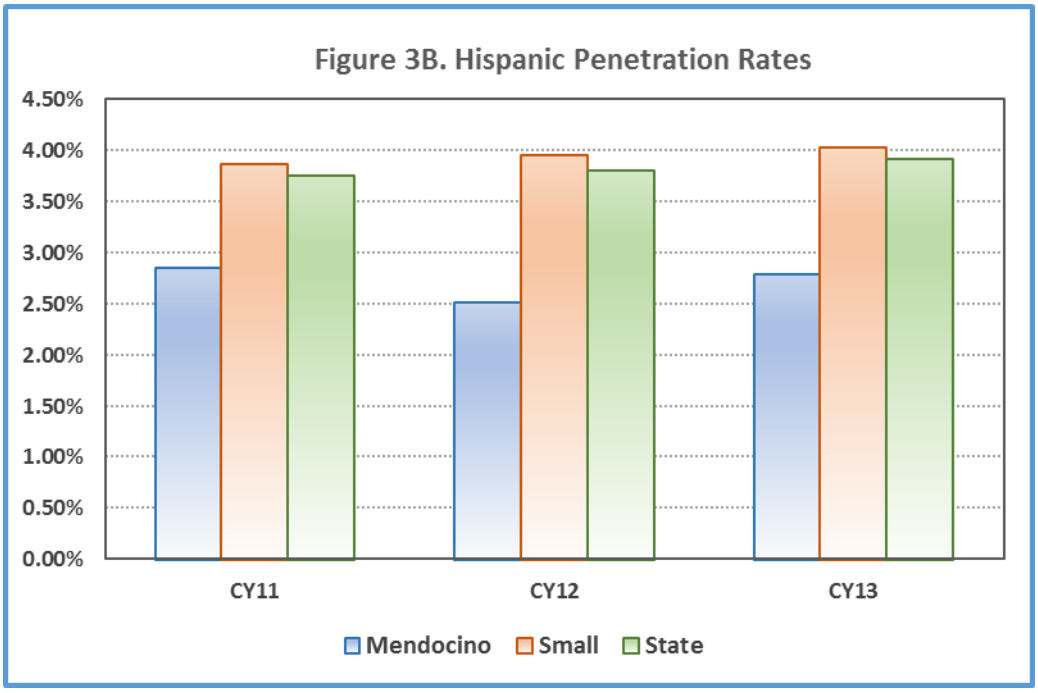
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.





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





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Mendocino	CY13	43	1,332	3.23%	$39,536	$1,700,029	23.09%
	CY12	75	1,434	5.23%	$42,332	$3,174,933	33.16%
	CY11	103	1,536	6.71%	$44,940	$4,628,803	38.37%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore

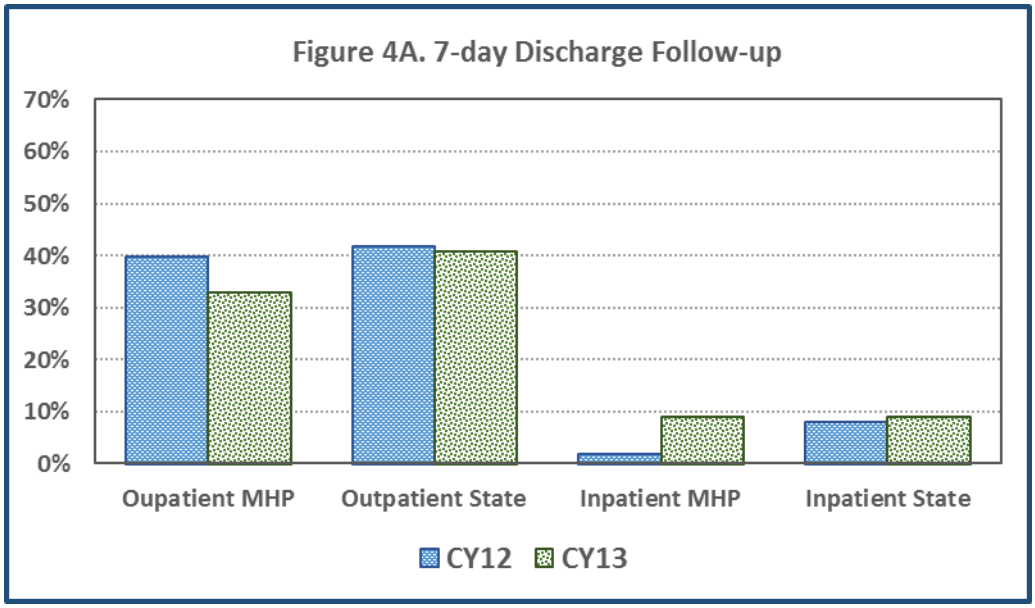
do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

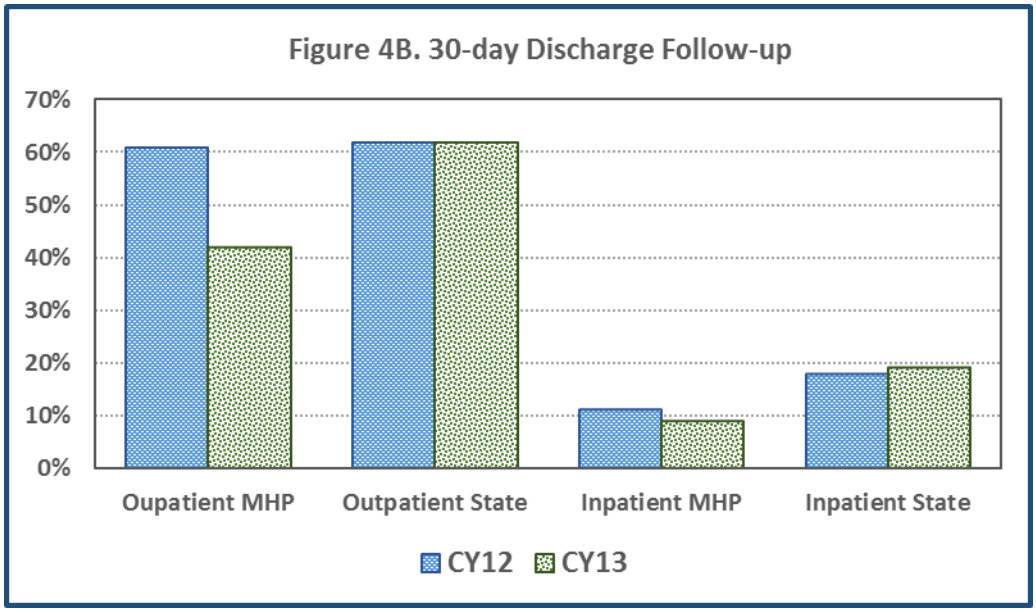
Table 3—TBS Beneficiary Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
Mendocino	No	917	27	2.94%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

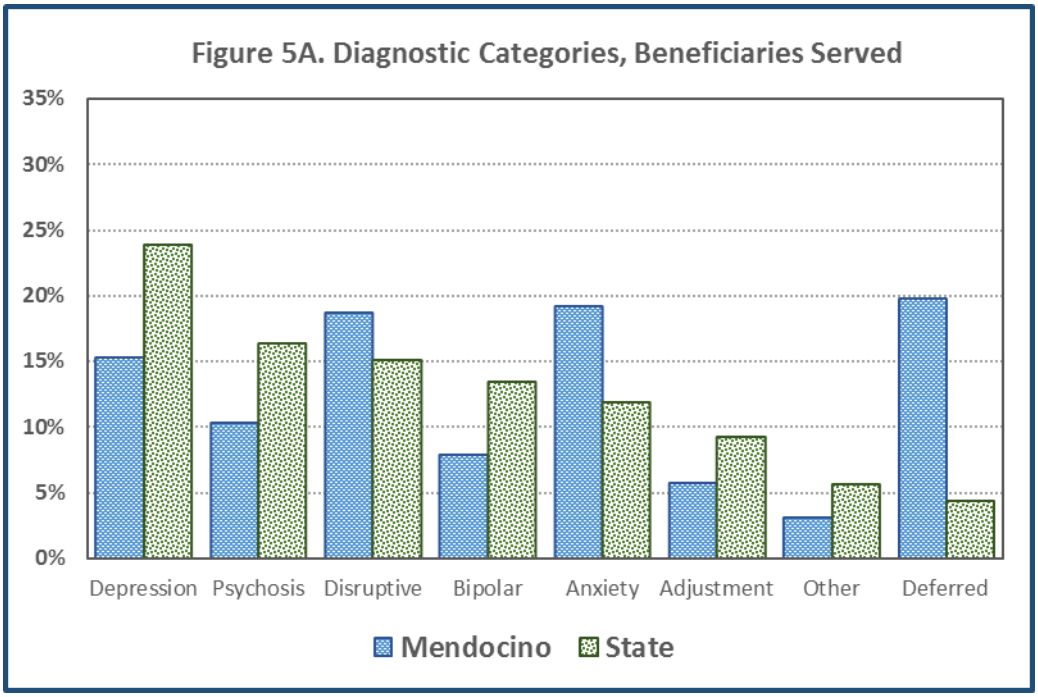
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

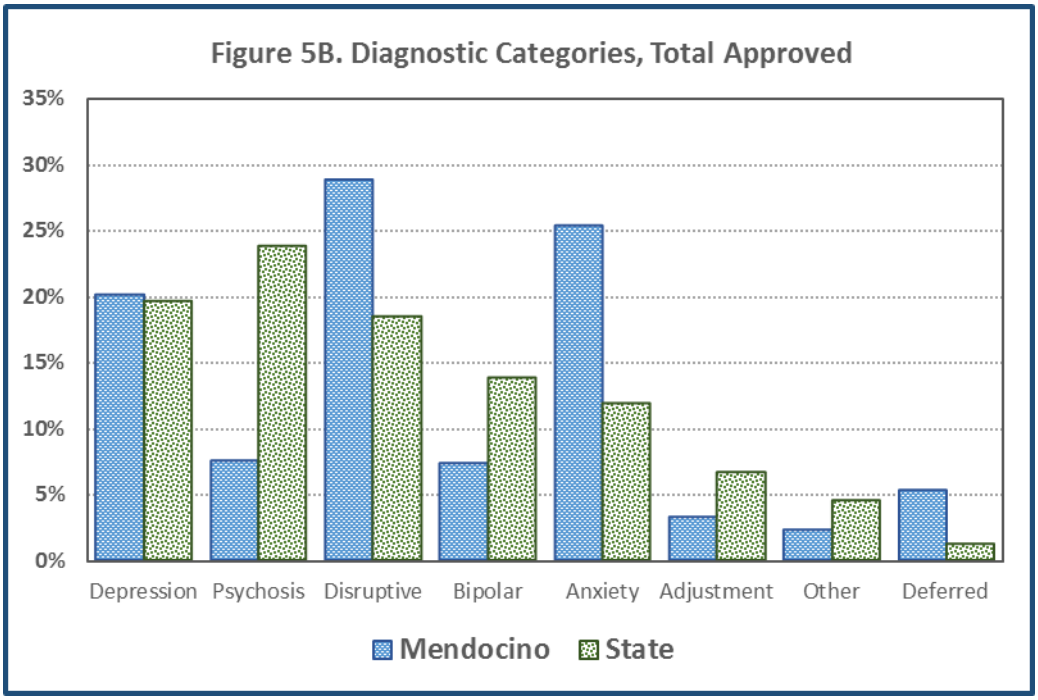




DIAGNOSTIC CATEGORIES

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 CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate is less than both small MHP and statewide averages.
  - The MHP's foster care penetration rate is greater than the small MHP average and comparable to the statewide average.
  - The MHP's Hispanic penetration rate is significantly less than both the small MHP and statewide averages.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after psychiatric inpatient discharge are below the statewide averages.
  - The MHP's 7 day inpatient recidivism rate is comparable to the statewide average and the 30 day recidivism rate is below the statewide average.
- Quality of Care
  - While the MHP's percentage of high-cost beneficiaries is greater than the statewide average, the corresponding percentage of total approved claims is less than the statewide average.

- The MHP's overall and Hispanic average approved claims per beneficiary are greater than the corresponding small MHP averages and comparable to the statewide averages. Foster care approved claims per beneficiary are greater than both small MHP and statewide averages.
- The MHP's distribution of diagnostic categories varies from the statewide distribution. The MHP has higher rates of anxiety and disruptive disorders and lower rates of depressive, psychosis, bipolar and adjustment disorders. The MHP has approximately four times the percentage of individuals with a deferred diagnosis compared to the statewide average.

- Consumer Outcomes
  - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (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 2013.

MENDOCINO COUNTY MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Mendocino County MHP submitted two PIPs for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Care Coordination Collaborative (CCC). Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	Improve Access Line Services. Onsite technical assistance was provided to identify future PIP topics.

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

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

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	PM	M
2	Study Question	2.1	Clearly stated	M	PM
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	NM	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	PM	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	PM	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NA	PM
		7.2	Interim data triggering modifications as needed	NA	PM
		7.3	Data presented in adherence to the plan	NA	PM
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NA	PM
		7.5	Interpretation of results and follow-up	NA	PM

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NA	PM
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	NM
		8.3	Threats to comparability, internal and external validity	NA	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NM
		9.3	Improvement in performance linked to the PIP	NA	NM
		9.4	Statistical evidence of true improvement	NA	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NM

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

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	12	15
Number Partially Met	3	8
Number Not Met	1	6
Number Applicable	16	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	84%	63%

CLINICAL PIP—CARE COORDINATION COLLABORATIVE (CCC)

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

- "Can we make a few key changes in communication and care coordinator roles and duties that significantly improves the integration and coordination of care among our SMI (Seriously Mentally Ill) population clients with co-existing disorders (specifically for those at risk for diabetes and cardiovascular disease) and results in improved health markers?"
- Date PIP began: July 1, 2013 – September 30, 2014
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

The MHP has participated in the multi-county Care Coordination Collaborative which targets establishing coordination between mental health and physical health providers, and of monitoring physical health key values with the aim of improving health outcomes for consumers. The selection process involves identification through case review or referral of the seriously mentally ill and/or substance/alcohol abuse adult population who have a serious comorbid condition.

The basic construct of this PIP rests upon epidemiologic studies that identify the shortened longevity of seriously mentally ill individuals and those who suffer from substance and alcohol abuse. The correlation of these conditions with comorbid physical conditions or risk comprises another element of the MHP's rationale. In addition the MHP also focused its attention on the rural nature of Mendocino County and the fragmented care delivered by various provider specialties.

During much of the last year, efforts have emphasized obtaining the necessary linkages between the MHP and health providers, obtaining required consents to share information, and recently are improving the focus on actual monitoring and tracking of physical health indicators.

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

The technical assistance provided to the MHP by CalEQRO consisted of greater focus on the actual health outcomes of its consumers and development of mid-course analysis of the data and any corrective action indicated.

NON-CLINICAL PIP—IMPROVE ACCESS LINE SERVICES

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

- "The County of Mendocino Health & Human Services, Behavioral Health & Recovery Services, Mental Health Services shall bring the 24/7 Access Line into compliance by improving the delivery of services when calling the Access Line. Some measures that will be taken to improve service deliver are: revising the "Greeting" Script, improving the Test Call Sheets, educating staff on specialty mental health services, and training staff in the use of the language line and logging all calls. The desired outcome will be that the Access Line will provide the level of service required for best outcomes for beneficiaries accessing Specialty Mental Health Services."
- Date PIP began: July 1, 2013 – September 30, 2014
- Status of PIP:

  ☐ Active and ongoing

  ☒ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

The MHP became aware of problems with the 24/7 Access Line (AL) response by a DHCS oversight review which found a 60% success rate (three of five calls were handled successfully) in the handling of AL test calls. The MHP performed additional testing, which provided further confirmation of the issue. The DHCS review standard is failed if any calls are not handled properly.

The MHP began a process of identifying and studying the component elements of the 24/7 AL. In the process, AL response was transferred to Integrated Care Management Solutions (ICMS), an organization that provides other services for the MHP's consumers. Also the MHP identified the various component elements of an appropriate Access Line response. These elements include: greeting question, crisis question, appeal/fair hearing question, identification of preferred language and language line usage as appropriate, and the logging of calls.

The MHP initiated its PIP, including a plan to perform six test calls to the AL each month, three by the contractor and three by MHP staff. The data would be captured monthly, and reported out quarterly, with the PIP documents containing the initial baseline data and one-year point a summary of the data.

The MHP found from test calls areas of greeting, crisis identification question, and call logging to have improved. The Language Line/preferred language question remained successful. The least

common question that would relate to grievance and appeals or state fair hearing question was not handled as the MHP planned in many cases.

The MHP is aware that the small number of test calls prevents any sort of valid or useful statistical analysis. The variation in response highlighted the need for ongoing training. However the absolute numbers of test calls were relatively low, particularly when contrasted with the total number of AL calls. In FY13-14 the Access Line received 3804 calls for assistance, and in only Q1 of FY14-15 the AL received 2420 calls.

In considering this topic, the MHP may have improved its AL information if it found a mechanism for providing at least some limited follow-up on actual AL calls. This follow-up could have sought satisfaction feedback from the caller with the information provided; or the MHP could have sought, at a later time, to provide follow-up with those callers who identify themselves sufficiently to allow the QA/QI team to perform outreach. The data from actual calls would provide greater depth of information about the quality of the MHP's response.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussion of other non-clinical PIP options that might be germane to the MHP's environment.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP's Non-Clinical PIP results indicate that challenges continue with the process of assuring proper and adequate response to the Access Line, this despite the transfer of this function to ICMS, a program which is familiar with mental health service delivery.
- Timeliness of Services
    - The Non-Clinical PIP activities may result in improved access as Access Line caller needs are better identified and coordination with face-to-face services is expedited.
- Quality of Care
    - The Clinical PIP provides opportunities for impacting physical health of its consumers through improved coordination of care and specific targeting of health indicators, and improving providers' awareness of all drugs consumers are prescribed.

- Consumer Outcomes
    - The Care Coordination Collaborative Clinical PIP shows the promise of reducing morbidity and mortality of MHP consumers through direct monitoring of health indicators, providing health education sessions, such as for diabetes, and improving the coordination between mental health providers and the consumer's primary care provider.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 5, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 5—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP hired an Ethnic Services Coordinator in the review period, and has increased the number of contractor bilingual clinical staff from eight, in the prior review period, to 16. Cultural competence efforts to improve services to Native Americans and Latino/Hispanic consumers continue to be an ongoing focus. Efforts in this area include an ongoing interface with a multi-community agency serving Hispanics, Nuestra Alianza, and meetings that seek input from Native American representatives.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	Adaption of capacity is evident in the effort to bring programs such as Manzanita into a case management service provision role and into Medi-Cal claiming. This is a natural and innovative expansion into case management with a provider who serves numerous severely mentally ill on a regular basis, but in a wellness center model. July 1st, the MHP implemented a TAY service track, in which youth aged 18-25 are not referred into the adult service system, improving the care for these transitional youth by keeping them in an expanded children/youth element.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP primarily operates an ASO model and its two main sub-contractors, Redwood Quality Management Company (RQMC) and Ortner Management Group (OMG) have relationships with existing non-profit organizations and have expanded the services of these programs in seeking to promote a diversified and accessible network of care that serves adult and child/youth populations.

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

Timeliness of Services

As shown in Table 6, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 6—Timeliness of Services			
	Component	Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP has a 14-day standard for initial clinical access, with an actual average of 3 days for adults and 12 days for children and youth.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP's standard is 30 days with an actual average of 14 days for adults and 12 days for children and youth.
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP tracks business hours (BH) separately from after-hours (AH). The BH standard is 1 hour, with 81% success for adults and 93% success for children. The AH standard is 2hours, with 92% success for adults and 98% for children/youth.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP's standard for psychiatric hospital aftercare is 7 days. For both adults and children the actual is 1 day, with 98-99% completion rate.
2E	Tracks and trends data on rehospitalizations	FC	For 372 total acute psychiatric admissions, the MHP reports a readmission rates within 30 days: adults - 11%; and children - 4%.
2F	Tracks and trends No Shows	FC	The MHP's No-Show (NS) standard for psychiatrists is 15%, with an actual of 10% for adults, 7% for children/youth services. The MHP's NS standard for non-psychiatric care is 10%; the data presented for children is 3%; no data is available for adult services.

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

Quality of Care

As shown in Table 7, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has significantly improved the QIC process and structure, with a consistent data focus and inclusion of consumers, family and community representatives for their feedback on services.
3B	Data are used to inform management and guide decisions	FC	The MHP is able to utilize service data and reporting capabilities from the Children/Youth ASO provider, which uses Exym for practice management, EHR, and reporting capacity. The adult services component remains significantly limited by the lack of clinical data aggregation and reporting capacity.
3C	Evidence of effective communication from MHP administration	FC	Consumers related hearing of system changes through case manager contact and the wellness centers. Contract providers report close communication with the MHP. Line staff report learning of system changes from supervisory staff.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	The QIC format change emphasizes the participation of consumers and key stakeholders. Meeting minutes reflect broad participation of various stakeholders. However, some MHP line staff continue to experience being out of the information loop at times, and resort to word of mouth communication for updates.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	Integration and collaboration is an inherent feature of the MHP's ASO operations serving adults and children/youth. The MHP and its contractors have routine clinical dialogue and meetings with FQHCs and other community partners in the provision of mental health care. The MHP participates in the "11 o'clock calendar," a court function very similar to a formal mental health court, where it seeks to coordinate with the judicial system and improve outcomes.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP is using the CANS and ANSA instruments to assist with the intake process, in the determination of level of care, and in regular reviews of need to continue with specialty mental health care. Data aggregation and use in determining most effective service packages is not yet occurring, complicated by the different systems in use by the MHP and it's RQMC, and the lack of PM/EHR with the adult ASO OMG. It is only a matter of time before this happens as this is clearly the direction the MHP seems headed toward.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP demonstrates a regular process of collecting consumer feedback on services, both state-mandated and local instruments, and reviewing the results within the QIC.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Consumers and family members are employed by the MHP's subcontractors, in both line and key leadership roles. There is also evidence that individuals with lived experience also occupy professional and other positions within the MHP and its providers.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP contracts with community organizations to provide Wellness Centers, including Manzanita, which operates two (Ukiah and Willits), fully staffed and operated by consumers and family members, including at the leadership level. This program has also expanded into delivery of case management services during the last year.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Timeliness tracking for the adult services requires a manual approach. Significant challenges must be overcome before an automated process will be possible – the groundwork lies in the adult services (OMG) adoption of an EHR system.
  - The MHP does track No-Shows; however is not able to do so system wide. It is also unclear why goals for Psychiatrists are so high given their crucial role in treatment
  - Improved access for Spanish speakers due to the increase in the number of bilingual staff in programs managed by OMG (adults) and RQMC (children's).
- Timeliness of Services
  - The MHP's attention to timeliness is evident in the tracking and review process undertaken, and the back-up data provided as evidence of this attention.
  - The MHP and its consumers would benefit from a re-assessment of the move to increase the number of days set as standard from initial contact to intake appointment and initial access to psychiatry services. In both cases, the MHP appears capable of meeting its prior, more rigorous standards.
- Quality of Care
  - The MHP's ASO programs collect consumer satisfaction from each component program.
  - Uneven data access within the adult services area is a potential barrier to enhancements that would improve aggregation of consumer outcome monitoring. This solution to this issue begins with adoption of PM/EHR for the adult ASO.
  - Recent development of a more robust TAY service track has provided an improved level of care to youth 18-25, with RQMC, the children's ASO, managing the care.
- Consumer Outcomes
  - The MHP's adoption of the CANS and the ANSA for all consumers served, children and adults respectively, offers utility in helping to manage the treatment process as well as future potential for identification of effective service delivery packages.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted a 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 one focus group, which included the following participant demographics or criteria:

- A culturally diverse group of adults who began receiving medications support services within the past twelve months.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This focus group in actuality included parent/caregivers and young adults, in addition to the adult consumers, who were the original target group. The meeting was held at MHP's main offices and included 13 participants.

The experiences of these individuals varied greatly, and have been influenced by the change to an ASO model that occurred approximately one year ago. There were not sufficient numbers with the same experiences to provide a meaningful summary; however, it is clear that many adult consumers experienced some disruption in care during the county to ASO transition process. This resulted, for some, brief uncertainty as to what agency would be serving an individual and who the provider would be. It should also be noted that the vast majority of participants believe this transition process to have been successfully completed at the time of this review.

Among the adult consumers, the majority receive psychiatry services and medications, in addition to case management, and a smaller number also receive psycho-therapy. Several had experience with the LPS conservatorship process as well. A number received housing support services. Some had disliked the provider that was assigned during the changeover, but were able to remedy this problem fairly quickly.

Psychiatry access is limited, in the view of a number of adult consumers. Ongoing psychiatry/med support visits are scheduled for most once per month, but that often stretches to every 7-8 weeks with the reschedules that occur. Consumers believe that part of the problem is the overbooking process used by the MHP to adjust for no-shows, and to maintain productivity.

Many of these adults also attend Manzanita Wellness Center, which has expanded during the recent system change process to include case management services. Some consumers experienced firsthand a period of time when these new duties and responsibilities seemed unclear and consumers felt they received mixed messages about the help they were to be provided.

Some of the adult consumers stated that they received psychiatry services from a local Federally Qualified Health Center, utilizing a Medicare benefit, deciding that this provider was preferred over the professional offered by the county. However case management support continued to be provided, for these individuals, from Manzanita, under the OMG adult service umbrella.

The youth and parent/caregivers who comprised the other segment of the focus group have received services from what is now known as Redwood's Community Services (RCS) and Tapestry, a children's service subcontractor. Timeliness of initial access for children and youth recipients that started services within the last year was quick, all within a one-week period of presenting.

Overall, the child/family members had a very positive response to the services provided, and felt that individual staff were readily available for support and consultation, even off hours.

Recommendations arising from this group include:

- More licensed clinical staff are needed for adult services (n=4)
- More assistance with affordable housing is needed (n=3)
- More assistance with transportation to medical/behavioral health and pharmacy w(n=6)

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1

Category		Number
Total Number of Participants		**13**
Number/Type of Participants	Consumer Only	11
	Consumer and Family Member	2
	Family Member	0
Ages of Participants	Under 18	2
	Young Adult (18-24)	2
	Adult (25–59)	8
	Older Adult (60+)	1
Preferred Languages	English	13
	Spanish	0
	Bilingual	0
	Other	0
Race/Ethnicity	Caucasian/White	8
	Hispanic/Latino	1
	Other	4

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Gender	Male	3
	Female	10

Interpreter used for focus group 1: ☒ No ☐ Yes Language:

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Initial access to care is reportedly fairly quick.
  - Psychiatry access is complicated by limited resources.
  - Psychotherapy access for adults is perceived by consumers to be constrained by small number of licensed clinical staff.
- Timeliness of Services
  - Few consumers in the group initiated services during the last year.
- Quality of Care
  - Consumers would like to see greater choice in psychiatry/medication support services within the MHP itself.
- Consumer Outcomes
  - Housing retention and availability of housing is a priority for focus group participants, and is an area in which the MHP provides assistance despite the limitations in availability.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	11.20%
Contract providers	88.11%
Network providers	0.69%
Total	100%

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

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

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

16.53%

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

9.1%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

CURRENT OPERATIONS

- The MHP continues to use the Netsmart Avatar product line for its EHR. The MHP has recently gone through a round of system maintenance to modernize and update the product line to the latest major version. The MHP extensively utilizes the practice management portion of the product suite but has yet to deploy clinical utility across the entire SOC or effectively implement practical HIE.

MAJOR CHANGES SINCE LAST YEAR

- County's Avatar system was upgraded to MyAvatar and Caché was updated to 2010
- The MHP has purchased new computers for staff
- The county has opted to retain the Netsmart product
- The county has awarded a contract to a contractor to assist in utilizing the EHR appropriately
- The MHP is entering medications into the Avatar system.

PRIORITIES FOR THE COMING YEAR

- Complete MHSA full service partnership testing with the State
- Meet federal Meaningful Use requirements.
- Sharing data information with Collaborative Care partners
- Acquire Consumer Connect module for MyAvatar
- Implement electronic version of the CANS with Katie A. beneficiaries
- Implement electronic version of the ANSA for the adult population

OTHER SIGNIFICANT ISSUES

- The MHP appears to have a properly functioning billing unit which is doing its due diligence around Short-Doyle Medi-Cal (SDMC) billings. The staff are regularly reviewing policies and procedures for consumer billing. They also report that their internal denial rate is a low 3%. This is a positive accomplishment. They report having significant difficulty in getting authorized for Medicare billing and hope to be successful in the next year, similar to other smaller MHPs.

- The county has determined that it will keep the Netsmart Avatar suite of products for internal use. While the Avatar product is a proven success for some MHPs in the state it has not proven to be fiscally manageable for many smaller MHPs like Mendocino. It is unclear if this county took the practical experience of its peers across the state into consideration when it chose to continue use of the product. The results of the work of the retained IS contractor, XPIO, will be informative, as the MHP seeks to craft a utilization model that will be beneficial to the executive team, clinical staff, quality improvement, beneficiaries while remaining affordable to the county.

- The MHP is currently disadvantaged by having legacy data collection protocols and multiple information silos to manage its SOC. The Youth ASO uses its own EMR. The Adult ASO utilizes legacy paper methodologies. Internal providers, who are being functionally transitioned to ASO integration have no access to the MHP's EHR. The MHP's SUD division utilizes a different EMR. None of these systems communicate clinical data in a way that is of broad utility to the MHP's QI initiatives. Data collection appears difficult enough that useful analyses like penetration rates were only calculated once in the past year (and indicated poorer performance than past data provided by the EQR). The positive note in this is that the MHP is very aware of the situation and is executing its strategies for remediation.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
MyAvatar PM	Practice Management	Netsmart	1	MHP
MyAvatar CW	Clinical Workstation	Netsmart	1	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The County has informed the MHP that they will be continuing to use the Avatar EHR system for the foreseeable future. The MHP has contracted with an outside IT vendor, XPIO, to assist them in the practical utilization of the toolset. Work with the vendor is in its opening phases.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Netsmart Avatar	X			
Clinical decision support				X	
Document imaging				X	
Electronic signature—client				X	
Electronic signature—provider				X	
Laboratory results (eLab)				X	
Outcomes				X	
Prescriptions (eRx)				X	
Progress notes	Netsmart Avatar	X			
Treatment plans	Netsmart Avatar	X			
Summary Totals for EHR Functionality		3		7	

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

- While it is clear that the MHP is making progress in staging its capabilities to have an integrated data system it is also clear that it is still working with inefficiencies resulting from not having CBOs enter data into the Avatar system or electronically sending HIE to be merged into the MHP's PM/EHR. The MHP relates that it is exploring solutions to this issue but has not come up with project timelines for its completion. The Youth ASO's EMR Exym has allowed it to move forward clinically but the Adult ASO is currently using legacy paperwork. At this point the only broad user of the MHP's PM/EHR systems data is fiscal, with some exceptions emerging from the youth HER reporting capability – otherwise manual tracking through external database capture is

required. The MHP notably has a strategy in place to change this. Not enough time has passed, however, to see if the MHP's plans will be successful.

- Progress related to certain aspects of EHR usage, such as Outcomes toolset tracking/analysis and eRx use, are reported as either narrow efforts within the MHP or the result of the standalone EMR used by the Youth ASO. Neither use case provides wide benefit to the MHP executive team or beneficiaries at this time.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
    - The MHP performed a penetration rate analysis during the review period and noted penetration rate findings that were less than previous data reported by the prior EQRO review. The MHP has long experienced difficulties with determining true penetration rates due to the existence providers, such as FQHCs and Beacon that claim outside of the Short-Doyle Medi-Cal system. The MHP would benefit from engaging these external providers who may serve MHP eligibles, and establishing a sharing of numbers served with demographic breakdown, until a health information exchange can be implemented.
- Timeliness of Services
    - The reporting out of timeliness data is limited to the RQMC and its Exym system. Otherwise, the data is manually recorded using external databases.
- Quality of Care
    - While the MHP appears to be struggling with the utility of its EHR beyond traditional practice management roles it does not appear to be impeding the positive work of the Adult ASO at this time. Of course, this is a temporary situation and soon both ASO will be well beyond the initial issues of any systemic implementation. The MHP will find it challenging to monitor performance of its SOC without seamless data exchange from the ASOs.
- Consumer Outcomes
    - The MHP currently does not possess the system-wide electronic capability to perform Level of Service/Level of Care analysis. It is clear that the MHP is moving in this positive direction but has not yet achieved this goal. The single largest impediment, at this point, appears to be underutilization of its EHR to establish a data repository common to the entire SOC. It would prove cumbersome for the MHP to try and systemically answer the question "How do you know your beneficiaries are getting well?"

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers affecting the preparation or the activities of this review.

CONCLUSIONS

During the FY14-15 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP established a PIP to improve responsiveness of its 800 number Access Line.
  - Through contract agency providers, the number of bilingual staff have increased from eight to 16 during the review period.
  - The MHP created a TAY service track, separate and distinct from Adults, which offers improved engagement for these consumers.
- Opportunities:
  - The MHP's Adult and Older Adult ASO organization, OMG, is in need of an EMR/Practice Management system, which would permit improved analysis of service and access data.
  - While the MHP tracks the number of Spanish speaking consumers that access care, it does not collect or present timeliness data broken out by primary language.

Timeliness of Services

- Strengths:
  - The MHP's data on initial access appears quite positive, with a 14-day standard for all populations, and actual averages of 3-days for adults and 12-days for children and youth.
  - Psychiatry initial access data is another area that appears quite positive, with a 30-day standard, and averages of 14-days for adults and 12-days for children and youth.

- Opportunities:
  - Ideally, the MHP would track and analyze timeliness data from its Avatar EHR for both the Adult/Older Adult and Children/Youth services, or develop a mechanism for real-time monitoring of separate EHRs of its two ASO organizations. That the Adult/Older Adult sector currently lacks an EHR is problematic for efficient data tracking and analysis, as well as quick access to clinical information.
  - The MHP and consumers would benefit from re-evaluation of the 30-day standard set for initial psychiatry access. The MHP's data indicates capacity, at this time, for a higher (shorter time) standard, such as those described in Knox-Keene standards.

Quality of Care

- Strengths:
  - The MHP's QI process rotates meetings through the major population centers, and leads off meetings with an innovative approach in which consumers and other stakeholders are invited to provide feedback about services. The meetings also consistently review important data elements such as timeliness, and minutes reflect meaningful discussion of relevant issues.
  - The MHP has shifted to an ASO model, with two central contractors providing the coordination and oversight of services to children/youth (Redwood Quality Management Company-RQMC) and adult consumers (Ortner Management Group-OMG).
  - During the review period, the MHP operated a Clinical PIP designed to improve coordination with primary care and support the improvement of consumers' physical health.
  - The MHP's ASO process has broadened the service roles of some of its long-term contract providers, such as Manzanita, which historically was a wellness center and now also provides case management.
  - The MHP and its ASO organizational providers use differing EHR/Practice Management systems which creates challenges in claiming and also in the tracking of data.
  - The Children/Youth ASO utilizes the Exym EHR which permits longitudinal analysis of service flow data.

- Opportunities:
  - The MHP may wish to initiate a study of consumer satisfaction with services, targeting in detail areas in which feedback or concerns have surfaced from either consumers/family members, other stakeholders, or data.

Consumer Outcomes

- Strengths:
    - The MHP is using the CANS (through Child/Youth ASO) and ANSA (through Adult/Older Adult ASO) to help with the intake process and in determining the level of care, tracking of progress, and service necessity.

RECOMMENDATIONS

- Utilize consumer and staff input on the development of a survey to assist the MHP in obtaining feedback on the strengths and challenges of the new dual ASO model of care.
- Broaden access tracking data, which already follows numbers of Spanish speakers, to include timeliness for Spanish speakers.
- Prioritize the implementation of an electronic EHR/Practice Management system within the OMG Adult ASO (Avatar or other selected option), and online integration of outcome instruments.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

Mendocino County MHP CalEQRO Agenda

Wednesday, December 10, 2014

8:30 am - 9:00 am	**Opening Session** • Introduction to BHC • MHP Team Introductions *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Conference Room 1	
9:00 am- 9:30am	**Review of Past Year** • Significant Changes and Key Initiatives • Use of Data in the Past Year *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Conference Room 1	
9:30 am - 10:50 am	**Performance Improvement Projects** • Technical Assistance *Requested Participants: MHP Leadership, Quality Management Staff, Key PIP Participants* Conference Room 1	
11:00 am - 12:00 pm	**Disparities and Performance Measures** • Access and Retention *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff* Conference Room 1	
12:00 pm - 12:30 pm	Lunch Break	
12:30pm - 1:00 pm	MHP Organizational Contractors Meeting Conference Room 1	
1:00 pm - 2:30 pm	**Consumer/Family Member Focus Group** • 8-10 participants as described in notification materials Conference Room 1	**ISCA/Fiscal & Billing** • FY13-14 Recommendations • EHR status & utilization • Contract providers • Claim processing - denied & replaced transactions • Tele-psychiatry Conference Room 2

Mendocino Final FY14-15 Agenda RW V3

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer
Duane Henderson, Information Systems Reviewer
Deb Strong, Consumer-Family Member Consultant

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

Sites of MHP Review

MHP SITES

Mendocino County Mental Health
1120 South Dora
Ukiah, CA 95482

Participants Representing the MHP

Name	Position	Agency
Adam Bramm	Compliance Officer	HHSA
Bryan Lowery	Assistant Director	HHSA, Social Services
Camille Schraeder	Systems Officer	RQMC
Chandra Gonsales	Special Projects	RQMC
Cliff Landis	MH Clinician II	KTA/Wrap
C. Joy Kinion	MHRS	BHRS
Connie Drago	Compliance Officer	OMG
Dan Anderson	COO	RQMC
Danielle Lower	Operations Manager	RQMC
Deborah Lovett	Senior Program Manager	HHSA
Debra Rogers	Case Manager	Manzanita
Doug Gherkin	CFO	BHRS
Jena Conner	Deputy Director	CWS
Jenine Miller	Deputy Director	BHRS
John Riley	Chief Medical Officer	Ortner Management Group
Karen Lovato	Program Manager	BHRS
Linda Wooton	MHRS	ICMS

Name	Position	Agency
Lois LaDelle-Daly	QA Coordinator	Redwood Quality Management Company (RQMC)
Manuel Orozco	Admin Services Manager	BHRS
Marina Baird	Staff Assistant	BHRS
Mark Montgomery	VP Operations	OMG
Masha McCarthy	Supervising MH Clinician	Katie A./WRAP BHRS
Serena Jones	Director Clinical Programs	Mendocino County Youth Project
Susan Wynd Novotny	Executive Director	Manzanita Services, Inc.
Sue Stever	Care Manager	Mendocino Coast Hospitality Center
Theresa Maraganis	Therapist	Tapestry Family Services
Tim Schraeder	CEO	RQMC
Todd Harris	Clinical Director	OMG
Tom Pinizzotto	Director	HHSA-Health
Venus Hoaglen	Staff Service Administrator	BHRS
Victoria Schmidt	Therapist	Mendocino County Youth Project

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Mendocino	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Care Coordination Collaborative		
Dates in Study Period: August 2013 Planning; Feb. 2014 Active		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Epidemiologic data supports the premise that seriously mental often suffer reduced longevity and comorbid health conditions Consumer/Family member participation were included in the P development process.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☒ High risk conditions *Non-Clinical:* ☐ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Hypertension, obesity, diabetes, CVD were a part of the PIPs fo however a significant component of the PIP emphasizes the lin and coordination aspects (non-clinical) of care. These activities include: assigning one individual to coordinate between health/mental health, making referrals for treatment to primar establishing bidirectional releases of information – linking with physical health care many whose main health contact had histo been only mental health.

Non-Clinical PIP:

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.calegro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Mendocino	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Improve Access Line Services		
Dates in Study Period: July 1, 2013 thru September 30, 2014		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The stakeholders included MHP and ASO agency key staff, and proxy DHCS reviewers input. The MHP could have considered consumer input.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Access Line test is considered failed if any of the test calls a appropriately managed. The MHP had access to the triennial r results and the local test calls performed by staff. This informa indicated that the current Access Line function was not meetin standards. After-hours Access response is a key responsibility of the MHP assuring that Medi-Cal beneficiaries can receive appropriate information about services at all times.