FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

County MHP Final Report

Marin MHP

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—1,865
  - MHP Size—Medium
  - MHP Region—Bay Area
  - MHP Threshold Languages—Spanish
  - MHP Location—San Rafael

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Marin 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; Marin MHP submitted two PIP(s) for validation through the EQRO review. The PIP(s) 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 two 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: Incorporate regular and consistent reporting of data in regard to access, timeliness, service capacity, and treatment effectiveness to monitor real-time performance and progress toward goals.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP utilizes data collection and reporting in multiple domains to monitor system demand and performance as well as to inform decision-making. Primary responsibility for data reporting lies with the Information Systems (IS) and Quality Management (QM) functions, both of which have increased staffing over the past year. Administrative and clinical staff shoulder primary responsibility for data collection and participate in data cleaning when relevant.

- Individual teams generate and maintain reporting to support specific functions and progress towards goals. Examples of this reporting includes: tracking referrals and dispositions for monolingual Spanish and Vietnamese speakers through the Latino and Vietnamese Family Health Clinics; tracking length of stay for individuals in non-community placements; tracking FSP outcomes and the performance of PEI and other MHSA-funded contracts; tracking hospitalization bed utilization and trends; and tracking consumer satisfaction-related trends such as grievances, change of provider requests and denial of rights.
- IS staff produce reports at regular (monthly/quarterly) intervals addressing individual clinician and team performance issues such as archived notes reports, draft/pending notes reports, client plan reports and direct services report (DSR). QM is currently working to create team-based reports that provide an overview of census, diagnostic mix, length of stay and other variables requested by supervisors. QM is also redesigning the internal POQI reporting format to create a more actionable overview of the data.
- Particular attention has been paid over the past year to the volume, type and disposition of initial requests for services, and timeliness of response to requests for assessment and initial psychiatry services.
- QM staffs are currently examining strategies for creating meaningful system overview reports starting with analyzing variables relevant to service location (city of residence versus city of service) and capacity (average length of stay/admissions/readmissions/discharges in a fixed period).
- QM is also working with clinical program staff to more fully utilize outcomes measures currently in use to move beyond individual to population-based outcomes reporting and to institute more meaningful measurement tools as needed.
- While it is clear that the MHP is moving towards incorporating regular data use into its system of care (SOC) it appears that the MHP is in a transitional period where these elements are not embedded into systems protocols routinely. This situation is likely due to the transitions in QI staffing, implementation issues within the electronic health record (EHR), and limited data analysis staff routinely tasked to clinical quality improvement analysis.

- Recommendation #2: Consider developing a Youth and Family Services (YFS) committee of the MHP staff and organizational provider staff for bi-directional input and to routinely analyze ongoing infrastructure change until routine practices are in place.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The Youth & Family Services (YFS) infrastructure continues to be redefined and shaped to meet the increased severity of needs of families currently seen in

these programs, as well as system changes at the state and county levels. Some initiatives implemented or enhanced over the last year are listed below.

- An off-site YFS & YES staff retreat was held in July 2014 to develop priorities and build team cohesiveness & morale.
- The MHP hired a bilingual (Spanish) licensed mental health professional in August 2014 to address the increased demand for services.
- In September 2014, YFS began dedicating the last half of weekly staff meeting to case consultation with staff and supervisors. Increased time was also designated for weekly peer consultation.
- In September 2014, YFS initiated twice weekly authorization committee sessions with supervisors and rotating staff members to review new assessments and Client Plans. This process has proved a valuable tool that promotes increased collaboration among staff.
- Strategic Planning process began in the fall 2014 to be completed by June 2015 for Children's Mental Health to identify and prioritize key mental health and substance use issues to provide a continuum of care from prevention through treatment and recovery. Broad stakeholder input continues to be sought during this process.
- In collaboration with the Community Action Marin (CAM) Family Partnership Program, the MHP began recruitment (December 2014) for Youth Mentors to meet the increased need for adult role models for the children served by our programs.
- YFS supervisors participate in monthly Marin Child Early Intervention Team meetings with county partners in Social Service, Public Health and community partners serving children.
- YFS supervisors participate in Marin Family Connection, a case consultation and networking model with Social Services and Public Health.
- YFS supervisor participates in monthly Seneca Wraparound meetings, a collaboration with Social Services, Probation, Education and Seneca, the CBO contractor.
- YFS staff provide weekly psycho education sessions for women at the Center for Domestic Peace in Spanish and English.
- YFS supervisor provides clinical supervision for CalWORKS clinical team, which consists of one mental health clinician and two social workers who work with adults struggling with mental health issues that impact their ability to maintain employment.
- YFS Chief and Supervisors participate in monthly Katie A meetings for planning and collaboration purposes.
- The MHP joined with six other Bay Area counties to apply for a SAMHSA grant to establish a Bay Area collaborative to address trauma-informed care for youth. The resulting collaborative, Bay Area Trauma Informed Systems of Care (BATISC) was awarded the grant for four years, with funding of one million dollars annually. San Francisco County is the lead agency for this project and handling most of the coordination. Marin County MHP representatives will include staff from YFS, IT and QI.

- Recommendation #3: Incorporate system-wide methods for bidirectional communication. Consider venues such as an electronic newsletter, suggestion box, staff surveys or all staff presentations.

  - ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has increased participation in existing communication venues and has initiated or improved additional methods over the past year which include the following:
    - The MHP utilized the county-wide newsletter inserting a bi-weekly "fyi" column and the Health and Human Services "Grapevine" news to communicate various events over the past year including National Depression Screening Day, and Black History Month and Lunar New Year celebrations.
    - The MHP Adult Case Management Team created a "Recovery is Possible!" video: http://youtube/UJCJ8uSZw6M
    - The MHP Director attended team meetings for every clinical team over the past year to provide the opportunity for information sharing, conversation and feedback.
    - Supervisor's meetings were redesigned to target bidirectional communication and collaboration between teams with similar functions (i.e. case management teams and crisis continuum teams).
    - The MHP is launching a monthly internal newsletter in February, 2015 featuring content written by the MHP managers and Director.
  - In response to stakeholder feedback the MHP has been redesigning the MHSUS website. The current development version of the website will be presented to the Mental Health Board, the Cultural Competency Advisory Board and the Quality Improvement Committee in March 2015 for input and approval.
  - Quality management is planning to initiate staff surveys this fiscal year to provide an additional feedback opportunity.
  - While it is evident that the MHP has made a commitment to be transparent, the MHP will need to continue these in order to embed bi-directional communication with stakeholders at all levels.

- Recommendation #4: Continue to apply strategies to increase Latino penetration and retention rates which currently reflect limited engagement. Examine Latino utilization by subgroups, including age and language capacity, monolingual Spanish use of the Enterprise Center, and provide written Spanish materials.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP continued to utilize a variety of strategies to provide services to Latinos:

- West Marin has increased its Latino outreach strategies, increased bilingual/bicultural staffing, increased integration with social services to reduce stigma and increase acceptability of mental health services. More information is available in the Clinical PIP.
- The MHP added bilingual positions and continues to hire bilingual, bicultural Spanish Speaking staff.
- The MHP provides a wide variety of materials in Spanish. A list of Spanish-language materials provided across the MHP was reviewed.

o Examples of services the MHP provides, funds or other supports include:

- The Enterprise Resource Center which has increased its ability to offer services to monolingual Spanish speakers by adding a part time Spanish-speaking provider.
- Successful recruitment of a bilingual Nurse Practitioner to provide psychiatry services to participants in the CalWorks program.
- Senior Peer Counselors and Peer counselors are trained in both English and Spanish with peer counseling services provided in both languages. An average of 232 Spanish language services were provided annually over the three years tracked.
- Latino Family Health—received referrals for 376 unique individuals. All referrals were for monolingual Spanish speakers. Of the 376, 138 received individual therapy, 177 received a group intervention, 13 were referred to promotoras, 43 were referred to the MHP Access Team and 88 were referred to other local resources.
- Integrated Behavioral Health in Primary Care (PEI-funded) grant plan to hire a bilingual clinician to served uninsured clients. The four local FQHCs (Marin Community Clinics, Ritter Center, The Marin City Health and Wellness Center and Coastal Health Alliance) all received funds to add bilingual clinicians to serve uninsured clients.

- Recommendation #5: Continue to develop ongoing communication channels with organizational providers. Consider assigning a MHP point of contact and input for discussion topics at regularly scheduled meetings.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

o In order to promote ongoing communication channels with organizational providers, the MHP holds a monthly meeting for its mental health and substance use services contractors. Documents distributed and discussed at Contractors meetings are now posted to the County Mental Health and Substance Use Services website to promote transparency. Agendas and handouts from July 2014 – current can be found on the Marin Health and Human Services website under provider meetings.

- Contract monitoring responsibilities for MHP programs are divided among the Chief of Adult and Older Adult Services, the Chief of Children's Services, the Program Manager I for Adult Outpatient Services and the Quality Manager.
- The MHP has achieved significant work from the prior year's review in strengthening its relationships and will need to continue these efforts to bear its true intention as mixed responses from review informants were expressed. Some indicated the groundwork for changes were made and others expressed the need to develop change.

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

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

- Access to Care
    - The MHP opened a Crisis Residential Program called Casa René in February 2014. This is a 10 bed program operated by its contractor, Buckelew Programs. This has been a significant addition to the crisis continuum of care as which lacked a crisis residential program. This program was designed to target Medi-Cal recipients and provide a less restrictive and more recovery oriented alternative to inpatient hospitalization.
    - The MHP created a new "Placement Team" to better coordinate transitions between levels of care. The team consists of a hospital liaison, a benefits specialist, and placement coordinator. The team will be adding a registered nurse (RN) to support oversight of medication management services in secured settings, Institutions of Mental Disease (IMDs) and enhanced board and care facilities with the goal of reducing lengths of stay in these placements. The placement team manager facilitates biweekly collaborative meeting with representatives from various placements, to enhance communication and support transitions between levels of care.
    - The Odyssey, a homeless full service partnership (FSP) program, is developing a "step down" component. This program will utilize paraprofessional/peer staff to support 20 consumers in achieving recovery and “graduation” from services.
    - The MHP is developing an outpatient clinic under a contract with Beacon Health to increase the capacity of the local network of providers serving the “mild to moderate” spectrum. Staff for this clinic include 1.0 FTE Licensed Mental Health Professional and a 0.5 FTE psychiatrist.
    - The APA-accredited pre-doctoral full-time Latino Family Health internship program filled its two positions on the 2014-15 with top candidates.

- Timeliness of Services
    - The MHP obtained an SB 82 grant to create a Mobile Crisis Team—this team provides field-based crisis intervention services. The team consists of both licensed clinicians and peer/family member providers, emphasizing the importance of engagement from the peer provider perspective. This team will work closely with law enforcement to explore the potential in assisting with

hostage negotiations and more fully realizing the CIT model in Marin. Services will be provided seven days/week from 1-9pm.

- Quality of Care
  - Latino Family Health interns facilitated workshops on mental health and two family reunification group series via Canal Alliance; the resulting paper was awarded 1st place at the National Latino Psychological Association professional conference.
  - The MHP's clinical graduate training program received the Distinguished Service in Multicultural Training in Psychology award in November 2014 from the Center for Excellence in Diversity. This award was given in acknowledgement of the demonstrated commitment to providing cultural awareness and competency in diversity training for doctoral students in clinical psychology in the San Francisco Bay Area.
  - The MHP entered into contracts with the University of California, San Francisco to become training sites for both psychiatric nurse practitioner students and licensed psychiatry fellows who are pursuing advanced training in mental health.
  - The MHP and Health and Human Services continue to experience transitions in key positions. The Health and Human Services Director and the MHP Medical Director are both retiring in March, 2015. The MHP Chief of Adult/Older Adult Services retired after 30 years of service, and a new Chief was promoted internally. Roles were reassessed and duties reassigned: this led to the creation of two new positions: a Program Manager I to oversee Full Service Partnerships (FSP), Adult Case Management and the Placement Team (hired 4/2014) and a second Program Manager I to oversee the Crisis Continuum of Care.
  - The Interim Ethnic Services Manager position was again allocated and filled in December 2014. The Workforce Education and Training (WET) Coordinator role became part of the Ethnic Services Manager's responsibilities to more effectively incorporate cultural competency into all of training and workforce development initiatives.
  - The MHP increased quality management staffing by allocating and hiring a Quality Manager and a Utilization Management Supervisor, a Utilization Review Specialist and an Administrative Services Technician to address data analysis and reporting. The interim QIC coordinator was replaced by a permanent hire employee, whose job duties were refocused on supporting documentation standards, the EMR and utilization management.
  - The MHP filled supervisor positions for adult case management and the Odyssey (homeless FSP) team and the Child Youth and Family Team, as well as created and filled a new supervisor position over the new mobile crisis and triage teams as well as over jail services.

- Multiple clinical and clerical line staff positions have been filled, including backfilling positions due to retirements, filling longstanding vacancies and expanding program capacity and linguistic capabilities.

- Consumer Outcomes
  - Peer/family partner positions for the two new teams are being filled through San Francisco Mental Health Association (SF MHA), a new contractor with the MHP. This partnership expands the resource pool of potential new peer staff in Marin.
  - The MHP obtained a second SB 82 grant to create a Triage Team which provides short term case management and linkage services, primarily to individuals identified at risk by the Housing Authority and other local homeless continuum support services. The team consists of both licensed clinicians and peer/family member providers, emphasizing the importance of engagement from the peer provider perspective. Services will be provided five days/week from 11am-7pm.

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

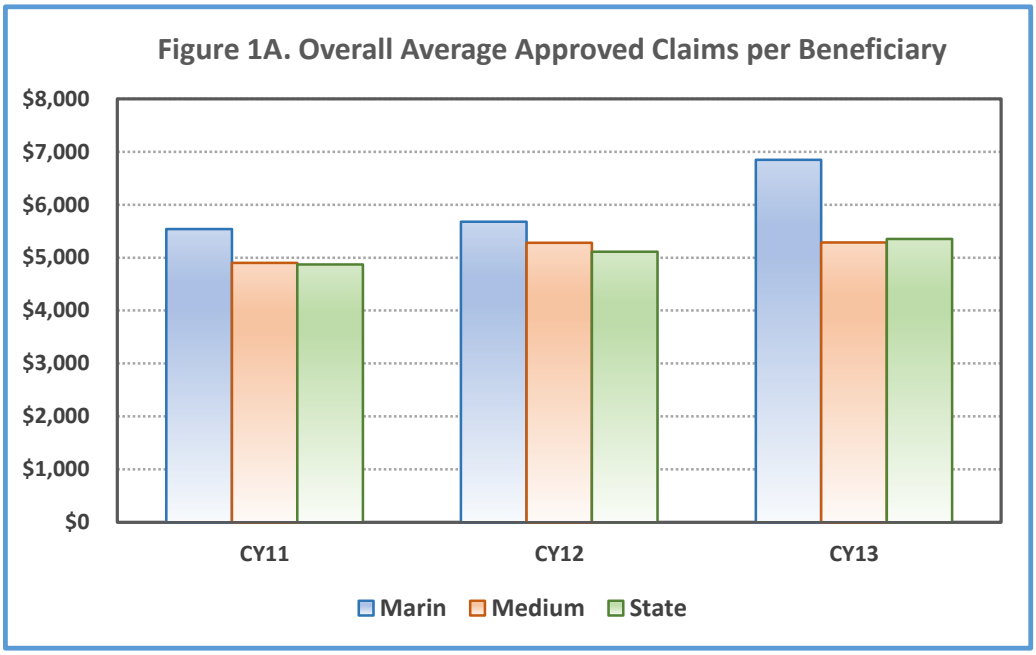
Table 1 provides detail on beneficiaries served by race/ethnicity.

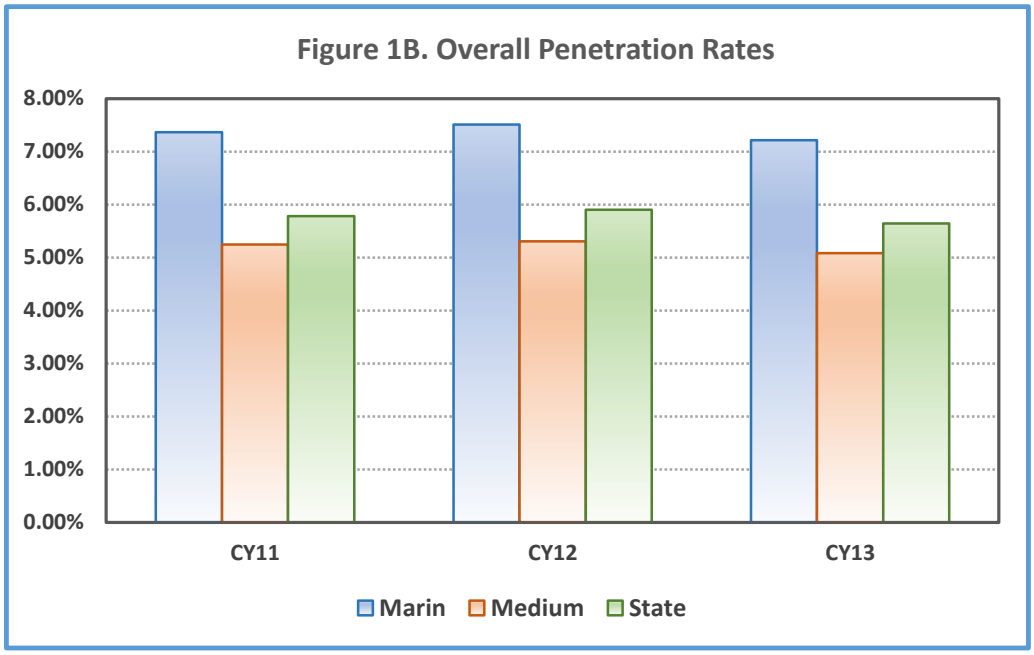
Table 1—Marin MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	7,503	1,010
Hispanic	13,711	419
African-American	1,595	178
Asian/Pacific Islander	1,391	85
Native American	52	9
Other	1,604	164
Total	25,855	1,865

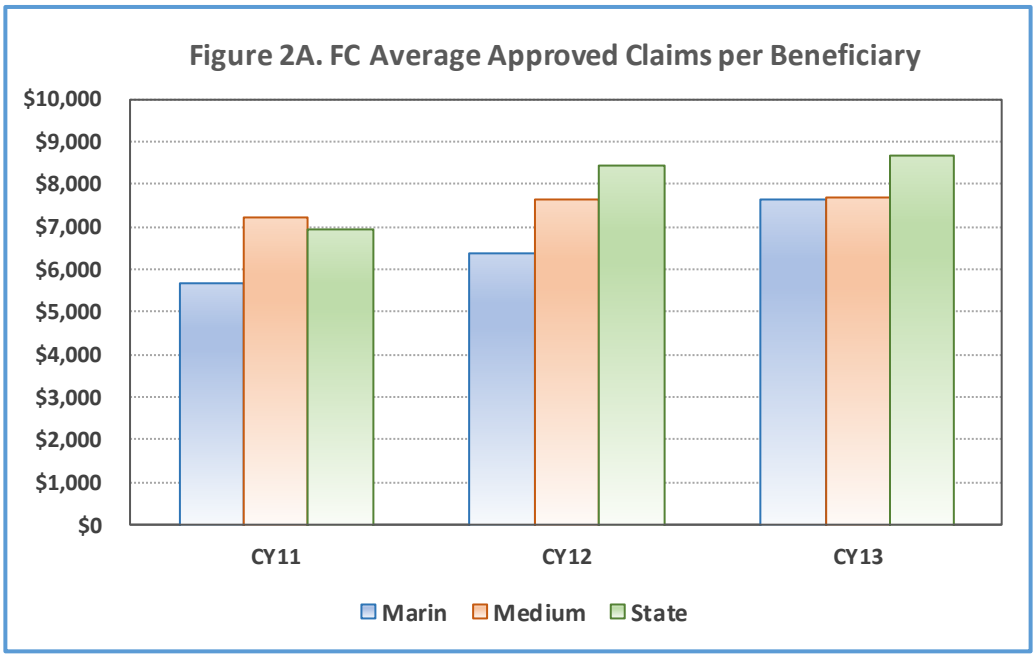
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

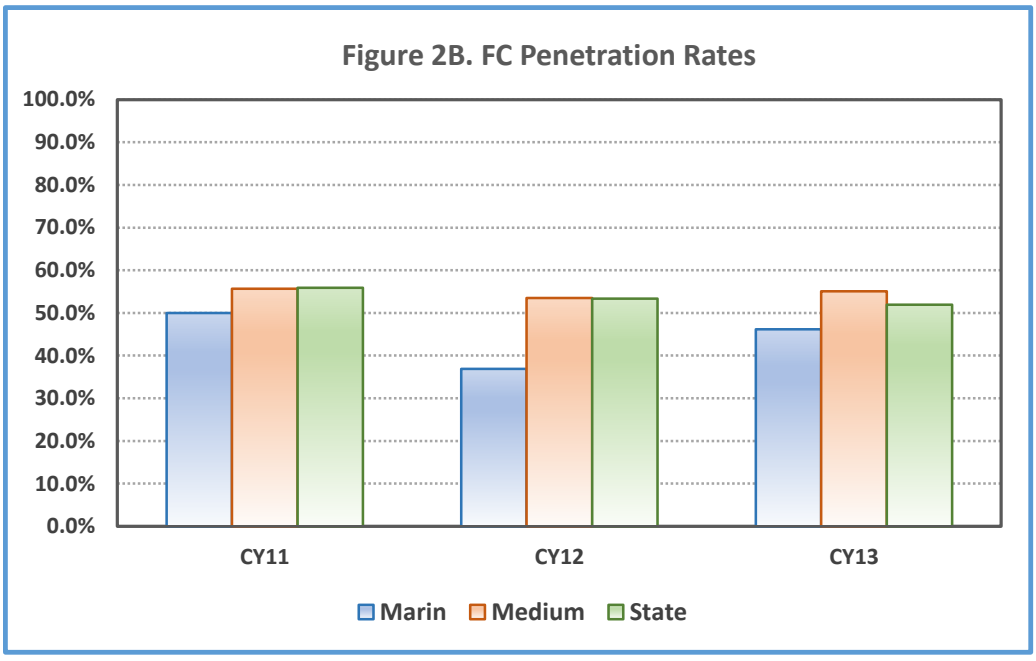
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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



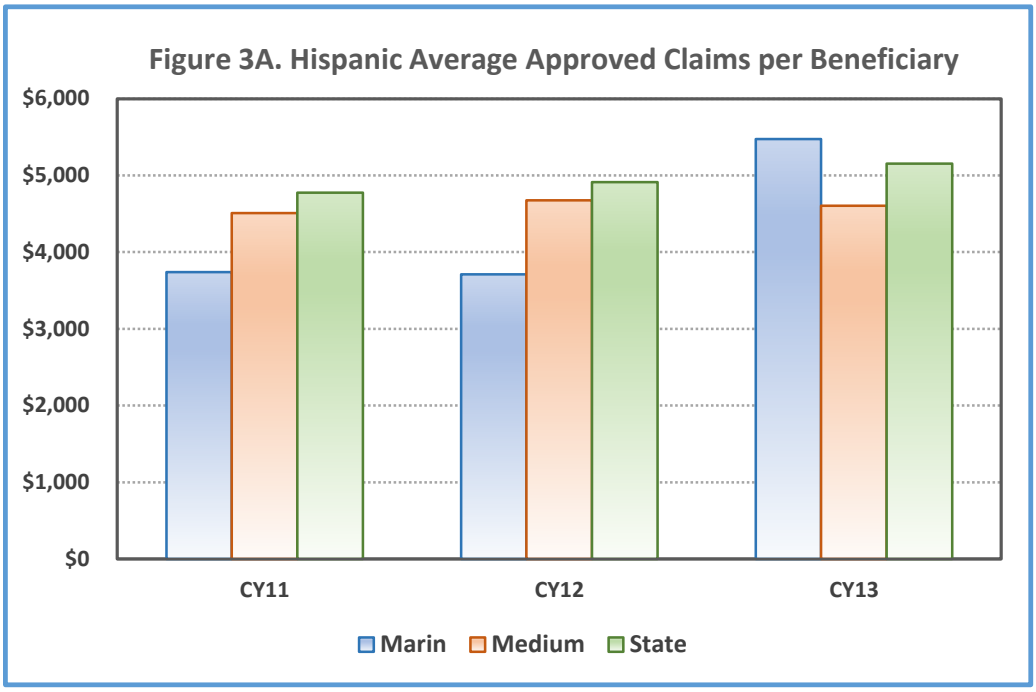


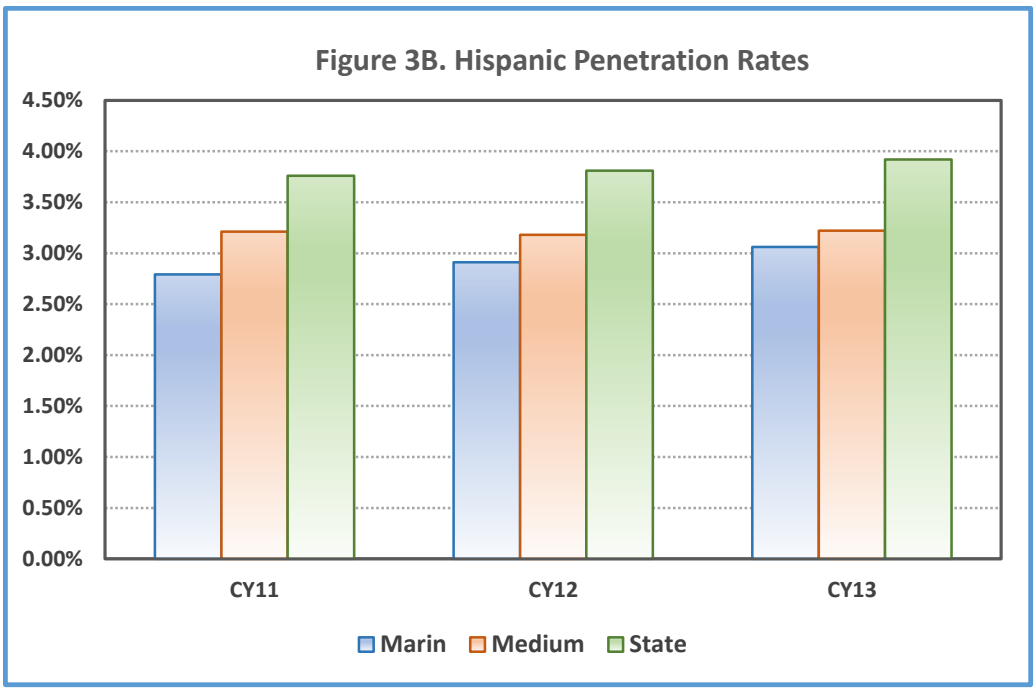
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for medium size MHPs.





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 medium size 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%
Marin	CY13	80	1,865	4.29%	$42,714	$3,417,135	26.76%
	CY12	51	1,802	2.83%	$41,919	$2,137,847	20.89%
	CY11	49	1,764	2.78%	$42,177	$2,066,669	21.12%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

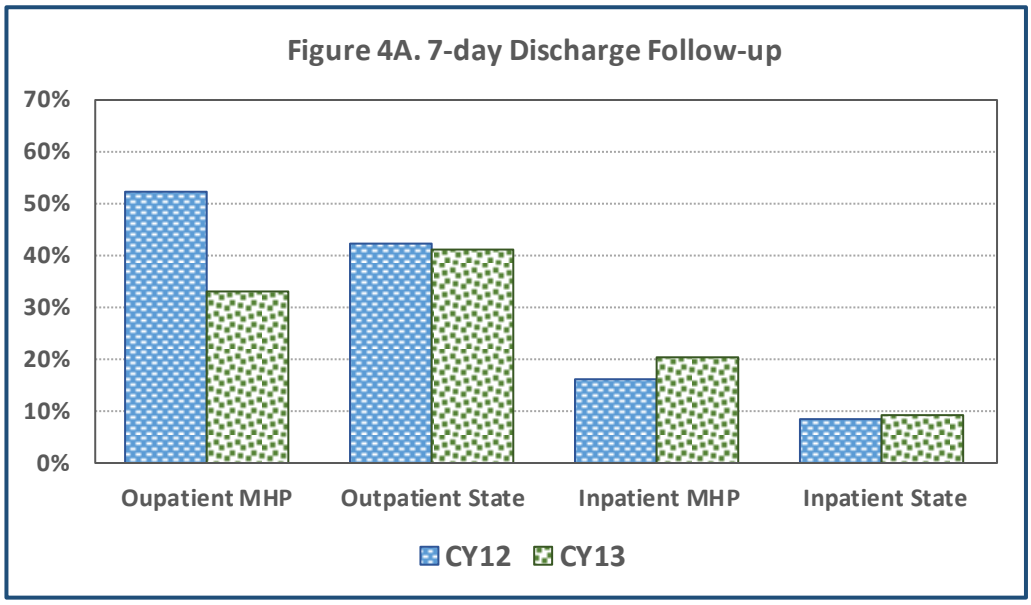
Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

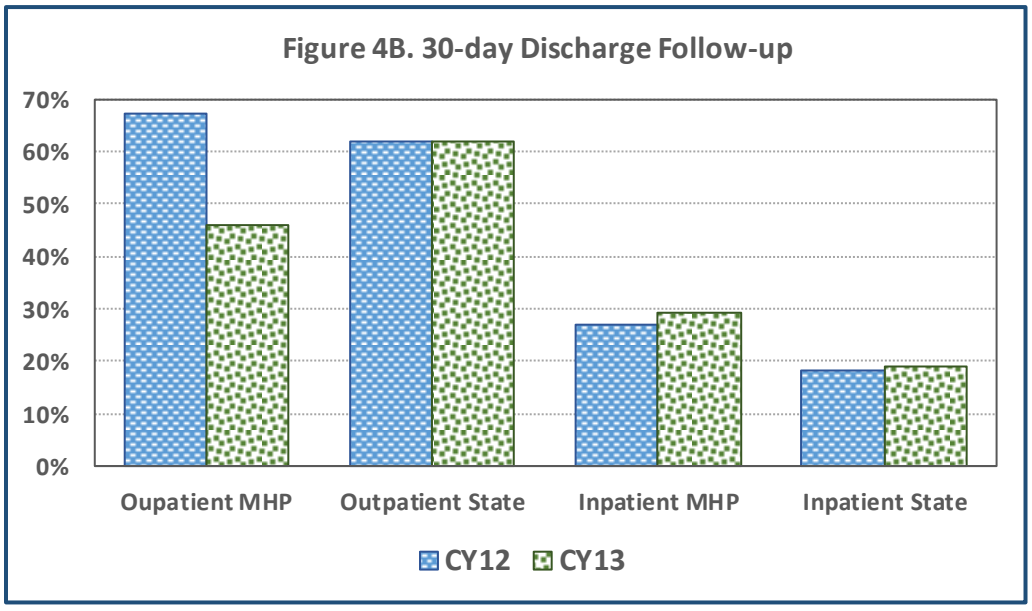
Table 3—TBS Beneficiary Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
Marin	Yes	618	16	2.59%
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

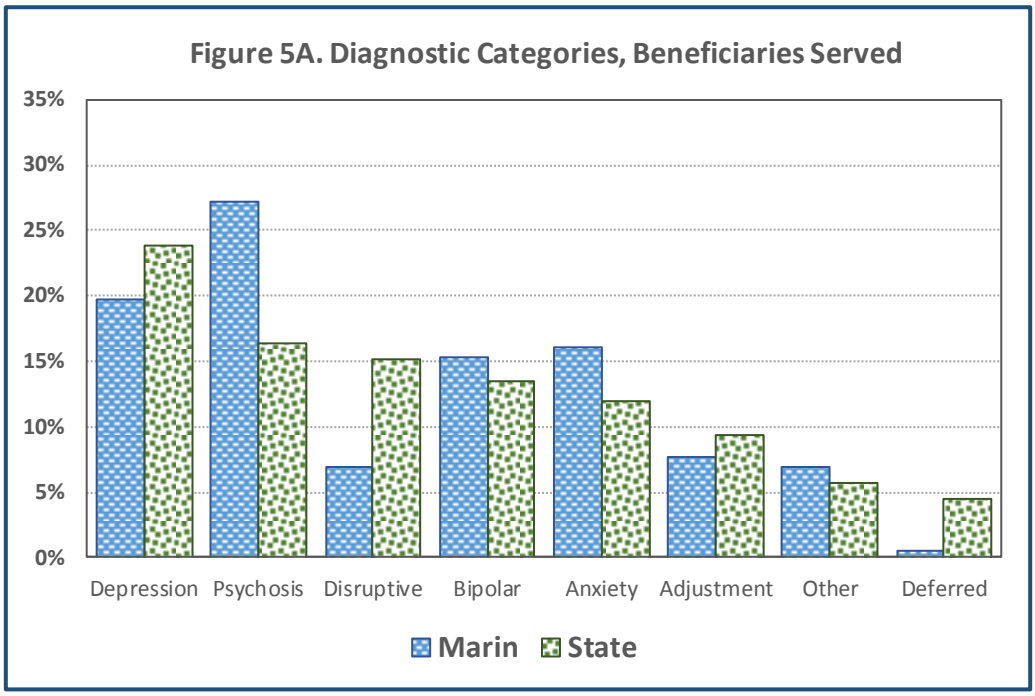
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

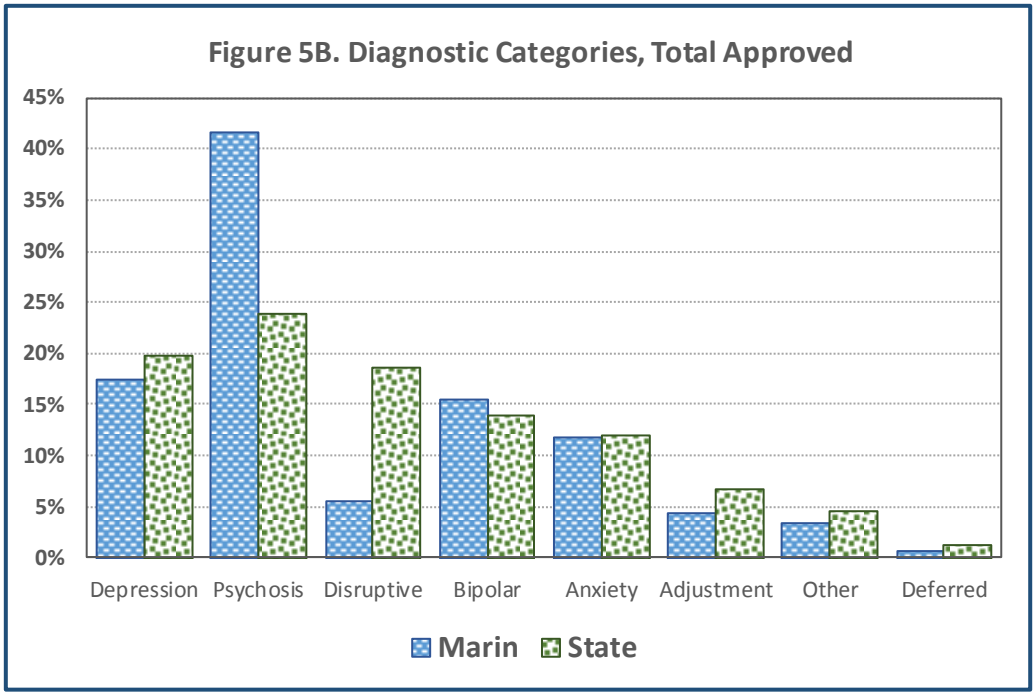




DIAGNOSTIC CATEGORIES

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

To be determined upon receipt of claims and eligibility data from DHCS using the following categories:

- Access to Care
    - In CY13, the MHP's approved claims dollars per Hispanic beneficiary served is greater than both statewide dollars and comparable sized counties however, its penetration rate (PR) for Hispanics remains lower when compared to both.
    - The MHP's approved claims per foster care beneficiary has gone up significantly from CY11 to CY13; however, it's foster care penetration rate remains lower than statewide and other medium size MHP average.

- Timeliness of Services
    - Given its approved claims dollars categories and the majority of its high cost beneficiaries appear to be diagnosed with psychosis, the MHP could benefit from determining if these consumers are served in the most timely manner to avoid high end service usage.

- Quality of Care
    - In CY13, the average approved claims per beneficiary served and the penetration rate were higher than both the statewide average and comparable sized counties.
    - The MHP's approved claims in CY13 was significantly higher than its approved claims per beneficiary in CY12.
    - The highest used diagnostic category as well as the highest approved claims dollars per category is psychosis, which could lead the MHP to examine its service methods for the most serious mental health issues.
- Consumer Outcomes
    - While the numbers of high cost beneficiaries (n=80) has significantly increased in CY13, the total approved claims dollars has only minimally increased from CY12.
    - In CY13, the MHP had a higher inpatient recidivism rate than the statewide average.

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.

MARIN MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Increasing Latino Access in West Marin.
Non-Clinical PIP	Measuring and Streamlining Access to Services.

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	PM	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	PM
		1.4	All enrolled populations	PM	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NM	PM
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	PM	NM
		6.2	Clear specification of sources of data	PM	PM
		6.3	Systematic collection of reliable and valid data for the study population	NM	PM
		6.4	Plan for consistent and accurate data collection	NM	UTD
		6.5	Prospective data analysis plan including contingencies	NM	NM
		6.6	Qualified data collection personnel	NM	PM
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NA	NA
		7.2	Interim data triggering modifications as needed	NA	NA
		7.3	Data presented in adherence to the plan	NA	NA
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NA	NA
		7.5	Interpretation of results and follow-up	NA	NA

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	NA
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	NA
		8.3	Threats to comparability, internal and external validity	NA	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA
		9.3	Improvement in performance linked to the PIP	NA	NA
		9.4	Statistical evidence of true improvement	NA	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NA

**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	7	9
Number Partially Met	3	6
Number Not Met	6	1
Number Applicable	16	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	53.13%	75%

CLINICAL PIP— INCREASING LATINO ACCESS IN WEST MARIN

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

- Will piloting a range of disparities-reducing efforts such as: increasing bilingual/bicultural staffing, attending local "caffecitos", appearing on local media, providing programming in partnership with local libraries/schools/and FQHCs and introducing Promotoras in the West Marin catchment area help to increasing the number of Latino Medi-Cal beneficiaries who enter into mental health treatment?
- Date PIP began: July, 2014
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ No PIP submitted

In This PIP, the MHP is trying to build upon its previous efforts to improve Latino access to behavioral health services and focusing at more remote region of the county where about 20% of Medi-Cal beneficiaries are Latino/Hispanic.

The MHP adopted its intervention based on strategies identified in a statewide reducing disparities project - 1) utilizing community-based organizations and co-located services, 2) participating in community events and social media, 3) providing psychoeducation to families and schools and 4) piloting innovative outreach and engagement strategies. Further the MHP sought to reduce perceived barriers to services by increasing bilingual/bicultural staff, and reducing structural barriers to use.

The PIP was in its initial stages of implementation at the time of the review. Based on the indicators that the MHP plans to track for this PIP, it is not clear if this project will ultimately qualify as a clinical PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommendations to identify, collect and analyze consumer outcomes as a result of these efforts. In addition, the MHP was advised to break down the study question into multiple questions so there are more discrete causal relationships to connect each intervention to plausible consumer outcomes or intermediate variables.

NON-CLINICAL PIP— MEASURING AND STREAMLINING ACCESS TO SERVICES

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

- By improving Access Team tracking and processes can we: 1) streamline entry into services for consumers and treatment staff, 2) improve our ability to track timeliness to services 3) meet the increased demand for services with the current staffing resources?
- Date PIP began: June, 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 found that since the beginning of the Affordable Care Act (ACA) implementation, and consequent expansion in Medi-Cal eligibility, the county had experienced 38% growth in its Medi-Cal eligible population between 2012 and 2014, with an additional 15% increase anticipated through June 2015.

This PIP aims to address the growing need for access to behavioral health services by this newly eligible population in a timely manner by adjusting its access processes including rapid screening for mild, moderate and severe mental illness, tracking urgent care access, and better tracking of access calls received.

As written, the PIP lacked any specific indicators that can be tied to consumer outcomes or beneficiary satisfaction as a result of this PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommendations to make sure that the indicators and the data collected can be linked to the interventions as causal agents; and that consumer level outcomes and/or beneficiary satisfaction data are collected.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Both these PIPs primarily address the issue of access to care.
  - The Clinical PIP has the potential to improve access for Latino/Hispanic beneficiaries in a remote part of the county served by the MHP.
  - The Non-Clinical PIP aims to streamline the access processes for a rapidly increasing Medi-Cal beneficiary population in the county.
- Timeliness of Services
  - While both PIPs also address timeliness, the Non-Clinical PIP addresses timeliness more explicitly for both routine service requests as well as for urgent conditions.
- Quality of Care
  - The Clinical PIP, as presented, appears to be a non-clinical PIP.
  - The Non-Clinical PIP lacks consumer level outcomes or beneficiary satisfaction indicators to make it a true PIP.
- Consumer Outcomes
  - The Non-Clinical PIP lacks consumer level outcomes or beneficiary satisfaction indicators to make it a true PIP.
  - The Clinical PIP needs more demonstrable linkage between the interventions and outcomes.

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	Leadership's commitment to diversity resulted in re-allocating and filling the Interim Ethnic Services Manager position. Under the exemplary guidance of this staffer, the Cultural Competency program has flourished, increasing membership to 37 diverse members, meeting monthly, dispersing detailed minutes, working subcommittees produce goals and action plans, and training presentations addressed a multitude of diversified topics. The MHP has become the lead in a Bay Area Coalition for both interpreter training and in trauma-informed care with certified competencies. It continues as a training site with the American Psychological Association (APA) pre-doctoral Latino Family Health internship.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	Under the direction of new leadership, and staff hired into key positions, the MHP began several new or expanded initiatives focused on managing care. Examples cited include a crisis residential program, mobile crisis unit, creating triage teams and placement teams, revising the Access Team protocols, and creating or hiring 33 additional staff. With the onset of numerous initiatives, it is prudent that the MHP engages in the formal evaluation of its strategies to meet beneficiary needs and then acts on these findings. Movement towards co-occurring services resulted in quarterly joint board meetings. It appears the coordination with substance use disorder services will benefit from closer collaborative ties such as this.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP has established significant partnerships, examples are: with San Francisco Mental Health Association (SF MHA) for peer partners, Beacon Health co-located with the MHP to assess the mild to moderate spectrum, contracts with UCSF as a nurse practitioner training site, and Buckelew for crisis residential.

**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 reports an overall standard of 14 days with an average of 11 days and reports meeting this 80% of the time. Adult services reports an average of 11 days and meets this standard 75.5% of the time. Children's services reports an average of 11 days and meets this standard 83% of the time. QI and IS staff are involved in creating strategies to combine data from multiple teams/programs for cohesive dashboard reporting.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP reports an overall standard of 14 days with an average of 20 days and reports meeting this 51% of the time. Adult services reports an average of 21 days and meets this standard 51% of the time. Children's services reports an average of 15.8 days and meets this standard 51% of the time. The MHP has made improvements to this goal from the previous review year and it now includes data from the children's services, and provides an urgent psychiatric appointment. Otherwise, it has engaged in limited tracking and improvements to this indicator. The MHP has created a training ground for both the Latino Family Health and the UCSF for NPs in hopes of creating its own staff resource pool to alleviate untimely waits. The MHP has indicated its preference is to provide face to face services and hence has elected not to invest in telepsychiatry at this time.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP reports an overall standard of two days. The Psychiatric Emergency Services (PES) unit delivers a significant portion of urgent care services which provides same day services, reports no waiting time and reports a 27% usage for 232 consumers. Urgent requests are also tracked via the Access Team and through urgent psychiatry slots and the MHP reports this data collection remains minimal at this juncture. It was unclear if this was a documentation concern or a low census at those sites. With the additional services of its new triage teams and mobile crisis unit, the MHP will need to consider collecting these response times into its data collection.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP reports an overall standard of seven days with an average of 18.66 days and reports meeting this 62.88% of the time. Adult services report an average of 20.64 days and meets this standard 60.34% of the time. Children's services reports an average of 4.25 days and meets this standard 81.25% of the time. Although the MHP has made improvements to this standard from the previous review period, it would benefit in determining any barriers in provision of follow up especially for the adult population. The newly hired utilization review staffer in the QI unit could enhance the monitoring of this data.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2E	Tracks and trends data on rehospitalizations	FC	The MHP tracks its readmission rate at 30 days, reports an overall 7% readmission rate with a total of 16 readmissions (n=223). For adults, a 6.9% rate was reported, comprised of 14 adults (n=202) and for youth, a 9.5% rate was reported, comprised of two youth (n=21). The addition of the new utilization review staffer in the QI unit will likely contribute to monitoring this data on going.
2F	Tracks and trends No Shows	PC	The MHP reports an overall goal of 10% or less for a no show rate with an average of 11% for clinicians and 7% for psychiatrists. Adult services reports an average rate of 15% for clinicians and 10% for psychiatrists. Children's services reports an average rate of 9% for clinicians and 7% for psychiatrists. Improvements include a reminder call to consumers to reduce missed appointments. The no show rates includes only consumer no shows. The monitoring of staff versus consumer cancellations is under review for methods of data collection.

**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	PC	QI has become an MHP priority. An adequately and increased staffed unit, a diverse committee, monthly meetings with detailed minutes and an extensive status evaluation of FY1314 was provided. While the FY1415 QI work plan includes multiple system goals, it could be enhanced with baseline parameters and measurable indicators to gage progress.
3B	Data are used to inform management and guide decisions	PC	The MHP has engaged in up to date strategies to address its meaningful use requirements. The MHP has embarked on an HIE project to deliver data sharing amongst its county wide partners and the FQHC clinics to enhance coordination of care for consumers. While the MHP clearly implements strategies to address its underserved population's cultural needs, it is less clear that it formally evaluates the success of these strategies. ~~The MHP will need to consider ways to coordinate efforts with the CWS data analysis staff to inform and improve Katie A service delivery.~~ The MHP will need to continually assess its staffing resources to determine if these meet the demands for its data driven system goals.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	PC	Various on-site informant groups indicated limited effective communications from administrative staff exist. This may be an unanticipated consequence of the recent changes in leadership. While the leadership appears to have made a commitment to this, it may be too early to gage its intended progress. The MHP will need to consider whether implementing the activities routinely will secure these efforts into its transparent model.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Various stakeholder groups indicated limited venues exist for input into system planning other than at the management level. Consumers had mixed responses, with some invited to participate in committees and others remained uninformed of opportunities.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	As mentioned throughout this report, collaborative initiatives are being implemented system wide to provide a more comprehensive continuum of care. Efforts engage the homeless, law enforcement, cultural groups, higher education, and primary care.
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	The MHP has yet to adopt system wide Level of Service/Level of Care tools and currently only uses outcomes tools in targeted programs for individual clinical assessment. The MHP noted that its use of outcomes data is limited to clinical use for individual treatment within specific programs.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	~~PC~~ FC	The MHP engaged in the distribution and tabulation of results for the annual Performance Outcome Quality Initiative (POQI) survey to consumers. Consumer surveys are distributed at the wellness centers for satisfaction feedback. In conjunction with crisis treatment plans, a consumer survey was provided to determine awareness of resources and satisfaction. Contract providers distribute satisfaction surveys to consumers. Evidence of improvements resulting from the surveys include extended mobile crisis hours until 9pm and extended hours serving the homeless until 7pm.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	Currently, CFM employment is limited to positions within contract organizations which do not provide clear employment paths. The MHP is aware of its limitations in this sphere and is working with county human resources to obtain a peer employee classification.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	A robust consumer center and consumer run café, and multiple drop-in centers county wide continue to provide venues for consumer participation. While the MHP has engaged in consumer driven programs and wellness endeavors, it is noteworthy that some monolingual consumer participants did not have knowledge of MHP wellness and recovery center locations or activities. The Cultural Competency committee does produce its minutes in Spanish as well as English. Consumers indicated information about the mental health department is obtained through the Enterprise drop-in center and NAMI Marin newsletter and website.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP has dedicated itself to initiatives which affect each spectrum of care at multiple entry points as evidenced in examples cited above.
  - Apparent re-invigoration into cultural competency and awareness has resulted in the committee's expansion and ability to address its goals.
  - The use of multimedia venues address cultural issues and includes a six segment series run on local television and a weekly radio show hosted by Latino staffers.

- Timeliness of Services
    - Now that the foundation for data collection has been established, the frequent and increased tracking, data collection and analysis of timeliness indicators would inform the MHP of meeting these metrics in a real-time routine basis.
    - The MHP could benefit from close monitoring of its timely follow up post hospitalization appointments given the high percentage of total approved claims for psychosis diagnostics and its significant increase in high cost beneficiaries in CY13.
    - A drop-in hour for medications support is established at the central office at Bon Air and at the wellness campus.
- Quality of Care
    - Increased staffing allocated to the QI unit supports the quality goals of the MHP.
    - It appears to be a well thought methodical planning process which the MHP has engaged in to become a comprehensive quality and data driven system.
- Consumer Outcomes
    - Expanding contracts to hire peers and priority placed on incorporating peer partners into MHP routine activities is indicative of recovery principles.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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 which included the following participant demographics or criteria:

- A culturally diverse group of parents/caregivers of child/youth beneficiaries, including both high and low utilizers of MHP services
- A culturally diverse group of adult beneficiaries, including both high and low utilizers of MHP services

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

The first focus group consisted of five family members of children receiving services with three participants also consumers. An interpreter was used for monolingual Spanish speaking participants. It was held at the Marin Health and Wellness Campus in San Rafael, CA. Length of receiving services varied from 1 to 5 years. Children and youth received counseling and medication management services or Therapeutic Behavioral Services (TBS).

Obtaining initial services typically took 2-3 months. All participants agreed that services were beneficial. The child of one participant has benefitted and seeks to come back for more therapy.

Group participants received information from the mental health department through flyers posted in lobbies and speaking with their therapist. Participants reported family participation is encouraged. In some cases, other family members besides the parent were involved in treatment.

A Spanish speaking family received services from a bilingual therapist and psychiatrist. A Spanish speaking participant attends a support group in Spanish twice monthly.

Recommendations arising from this group include:

- ~~Establish a family support group in English~~
- Expand the hours during the day that therapy is available
- Provide venues to meet a therapist closer to where families reside.

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		
Number/Type of Participants	Consumer Only	0
	Consumer and Family Member	3
	Family Member	2
Ages of Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	5
	Older Adult (60+)	0
Preferred Languages	English	3
	Spanish	2
	Bilingual	0
	Other	0
Race/Ethnicity	Caucasian/White	3
	Hispanic/Latino	2
	Other	0
Gender	Male	1
	Female	4

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group of culturally diverse group of adult beneficiaries, including both high and low utilizers of MHP services was held at the Marin Health and Wellness Campus in San Rafael, CA. and included 15 participants. An interpreter was utilized for the Spanish speaking participants.

Participants noted that they were generally satisfied with their treatment. This group of long term participants with MHP services noted medication support services were on average scheduled monthly and therapy weekly. Many expressed a desire for more service. Participants spoke of receiving services from a variety of providers, including therapists, case workers, nurses and psychiatrists.

Participants in the group have been receiving services from 2-1/2 to over 30 years.

Overall, consensus indicated effective coordination between the MHP and their primary care provider. It was noted information from administration was generally available but opportunities for employment or to communicate with leadership could increase.

Some participants use the Enterprise Resource Center. A number of participants were active in Marin Advocates for Mental Health Services. Two individuals volunteer their time to work on the local warm line. One person serves on the board of the Shelter Plus Care program. A Spanish speaking participant reported therapy in Spanish is provided.

Recommendations arising from this group include:

- Restore morning warm line hours
- Increase available housing for consumers
- Add therapists, case workers and psychiatrists and inpatient bed capacity
- Strengthen employment services.

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants		
Number/Type of Participants	Consumer Only	15
	Consumer and Family Member	0
	Family Member	0
Ages of Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	8
	Older Adult (60+)	7
Preferred Languages	English	14
	Spanish	1
	Bilingual	0
	Other	0
Race/Ethnicity	Caucasian/White	11
	Hispanic/Latino	1
	Native American	2
	Other	1

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Gender	Male	6
	Female	9

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Consumers indicate staffing shortages may affect the ability to obtain care in some instances.
  - The MHP is effective in provisions of preferred language for consumers.
  - Field based services appear to be provided, and could be expanded based on feedback.
  - The MHP could review the operations hours and consider extended evening hours.
- Timeliness of Services
  - The MHP could review its timeliness to first service based on feedback for youth.
- Quality of Care
  - Overall, consumers indicate genuine concern is expressed by staff.
  - Information flow to consumers could be structured to receive updates uniformly across programs.
  - Opportunities exist for consumer wellness and volunteer activities.
- Consumer Outcomes
  - The MHP staff have increased efforts coordinating care with primary care providers.

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	32%
Contract providers	65%
Network providers	3%
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:

32%

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

7%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- It should be noted that the MHP calculates its own penetration rate (PR) annually for all its consumers and additionally conducts prevalence calculations as well. It has also made regular use of the EQRO data in these areas. The MHP's penetration rates for the Latino population across the entire SOC were substantially better than those reflected in the SDMC Approved Claims data and indicate wider service provision within alternative funding sources such as MHSA programs.

CURRENT OPERATIONS

- The MHP continues to use the ShareCare system as its practice management software. It pairs this with the Clinician's Gateway product for EHR functionality including outcomes, progress notes, treatment planning and assessments. The MHP currently uses the stand-alone RxNT product for eRx functionality.

MAJOR CHANGES SINCE LAST YEAR

- Upgrade of eRx system (RxNT) to v7.1
- Rollout of eSig pads to prescribers
- Upgrade of Clinicians Gateway to meet Meaningful Use (MU) Stage I requirements
- Upgrade to the server room
- MU IT Security Risk Assessment conducted and remediation team formed to act on findings
- Designation of IT Security Officer for MHP
- Installed Rapid Insight Analytics for use with ShareCare PM system to perform analysis
- Implementation of monthly security reminders on EHR and PM systems

PRIORITIES FOR THE COMING YEAR

- Rollout of eSig pads to Case Management staff
- FSP data cleanup
- Continuation of MHSA-EHR upgrades to attain MU Stage II requirements
- MHSA scanning project to convert paper charts to electronic format

- MHSA BH crosswalk to create secure data sharing
- MHP will begin health information exchange (HIE) project with hired consultants
- MHSA Disaster recovery planning project
- Increase IT staffing to support growing program and data requirements
- ICD-10 implementation
- Rollout of Tablet PC/eSig pads for field based staff.
- PQRS reporting per CMS requirements to include PHQ9 and SBQ-R
- RxNT data clean up

OTHER SIGNIFICANT ISSUES

- The MHP has chosen not to redistribute internal psychiatric capacity via tele-psychiatry technology.
- The MHP described their plans to continue with meaningful use (MU) attainment. As an appropriate piece of this process the MHP also related their plans to begin practical HIE in the next year. This process, while furthering very tangible benefits to beneficiaries, brings with it regular and ongoing infrastructural and risk management challenges that are integral to a fully funded and functioning healthcare operation. The MHP will need to assure that it has the attention of county leadership so that it can mitigate these issues appropriately with adequate resources and functional disaster recovery planning.
- MHP staff noted that they are still awaiting resources from the vendor to have final implementation pieces done on the PM system. This news is unsettling as the MHP has been working on the PM implementation for some time now. Staff also report that getting development of new pieces for the PM system is also extremely slow. This makes the MHP's progress towards a data driven clinical system more difficult than it should be.
- The MHP has seriously bolstered its QI staffing during the past year in an effort to move toward a quantitative, data driven and consumer focused clinical quality improvement model. This presents benefits for both MHP operations and consumer wellness. The MHP is not yet at a point where its data analysis capability is fully staffed and may need from 2-4 additional FTEs to attain regular relevant quantitative knowledge out of the data mining it is already accumulating. Currently the MHP does not have staffing to meaningfully engage on a regular basis with peer or program staff (for example, the CWS data analysts working with Katie A. data) or other relevant projects such as timeliness reporting or the assessment of treatment within its system of care.

- The MHP noted that it has not, as yet, begun the use of consistent Level of Service/Level of Care tools across the entire SOC. Current use appears to specific programs and used at the individual level. There appear to be a number of systemic impediments however, the MHP could begin committing to this endeavor.

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
ShareCare	Practice Management	The Echo Group	4	MHP
Clinician's Gateway	EHR	Krassons	8	MHP
RxNT	eRx	RxNT	5	MHP
Analytics	Data Analysis/Teleform/POQI	Prins-Williams Group	6	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The ShareCare PM system continues to be a work in progress for the MHP while the MHP has moved forward with upgrades to its Clinician's Gateway clinical record to attain MU Stage II compliance. Last year's EHR assessment team chose to advise the MHP to retain its current hybrid PM/EHR MIS for the immediate future.

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	Clinician's Gateway	**X**			
Clinical decision support				**X**	
Document imaging				**X**	
Electronic signature—client	Clinician's Gateway	**X**			

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Electronic signature—provider	Clinician's Gateway	**X**			
Laboratory results (eLab)				**X**	
Outcomes	Clinician's Gateway	**X**			
Prescriptions (eRx)	RxNT	**X**			
Progress notes	Clinician's Gateway	**X**			
Treatment plans	Clinician's Gateway	**X**			
Summary Totals for EHR Functionality		7	0	3	0

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

- The MHP notes that it is working with its vendor, Krassons Technology, to upgrade the EHR to MU Stage II compliance. This includes working with the vendor group to conceptualize and innovate practical Clinical Decision Support tools within the product.
- The MHP intends to implement document imaging within the EHR in the next year so that it can move forward towards complete paperless records.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP will need to consider methods to become more regular in the use of PR data, and other systemic flow reporting such as monthly dashboards, to assist the executive team in the regular monitor of its access strategies. An organization the size of this MHP is encouraged to be conducting regular analysis in these areas no less than quarterly to provide adequate navigational intelligence to management.
  - The MHP may be experiencing both systemic and operational barriers to appropriate co-occurring disorder reporting which is denying the executive team the appropriate information it needs to adequately structure program capacity and service mix.
- Timeliness of Services
  - The MHP appears hesitant to either redistribute current psychiatric resources or attain more capacity via tele-psychiatry. This could extend its services in the

rural regions and provide the large number of Hispanic beneficiaries service options.

  - The MHP has located a bilingual psychiatrist at the rural West Marin service site. That psychiatrist's hours in West Marin were reduced based on an analysis of service utilization data.

- Quality of Care

  - The MHP is looking to use HIE to improve beneficiary wellness to coordinate total consumer care.

- Consumer Outcomes

  - The MHP does not appear to have an objective system in place, system-wide, to answer the question "How do you know consumers 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 has made rigorous efforts contributing to its overall continuum of care with changes in the access protocols, delivery of mobile crises teams, contracting for crisis residential and establishing business protocols within its youth and family services unit.
  - Both current PIPs address access issues.
- Opportunities:
  - It appears that secondary to its early stages of development, data has not been collected, reviewed or analyzed for the majority of new initiatives.

Timeliness of Services

- Strengths:
  - The MHP has developed an electronic framework to begin to track its timeliness indicators to inform it of meeting its goals.
  - The non-clinical PIP also addresses timeliness to services for the expanding Medi-Cal beneficiaries in the county.
- Opportunities:
  - Timely and routine data collection and subsequent review and analysis remain limited.
  - The MHP notes that although the average wait time to psychiatry is 21 days for adults and 16 days for children the metric is met 51%, and considering the rural character of much of its SOC the MHP has not selected to use tele-psychiatry technology.

Quality of Care

- Strengths:
  - The MHP has strengthened its commitment to quality activities with the increased staffing in the QI unit comprised of a manager, UR supervisor, UR specialist and administrative support staff.
- Opportunities:
  - Leadership's commitment to inclusion and transparency are apparent, however in its early stages, it appears this vision is evidenced at the managerial level to date.
  - The current FY1415 QI work plan has not identified baseline indicators with measurable goals and specific timelines for improvements.

Consumer Outcomes

- Strengths:
  - The MHP has engaged in practices which include utilizing peer partners in committee work and meaningful activities.
- Opportunities:
  - The MHP has not engaged in utilizing a system wide Level of Service/Level of Care toolset for administrative and CQI purposes to facilitate targeted clinical care to beneficiaries.
  - Peer employee positions remain contracted positions and void of a career ladder.

RECOMMENDATIONS

- Continue the current data collection endeavors and schedule routine reporting of timeliness indicators, analyze for effectiveness and improvements.
- Create measurable goals within the QI work plan to measure its progress; establish baselines and timeline indicators.
- Select and implement use of a system wide outcome tool to measure consumer progress and treatment effectiveness with routine reporting of the results.
- Consider extending psychiatric availability via telepsychiatry.

- Continue to identify barriers to creating peer employee positions and begin classification process.

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 Marin County 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

Marin County MHP CalEQRO Agenda
February 25 & 26, 2015

Time	Day One Activity	
9:00 – 9:30	**Opening Session** • Introduction to BHC • MHP Team Introductions *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* 20 North San Pedro Road, San Rafael, CA Point Reyes Room	
9:30 – 10:00	**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*	
10:00 – 11:00	**Disparities and Performance Measures** • Access and Retention • Timeliness *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff*	
11:00 – 12:00	**Performance Improvement Projects** • Technical Assistance *Requested Participants: MHP Leadership, Quality Management Staff, Key PIP Participants All BHC Staff*	
12:00 pm – 1:00 pm	BHC Cal-EQRO Working Lunch	
1:00-2:30	**Consumer/Family Member Focus Group- of Children-Youth** • 8-10 participants as described in notification materials 3240 Kerner Blvd- Connection Center Room 105 WS/SSG/RP	**ISCA/Fiscal & Billing** • FY13-14 Recommendations • EHR implementation • Contract providers • Claim processing - denied & replaced transactions • Tele-psychiatry • Primary care collaboration • Meaningful use 3230 Kerner Rm 109 San Rafael, CA

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Executive Director
Duane Henderson, Information Systems Consultant
Walter Shwe, Consumer Family Member Consultant
Rachel Phillips, Reporting Manager
Judith Toomasson, Information Systems Reviewer

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

20 North San Pedro Road, San Rafael, CA
3240 Kerner Blvd- Connection Center, San Rafael, CA
3230 Kerner Blvd, San Rafael, CA

CONTRACT PROVIDER SITES

None

Participants Representing the MHP

Name	Position	Agency
Aldemar Martinez	MH Practitioner	MHSUS
Alexis Padilla-Gonzales	MH Practitioner	MHSUS
Amanda Davis	Licensed MH Practitioner	MHSUS – Access Team
Andrew Frierson	Peer Case Aide	STAR
Angela Tognotti	Unit Supervisor	MHSUS
Ann Pring	Division Director – YFS	MHSUS
Anne Lauver	Family Partner	CAM
Bill Rehfield	Patients' Rights Advocate	CAM
Bob Brown	Director – Community Svcs.	Buckelew Program
Brian Robinson	Unit Supervisor	MHSUS
Cammie Duvall		Cultural Comp Advisory Board

Name	Position	Agency
Catherine Condon	Resource Dev Administrator	MHSUS
Cathy Zane	Unit Supervisor – YFS	MHSUS
Celia Allen	CFO	HHS
Cesar Lagleva	ESM/WET Coordinator	MHSUS
Chris Kughn	Program Mananger	MHSUS
Chua Chao	Manager	Child Welfare – Marin County
David Rothery	Privacy/Compliance Analyst	MHSUS
Dawn Kaiser	Quality Manager	MHSUS
Debi Moss	Child Welfare Director	Children & Family Services
Donna Mills	Facility Manager	MHSUS
Egda Haro	Support Services Worker II	MHSUS
Erin Gray	Licensed MH Practitioner	MHSUS
Janice Wells	Program Manager – ASOC	MHSUS
Jeanne Scott	Director of Marin Programs	Sunny Hills Sevices
Jennifer Rossi	Unit Supervisor	MHSUS
Jessica Diaz	MH Practitioner	MHSUS
Joanne Bender	UM Coordinator	MHSUS
Kasey Clarke	MHSA Coordinator	MHSUS
Kathy Chestnut	Unit Supervisor	MHSUS
Keely Martin	Accounting Tech	MHSUS – Marin County
Kimberly Carroll	Deputy Executive Director	Marin Housing Authority
Kristen Gardner	MHSA PEI Coordinator	MHSUS
Kristine Kwok	Unit Supervisor – ACM	MHSUS
Larry Jacobs	PES Unit Supervisor	MHSUS
Larry Lanes	Medical Director	MHSUS
Laurel Hill	Executive Director	Community Action Marin
Leigh Steffy	Resource Development	MHSUS
Lillian Jang	Office Svc. Supervisor	MHSUS
Liz Ramos	Sr. Peer Case Manager	Odyssey
Lydia Villanueva	Tech Systems Specialist	MHSUS – Marin County
Lynda Beth Unkeless	Sr. Peer Case Manager	Adult Case Management
Maria Garcia	Family Partner	CAM/YFS
Marisol Muñoz-Kiehne	Bit Clinical Psychologist	MHSUS
Michele Stewart	Peer Case Aide – CAM	Marin Housing Authority

Name	Position	Agency
Nicole Nelson	Executive Director	Seneca
Pamela Roman	Licensed MH Practitioner	MHSUS
Patty Lyons	Unit Supervisor	MHSUS
Rachel Gilla	MH Registered Nurse	MHSUS
Richard Jang	Supervising Tech Sys Specialist	MHSUS
Robert Bordeaux	MH Practitioner	MHSUS
Robin Furner	FSA Clin. Adm Director	FSA – Buckelew
Sandra Ponek	Program Director	Canal Alliance
Sandra Ramirez Griggs	MH Practitioner	MHSUS/YFS
Scott Hamner	Tech Systems Specialist	MHSUS – Marin County
Susan Davis	RN/PES Unit Supervisor	MHSUS
Susanna Struzzo	Peer Case Manager	MHA Shelter Care
Suzanne Tavano	MHP Director	MHSUS
Tim Miller	Sr. Peer Case Manager	Odyssey
Todd Paler	PES Unit Supervisor	MHSUS
Walter Ongwongsakel	Administrative Services Tech	MHSUS
Ziya Dikman	Unit Supervisor	MHSUS

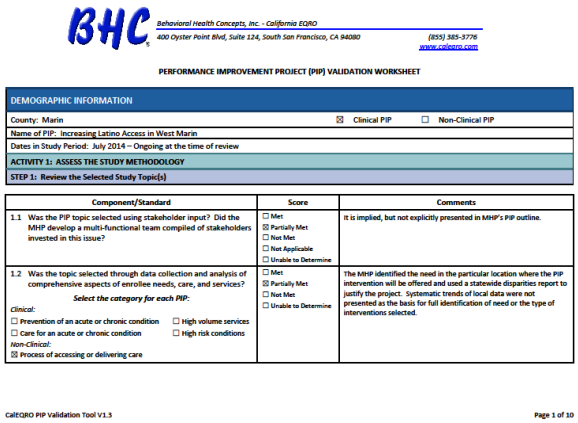
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Marin	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Increasing Latino Access in West Marin		
Dates in Study Period: July 2014 – Ongoing at the time of review		
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	It is implied, but not explicitly presented in MHP's PIP outline.
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 MHP identified the need in the particular location where the PIP intervention will be offered and used a statewide disparities report to justify the project. Systematic trends of local data were not presented as the basis for full identification of need or the type of interventions selected.

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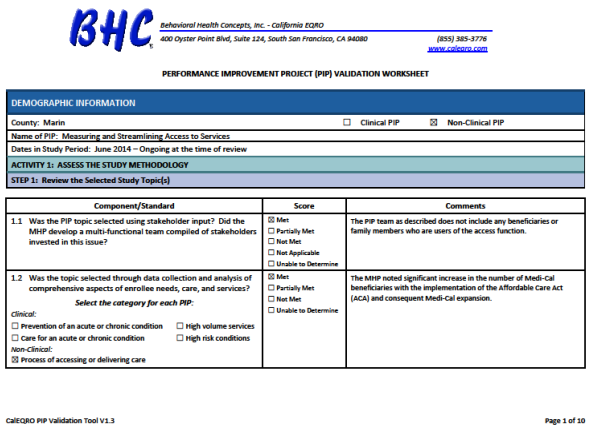
Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Marin	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Measuring and Streamlining Access to Services		
Dates in Study Period: June 2014 – Ongoing at the time of review		
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 PIP team as described does not include any beneficiaries or family members who are users of the access function.
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 MHP noted significant increase in the number of Medi-Cal beneficiaries with the implementation of the Affordable Care Act (ACA) and consequent Medi-Cal expansion.

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