FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Marin

Conducted on

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MARIN MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—1,680
- MHP Threshold Language(s)—Spanish
- MHP Size—Medium
- MHP Region—Bay Area
- MHP Location—San Rafael
- MHP County Seat—San Rafael

Introduction

The Marin MHP is categorized as a Medium, Bay Area MHP. The official name is Marin Behavioral Health and Recovery Services, which includes both specialty mental health and substance abuse services. The MHP has three service locations: San Rafael (the Kerner Campus), Greenbrae (the Bon Air campus) and Point Reyes Station. The MHP's administrative offices are in San Rafael, in a separate location. The MHP provides outpatient, residential, mobile, and crisis stabilization services.

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

Access

The MHP has improved entry into services, but is challenged with access to ongoing psychiatry and medication management. Within the last six months, the MHP has made a number of changes, specifically with their Access department, to facilitate entry into services: walk-in appointments; modifying the staffing structure to enable more assessments; streamlining referrals to go through the Access team; and relocating the department to integrate with crisis and mobile treatment. By contrast, psychiatric coverage is unstable, despite the MHP's efforts—use of locum tenens and psychiatric nurse practitioners. Stakeholders reported shortages and constant turnover of psychiatric providers. The MHP has identified some of their obstacles to recruiting providers (e.g., less than competitive salaries). The MHP has improved access to services for Latino consumers by increasing the number of Spanish-speaking and bicultural staff.

Timeliness

With the exception of current access to psychiatry, the MHP is able to provide timely services. The MHP's timeliness to services has been improved by the changes to the Access department and will be further enhanced with the development of a web platform to enable field-based staff to capture

and track their timeliness to services, albeit for services not claimed to Medi-Cal. An opportunity to improve timeliness exists for follow-up after hospitalization. Although the MHP has two hospital liaisons, dedicated positons that facilitate and provide post-hospital appointments, the MHP only achieves 7-day appointments 67% of the time.

Quality

The MHP has prioritized integration of services. The MHP's Clinical PIP features a project with a health clinic to provide integrated services to consumers with comorbid physical health conditions and/or substance use disorders and serious mental illness. The MHP has co-located their adult case management at the Bon Air Campus. This move facilitates continuum of care, whereby services for consumers who require lower (or higher) intensity and/or short-term case management services can be coordinated. The MHP (administration) made these and other program changes to improve quality and attempted to engage staff in this process (e.g., through ongoing meetings and refresher trainings). However, the perception of many stakeholders was that these changes tended to happen without their input and that of others who would be directly affected. For example, caseloads of staff in adult case management have increased, at the same time, staff have to maintain certain levels of productivity. The consensus from several stakeholder groups was that communication, more generally, within the MHP was not transparent, which affects morale. The MHP has made other changes to improve quality, particularly at the Crisis Stabilization Unit (CSU). The changes address staff and consumer safety and, with the redesign of the CSU slated to begin in 2017, capacity. The MHP has a data-driven quality management department.

Outcomes

The MHP strives to address the needs and improve the outcomes of consumers in their community. Staff use outcomes tools (e.g., Child and Adolescent Needs and Strengths and Milestones of Recovery Scale) on an individual basis to assess consumer outcomes. The MHP has yet to move toward systemic outcome evaluations. The MHP also uses surveys to obtain consumer feedback. Stakeholders reported that when post-care options are limited or difficult to organize, the MHP continues to serve consumers who might be better served in a mild-to-moderate or less intensive program.

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 rules (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations [MCOs]) specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the FY16-17 findings of an EQR of the Marin MHP by the California EQRO (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 **eight Mandatory Performance Measures (PMs)** as defined by DHCS. The eight performance measures include:

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

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs) during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM 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.

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when 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 is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Address barriers to recruitment and hiring of prescribers into existing vacancies – psychiatry and PNPs. This is essential to the delivery of this key service, impacting both consumers and program operations.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has an understanding of the barriers to recruitment of psychiatric providers, including the challenging of offering competitive salaries compounded with the relatively high cost of living in Marin. The MHP has presented to the County Administrator Office a proposal for increased salaries and benefits for psychiatrists and psychiatric nurse practitioners.
  - The MHP is exploring a contract with an agency to provide psychiatric services and is negotiating (or in communication) with the union about this.
  - The MHP utilizes the services of locum tenens to meet their psychiatric shortfall. The MHP will need to consider other strategies for increasing their capacity, including the addition of more psychiatric nurse practitioners and use of

telepsychiatry, which currently appears to be limited to after-hours/crisis services.

- The MHP's efforts are focused on recruitment; the MHP does not believe that retention of psychiatric providers is an issue.

- Recommendation #2: Provide a refreshed focus on the concepts and principles of wellness and recovery that includes training, with emphasis on the important value brought by individuals with lived experience and their roles in service delivery.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In July 2016, the MHP partnered with Workforce Integration Support and Education (WISE), whose focus is on the peer experience, integration in the workplace, and peers' role in reinforcing Wellness and Recovery.
  - The MHP acknowledged that peer integration is a cultural shift for them. Most of the peer positions within the MHP (over 16) are through two contract providers, Community Action Marin and Mental Health Association of San Francisco. The MHP, through their Ethnic Services and Training manager, and WISE have facilitated trainings on peer integration.
  - Currently, the MHP has one county peer position. The MHP has established a job classification that recognizes lived experience. This job classification is expected to be finalized in February 2017, after which the MHP anticipates hiring more peers.

- Recommendation #3: Evaluate the process used for tracking individuals placed in acute psychiatric inpatient units, with particular focus on the discharge and aftercare planning component, ensuring that data reporting separates those who are discharged to non-MHP resources, or other locales, from those who are or will become MHP consumers. The process should seek to identify and target any bottlenecks in the process that create long delays in follow-up.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has improved tracking for Medi-Cal beneficiaries discharged from the hospital through improved communication and a shared database for the Adult and Youth Hospital Liaisons and Inpatient Quality Management. This communication ensures early identification and development of a discharge plan for hospitalized beneficiaries.
  - To address long delays to follow-up appointments post hospital discharge, the MHP's Access Department reserved several appointments during the week for individuals that were recently discharged. Consumers discharged from the hospital can also come to walk-in appointments.
  - As the modifications were only recently implemented (in the past three months), they did not affect the MHP's timeliness to follow-up appointment reported on their Self-assessment of Timely Access. The MHP should monitor

closely post-hospitalization follow-ups to determine impact and need for other modifications/resolution.

- Recommendation #4: Review and analyze High Cost Beneficiaries' service patterns as both percentages of client counts and billed Medi-Cal services are significantly higher than statewide experience.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP analyzed High Cost Beneficiary (HCB) service patterns for all their beneficiaries not just Short-Doyle Medi-Cal (as the CalEQRO does).
  - The MHP's three-year analysis shows that for some beneficiaries (e.g., youth), high cost utilization is a temporary phenomenon and for others (14% of adults), high costs characterize their utilization of services. Such an analysis can equip the MHP with how to allocate resources and attend to different consumer populations.
  - While the MHP conducted a detailed examination of HCB, the MHP's analysis varied from the CalEQRO recommendation by including all MHP beneficiaries, regardless of payor, and all services rather than paid claims only. An analysis of High Cost Medi-Cal specific beneficiary service patterns was not conducted.
  - The MHP's percentage of high cost beneficiaries has been increasing steadily—from 2.83% in calendar year 2012, to 4.29% in 2013, to 6.32 in 2014, and 6.90% in 2015. However, in their analysis, the MHP noted that the increase in their HCB is not unusual for Bay Area MHPs. Of the nine Bay Area MHPs, eight are in the top ten in the State for the highest percentage of HCBs. Nevertheless, the MHPs HCB is significantly greater than the CY15 statewide average (2.86%).

- Recommendation #5: Investigate the adequacy of IT and QI staffing resources to support data analytical and dashboard requirements, especially with the numerous planned projects and new software implementation.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP added one department analyst over the past year, and currently (at the time of the review), the MHP is recruiting another analyst. The analyst will contribute to data analysis for the Quality Management department.
  - The MHP only recently filled two System Technology Specialist positions within their IT department. For most of the year, the positions were vacant and, although some initiatives were multi-year in duration, the MHP was unable to complete or make significant progress on many of the planned IT initiatives over the past year.
  - The MHP's IT staffing is under-resourced. IT staffing is comprised of three full time equivalents (FTE), two System Technology Specialist positions and one supervisor. While these positions are now filled, the IT supervisor will be retiring in March 2017 and a replacement is being recruited. With the departure

of the IT supervisor, all three IT staff will have less than six months experience and the MHP's IT support will be in a rebuilding phase regarding knowledge of the department and the systems supported.

- Despite over one year of implementation, the MHP still uses a paper format of the Child and Adolescent Needs and Strengths (CANS) and cannot scan these into their electronic health record. The MHP has plans to implement a web based CANS tool, but there is no definitive target date for the implementation.
- Data analysis is largely the responsibility by Quality Management (QM) staff. One additional Department Analyst was added in the last year and a second Department Analyst position was in recruitment at the time of the review. The MHP also engages Marin County Health Services resources for analysis, including collaboration over the past year with an epidemiologist.

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 moved the Access team to the Bon Air Campus, from the (Kerner) Health and Wellness Campus, in August 2016. The Access team is now located with the Crisis Stabilization Unit, the Mobile Teams, and Marin General Hospital's inpatient psychiatric unit. With this move, the MHP can facilitate greater coordination among these services and facilitate ease of entry into voluntary outpatient services.
  - In November 2016, the Access team began providing walk-in appointments enabling more consumers to be seen and to be seen quickly. The walk-ins provide consumers with flexibility and ease of access to mental health services.
  - In August 2016, the MHP also merged the Adult Case Management and the Adult Medication clinics to form an integrated multi-disciplinary team. The MHP co-located this integrated team, at the Bon Air Campus and the Kerner Campus. As a result of this merger, consumers with high level needs are transitioned to Full Service Partnerships, while those who are lower intensity and stable, but continue to meet Specialty Mental Health criteria are served by the integrated teams. The MHP contends that because of lower intensity and needs, staff can handle more consumers on their caseload and that with the new teams, staff are also supported by both support service workers and social service workers.
  - The MHP discontinued its contract with Beacon Health Strategies to staff a mild-to-moderate clinic due to difficulties with the retention of medical staff, lack of

adequate demand for therapy services, and a suboptimal reimbursement structure.

- Timeliness of Services
  - The MHP's provision of walk-in appointments should decrease no-shows, as consumers would have greater flexibility and control of scheduling. With fewer no-shows and correspondingly more appointment slots available, the MHP can provide consumers with more immediate or earlier appointments.
  - The MHP has modified their processes such that the Access department conducts assessments of new or returning consumers. Because the assessment are completed by Access, the MHP is able to link consumers with services faster.
- Quality of Care
  - The reorganization, with the Access department as the primary entry point, has increased caseloads and the demand on clinicians and case managers' time. The MHP also reported that they analyzed the number of beneficiary served and the number of services provided compared to the productivity and found lower levels of performance by a portion of staff. The MHP has implemented measures to align performance with services. Understandably, staff have perceived this as an emphasis on the quantity of services.
  - While there is frequent turnover of both locum tenens and contractors, the majority of psychiatry services are documented in a single medical record to which interim providers have access and can preserve continuity of information and care. However, some consumers reported inconsistent medication adjustments and lack of medication monitoring, which have contributed to their noncompliance/non-adherence to medications.
  - The MHP hired a new medical director (Katherine Ballinger, MD) in May 2016, whose approach to care emphasizes and values the input of a treatment team including peers.
  - The MHP implemented a few measures (e.g., presence of security guard, ongoing training in restraint and seclusion, and installment of under-desk alarms) to increase the safety of the crisis stabilization unit (CSU), following a number of assaults on the unit in 2016. The MHP will continue to address and prioritize safety in the redesign of the CSU, slated for 2017.
  - The MHP developed parameters for admission to make decision making regarding medical clearance from an Emergency Department prior to admission more consistent.
  - An Addiction Psychiatrist was hired in October 2016. This position is playing a key role as liaison and program developer with key stakeholders and community partners regarding Drug Medi-Cal Organized Delivery System (ODS) and Medical Assisted Treatment.
- Consumer Outcomes

- A number of stakeholders identified consumers with substance use as an underserved population. Through the Drug Medi-Cal ODS, the MHP can provide more targeted services and improve the outcomes for this population of consumers. To prepare for Drug Medi-Cal ODS, the MHP has expanded its programs, hired staff (e.g., an Addiction Psychiatrist), and integrated substance use services into the Quality Improvement committee and plan.

PERFORMANCE MEASUREMENT

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

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

TOTAL BENEFICIARIES SERVED

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

Table 1—Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity Marin

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	9,546	29.9%	895	53.3%
Hispanic	16,725	52.4%	339	20.2%
African-American	1,578	4.9%	139	8.3%
Asian/Pacific Islander	1,994	6.2%	77	4.6%
Native American	61	0.2%	11	n/a
Other	2,017	6.3%	222	13.2%
Total	31,919	100%	1,680	100%

**The total is not a direct sum of the averages above it. The averages are calculated separately.*
The actual counts are suppressed for cells containing n ≤11.

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

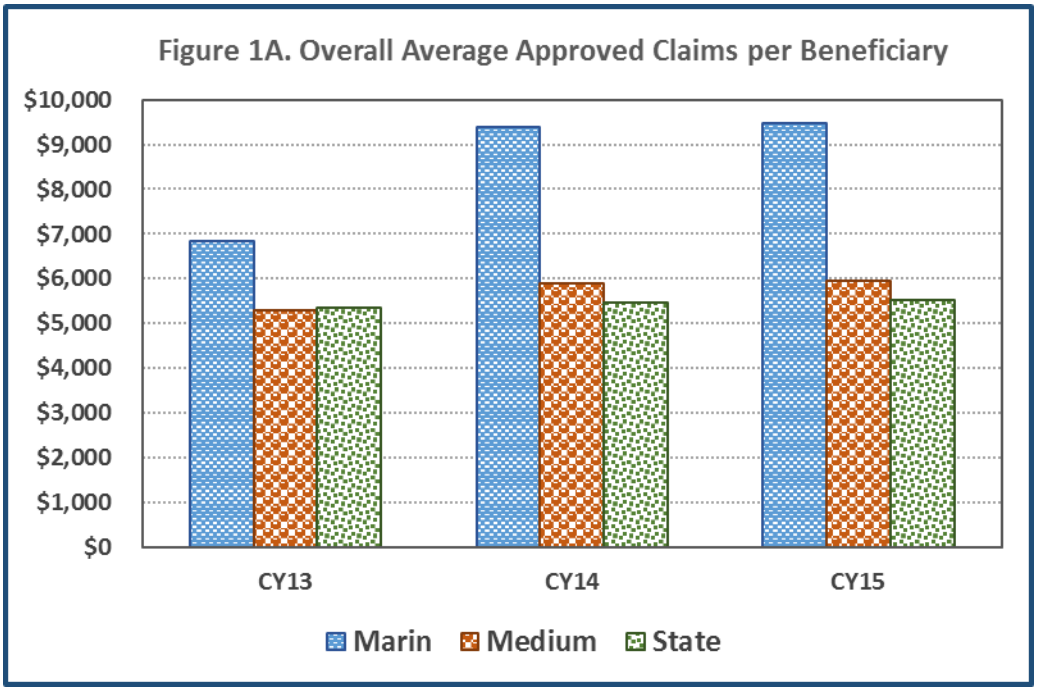
Regarding calculation of penetration rates, the Marin MHP:

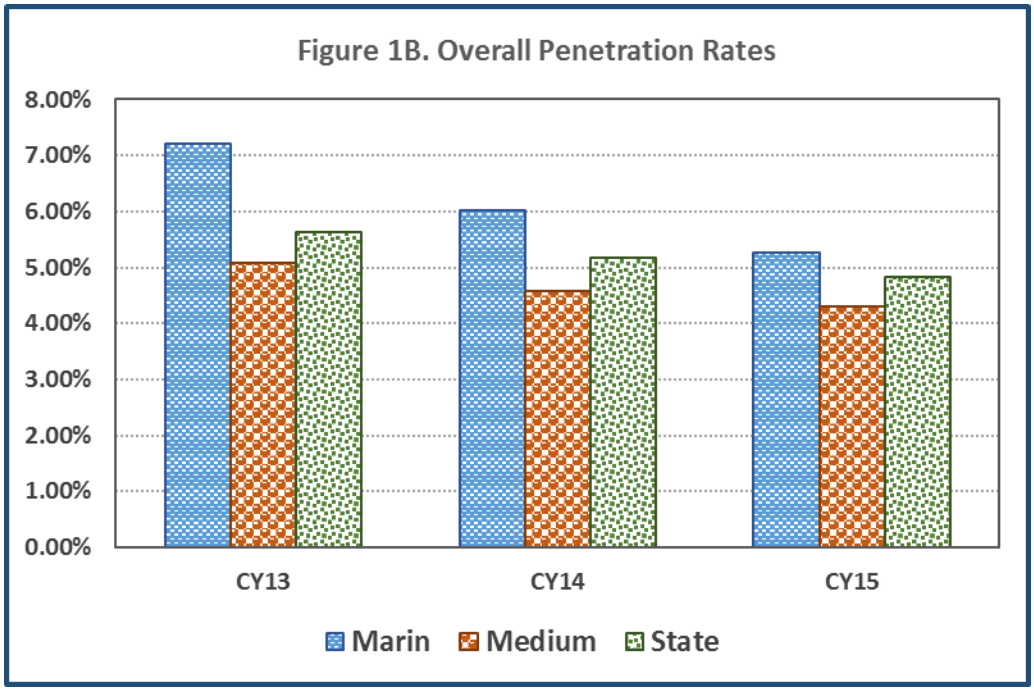
☒ Uses the same method as used by the EQRO.

☐ Uses a different method.

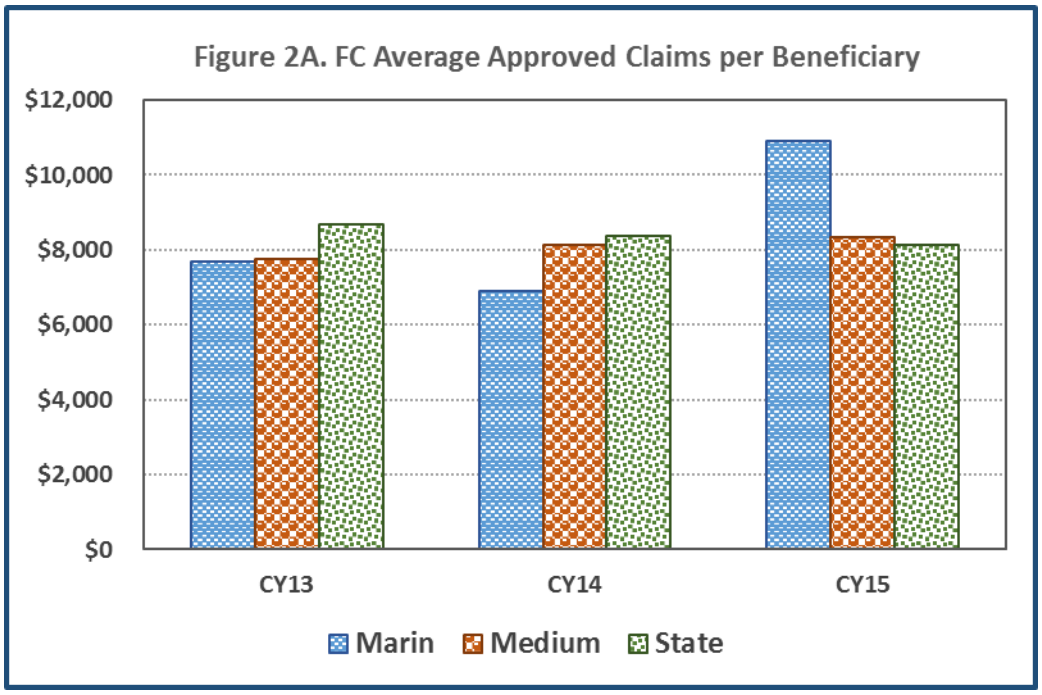
☐ Does not calculate its penetration rate.

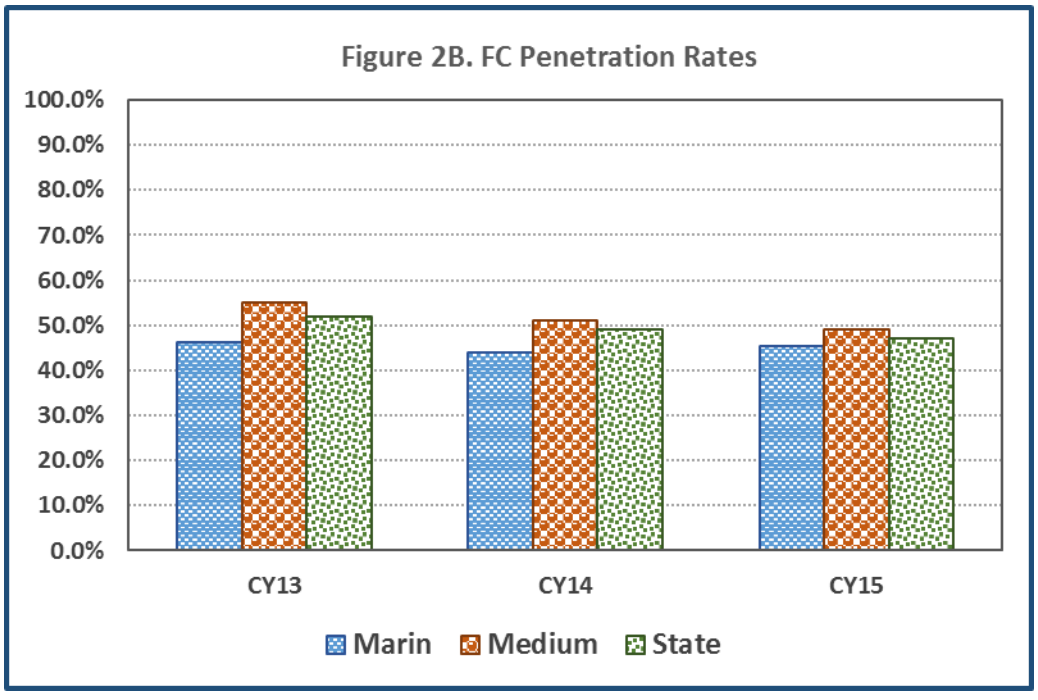
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Medium MHPs.



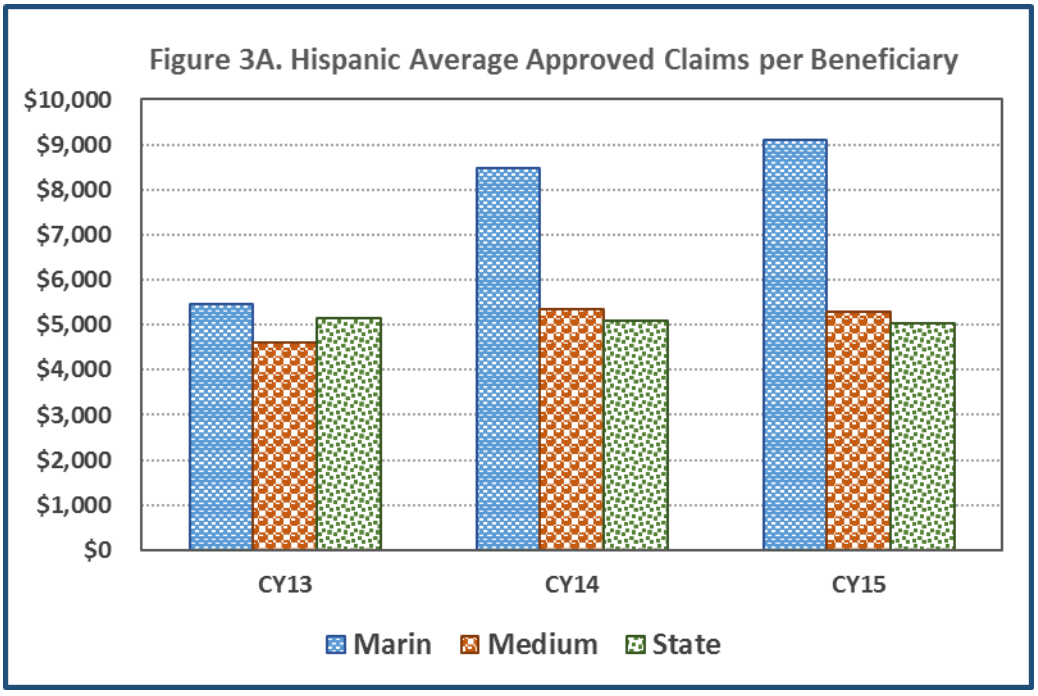


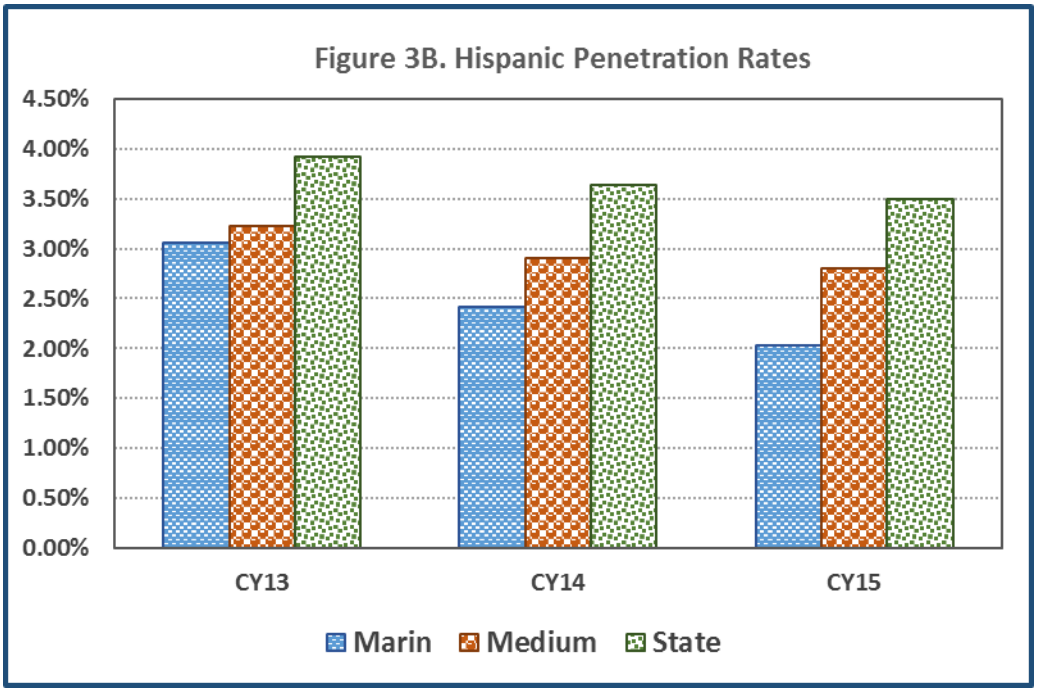
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Medium MHPs.





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 MHPs.





See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary.

HIGH-COST BENEFICIARIES

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

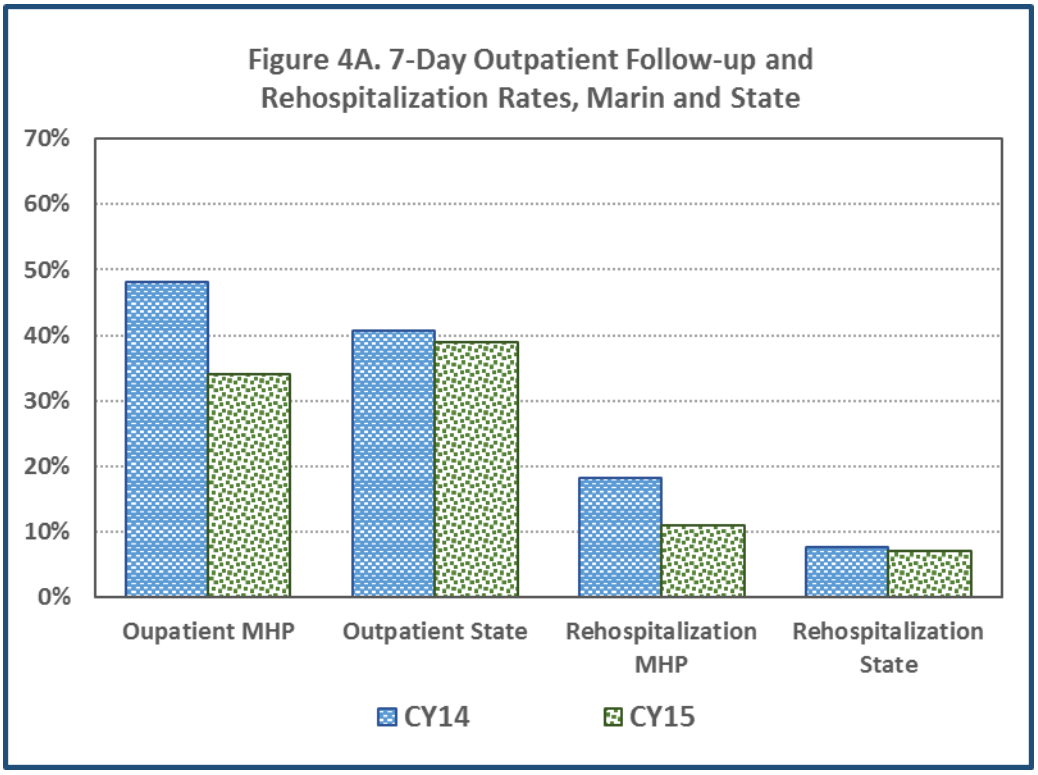
Table 2—High-Cost Beneficiaries

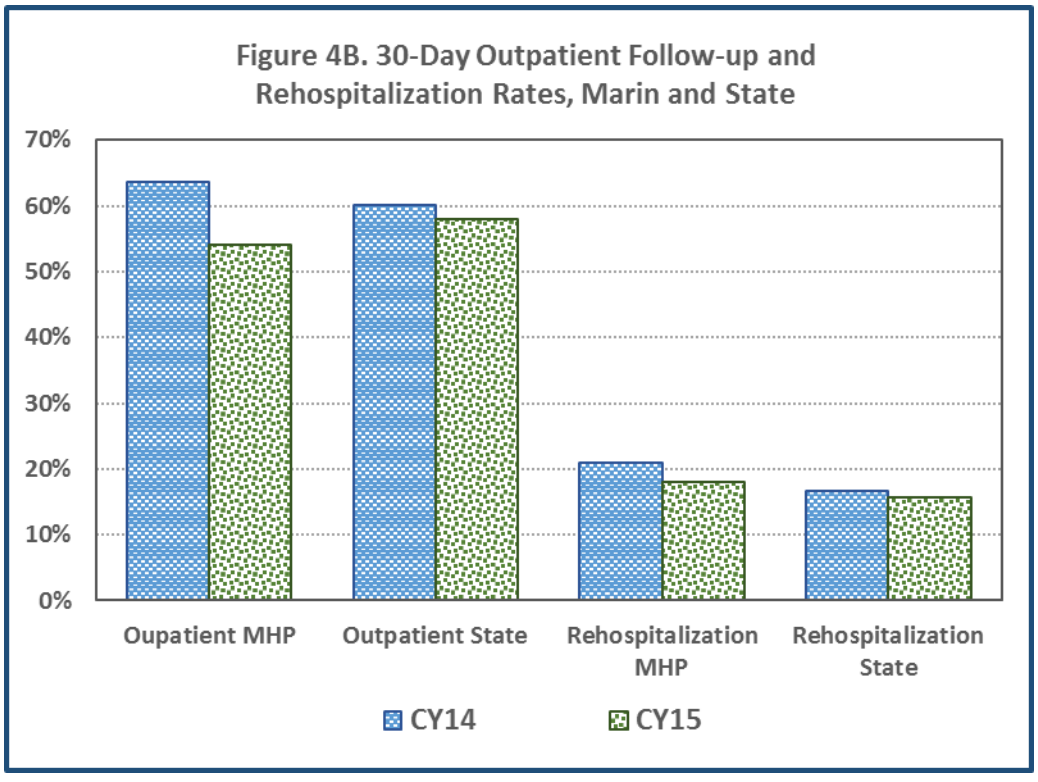
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Marin	CY15	116	1,680	6.90%	$46,961	$5,447,493	34.30%
	CY14	115	1,820	6.32%	$46,505	$5,348,118	33.32%
	CY13	80	1,865	4.29%	$42,714	$3,417,135	26.76%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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

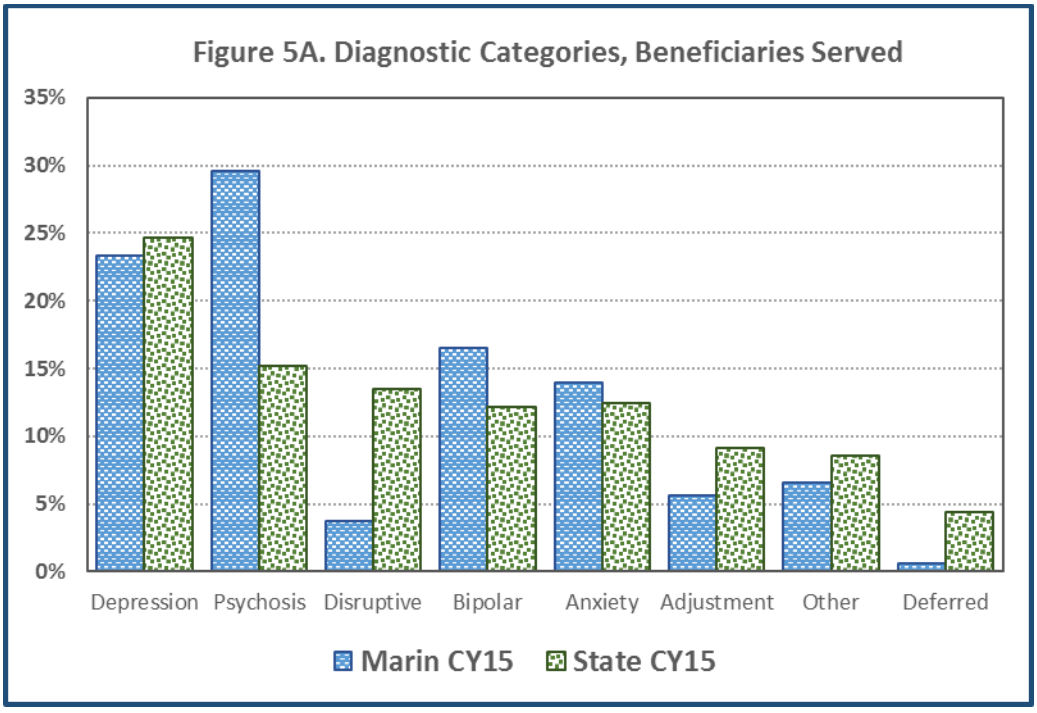


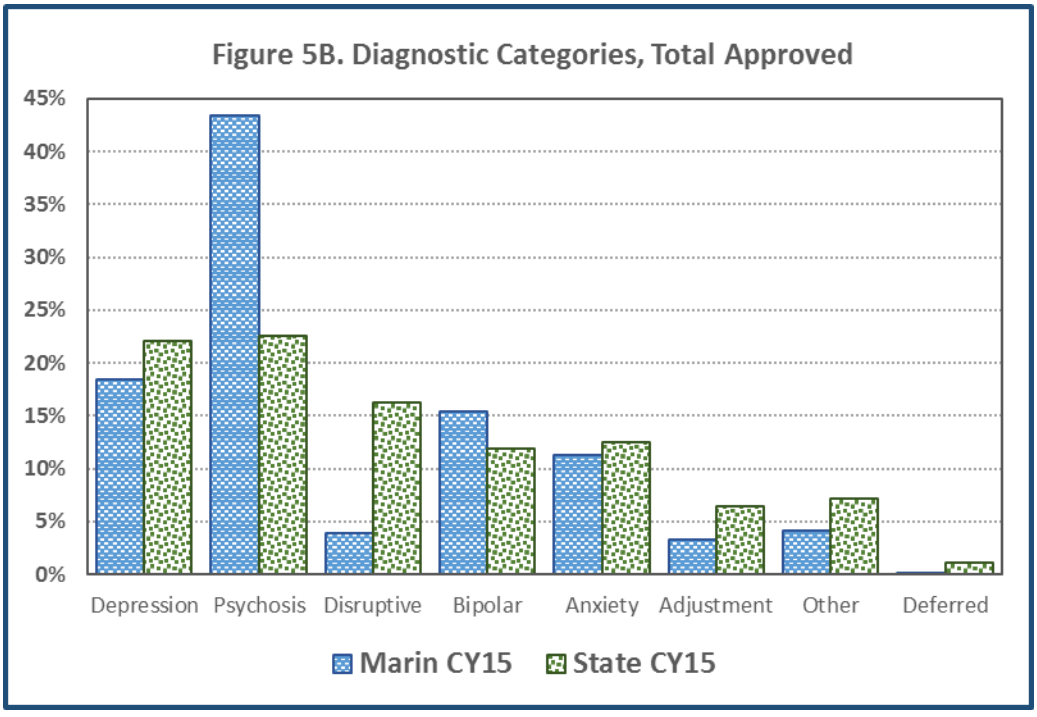


DIAGNOSTIC CATEGORIES

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

- MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 33%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - While the MHP's number of eligibles rose from 30,419 in CY14 to 31,919 in CY15, beneficiaries served dropped from 1,832 to 1,680 during this period. This correlates to a drop in penetration rate from 6.02% in CY14 to 5.26% in CY15. While the MHP has experienced a penetration rate decline each year from CY13 to CY15, the MHP's CY15 Overall penetration rate remains greater than both the medium county (4.31%) and statewide (4.82%) averages.
  - The MHP served 488 Affordable Care Act (ACA) beneficiaries, of 7,885 eligibles in CY15 for a penetration rate of 6.19% for this sub-group (see Table C1 in Appendix C).
  - When combining the Medi-Cal and ACA data, the MHP's CY15 average monthly eligibles increased to 39,804 with 2,168 beneficiaries for a combined increase from CY14 to CY15 of 9,385 eligibles and 336 additional beneficiaries.
  - The MHP's Foster Care penetration rate increased from 43.97% in CY14 to 45.45% in CY15, but remains less than both the medium county (48.98%) and statewide (47.19%) averages.
  - The MHP's Hispanic penetration rate declined from 2.41% in CY14 to 2.03% in CY15 and remains less than both the medium county (2.80%) and statewide (3.49%) averages. It should be noted that the MHP states that 97% of White eligibles have full scope Medi-Cal compared to 67% of Hispanic eligibles.
- Timeliness of Services
  - In CY15, the MHP's 7-day outpatient follow-up rate after discharge from a psychiatric inpatient episode declined when compared to the corresponding CY14 rate and is now less than the statewide average. The MHP's 30 day follow-up rate declined when compared to its CY14 rate and is now less than the statewide average.
- Quality of Care
  - The MHP's average Overall approved claims per beneficiary remained stable from CY14 ($9,398) to CY15 ($9,467), and remains significantly greater than both the medium county ($5,943) and statewide ($5,522) averages.
  - The MHP's Foster Care approved claims per beneficiary increased from CY14 ($6,880) to CY15 ($10,915), and is now greater than both the medium ($8,324) and statewide ($8,127) averages. The MHP had 50 Foster Care beneficiaries in CY15.

- The MHP's CY15 average Hispanic approved claims per beneficiary increased from CY14 ($8,480) to CY15 (9,114), and remains greater than both medium county ($5,287) and statewide ($5,045) averages.
- While the MHP's percentage of HCBs increased notably from CY13 (4.29%) to CY 14 (6.32%), it increased only slightly in CY15 (6.90%), but remains significantly greater than the CY15 statewide average (2.86%).
- The percentage of total HCB claim dollars remains greater than the statewide average in CY15 (34.30% vs. 26.96%). The MHP's CY15 average approved claims per beneficiary remained stable from CY14 (46,505) to CY 15 ($46,961) and remains less than the CY15 statewide average ($51,635).
- Varying from the statewide diagnostic pattern, a primary diagnosis of psychosis accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a notably higher rate of bipolar diagnosis and a lower rate of disruptive, adjustment and deferred diagnosis when compared to statewide averages.
- Corresponding with the MHP's diagnostic pattern, the percentage of total approved claims for individuals with psychotic disorders were significantly higher than that of other diagnostic categories. Other diagnostic approved claims dollars also aligned with the MHP's diagnostic patterns.

- Consumer Outcomes
  - The MHP's CY15 7- and 30-day re-hospitalization rates declined from CY14, but remain above statewide averages.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

MARIN MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Care Coordination in the Integrated Clinic
Non-Clinical PIP	1	Improving Access to Outpatient Services

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

Table 4—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating* Clinical PIP	Item Rating* 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	NM
		1.3	Broad spectrum of key aspects of enrollee care and services	M	PM
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	PM	PM

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		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; NR = Not Rated (Concept Only or None Submitted)*

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	5	6
Number Partially Met	10	10
Number Not Met	2	4
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	16	21
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	62.5%	52%

CLINICAL PIP—CARE COORDINATION IN THE INTEGRATED CLINIC

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

- "If we improve processes related to coordination of care will it improve system capacity and outcome for consumers with complex medical, mental health and substance use issues?
- Date PIP began: February 2016
- Status of PIP:

☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

The MHP serves consumers with chronic and complex medical and substance use issues, in addition to their mental health conditions. Historically, the MHP has partnered with Marin Community Clinic (MCC) to operate an integrated clinic for these consumers that enables coordinated care in a setting that engages and promotes health. Over time, this clinic had become less integrated and the MHP developed this PIP to improve coordination, increase capacity, and ultimately improve health outcomes for consumers. The PIP lays out four interventions: assign a care coordinator to each consumer; develop a care coordination form; provide medication review; and implement criteria for enrollment in the clinic. The interventions are most effective in facilitating coordination between the MHP and MCC. While the PIP increases access to the clinic, through an inclusion/exclusion criteria, it does not specifically address capacity. The PIP does not articulate how the MHP will target and serve a finite number of high need consumers who would benefit from this integrated clinic, but as yet are not part of the clinic. Regarding the health outcomes, the MHP identified two, medication monitoring/reconciliation and adherence to twice annual clinic appointments, both of which could also be considered physical health outcomes. In a previous iteration of this PIP, the MHP had mental health indicators (e.g., number CSU or inpatient hospital admissions); it is unclear why those measures were not included in this version. As the MHP continues this PIP, they should focus on and highlight the impact of care coordination on the mental health of their high need consumers.

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 simplify the PIP; remove the components that were only relevant to the CIBHS Learning Collaborative project; and refine the scope to be able to relate specific interventions with outcomes. This PIP was originally submitted as a Non-Clinical PIP. CalEQRO discussed with the PIP team their thoughts on submission as a Clinical PIP. The MHP made the modifications and also resubmitted the project as a Clinical PIP. However, in so doing, the MHP removed some components that featured the clinical outcomes of the project.

NON-CLINICAL PIP—IMPROVING ACCESS TO OUTPATIENT SERVICES

The MHP presented its study question for the Non-Clinical PIP as follows:

- "Will changing the staffing mix for the Access Team improve the capacity to provide face to face assessments without decreasing the current level of service to the Access Line? Will adding Walk-In days increase the overall capacity of Access to provide assessments?"
- Date PIP began: October 2015
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year *(Not Rated)*

  ☐ Concept only, not yet active *(Not Rated)*

  ☐ Submission determined not to be a PIP *(Not Rated)*

  ☐ No PIP submitted *(Not Rated)*

The MHP has set out to improve Access services to meet the increased demand for services and anticipated continued increase (i.e., following Drug Medi-Cal Organized Delivery System). The MHP identified a need to restructure the Access team to enable more assessments and more timely assessments. While the MHP presented eight interventions, only four were applicable to the PIP; the others were either not well linked to the PIP or were part of another project (increasing access to services for Latino consumers). The MHP collected data on call handling and on assessments, specifically the number of assessments completed monthly. Although the MHP suggests that current structure of Access team affects time-to-services, no timeliness measures were collected. This oversight relates to a common thread of the PIP—that the MHP has not identified a specific problem to address. The MHP did not present evidence that the Access team was underperforming or that time-to-services were protracted or that there were barriers to Access. The PIP focuses on optimizing performance.

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 clarify the timeline and sequence of interventions.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Both PIPs have the potential to improve access to care for consumers. The Clinical PIP will enable higher-need consumers to access integrated health care and the Non-Clinical PIP improves initial access to mental health services.
  - The Non-Clinical PIP uses multiple approaches to improve access. In particular, the walk-in clinic will likely have a significant impact on consumer access.
- Timeliness of Services
  - In the Non-Clinical PIP, the MHP makes a connection between availability of assessments at Access and timeliness of services (e.g., post hospitalization and routine appointments), but does not actually address timeliness of services.
- Quality of Care
  - The MHP can affect the quality of care for a vulnerable population of consumers by better coordinating and integrating mental health services with physical health care.
  - As part of the Clinical PIP, the MHP will create a mechanism to review criteria for services, thus connecting consumers with the most appropriate level of care.
- Consumer Outcomes
  - The MHP indicates improved health care and longevity as general benefits of integrated healthcare. There are more immediate benefits and benefits specific to the target population that the MHP should consider (e.g., understanding of their health status and social connectedness).

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 6, 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 6—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 has an active Cultural Competency Advisory Board that aims to reach various underserved populations in the community. They are also trying to address disparities in their workforce with underrepresented ethnicities and races—and creating opportunities for workforce development among African-Americans and Latinos—scholarships, training. The MHP has hired Spanish-speaking staff and has Vietnamese-speaking staff, although more Vietnamese-speaking staff are needed. Partnerships with agencies that have *promotoras* and other navigators were mentioned (e.g., at the primary clinic). Novato and West Marin were mentioned as underserved areas. Some programs (e.g., Youth & Family) have located (or attempting to locate) satellite offices there. Language capacity in Access was increased by the addition of two bilingual/bicultural (Spanish) psychology post-doctoral interns.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP captures a considerable amount of service utilization data and appears to be able to parse it to assess the types/numbers of practitioners. The MHP's use of locum tenens is an effort to facilitate access to psychiatry while dealing with their staffing shortage. However, the MHP urgently needs other strategies to address inadequate number of psychiatric providers. The MHP has co-located the Adult case management which provides ease of access to consumers needing both medication management and therapy/case management. Staffing for the merged clinic teams was enhanced by the addition of four non-licensed case management positions. The Access team began

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			providing three-day walk-in clinics. While the MHP monitors services and evaluates implementation of strategies, the MHP should monitor the impact of implemented strategies.
1C	Integration and/or collaboration with community based services to improve access	PC	The MHP has a broad network of community based provider and the MHP's staff partner and collaborate with these community agencies. The MHP relocated the Access team to facilitate integration with both internal, at the CSU and the Mobile teams, and external, with Marin General Hospital. A number of stakeholders indicated that regular meetings between them and the MHP did not take place. There was also a need for improved contract monitoring or opportunity for regular dialogue.

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

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. 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 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP utilizes a 14 day standard. Adult services are reported as averaging 8.3 days (91.6% meeting standard; range: 0-39 days); and children/youth 10.4 days (85.7% meeting standard; range: 0-34 days). The MHP's time to first contact falls within a reasonable range (0-39 days). The MHP investigates routines why latency that far exceed their standard.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP utilizes a 30 day standard. Adult services are reported as averaging 16.7 days (94.3% meeting standard; range: 0-74 days); and children/youth 19 days (100% meeting standard; range: 0-19 days). The data reported predates significant loss of psychiatric providers. The MHP has yet to assess the impact of modifications in programs and services on psychiatry.
2C	Tracks and trends access data for timely	FC	The MHP utilizes a 180 minute standard. Adult services are reported as averaging 86 minutes (86% meeting

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
	appointments for urgent conditions		standard); and children/youth 79 minutes (91% meeting standard).
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	The MHP utilizes a 7-day standard. Adult services are reported as averaging 17 days (66.9% meeting standard); and children/youth 13 days (66.7% meeting standard). The MHP has a dedicated staff person, a hospital liaison, who provides follow-up appointments. The hospital liaison does not consistently claim contacts contributing to low rates for timelines.
2E	Tracks and trends data on rehospitalizations	FC	The MHP has an inpatient readmission rate of 15% for adults and 8% for children/youth. The readmission rates are reasonable, although they exceed their standard (10%).
2F	Tracks and trends no-shows	FC	The MHP tracks and trends No-Shows for psychiatrists and clinicians with a standard of 10% for both groups. The clinician no-show rate for adult services is 5%; children and youth have a 6% no-show rate. For psychiatry, no-show rate is less than 5%.

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

Quality of Care

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

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has a quality improvement (QI) plan that is produced timely (subsequent to the evaluation) and that guides activities for the year. The plan has a number of measurable goals/objectives, but some objectives were activities and not actually measurable. The QM plan references and includes objectives from various programs and will eventually include SUD objectives. QM staffing was increased by a 0.5 FTE to process Treatment Authorization Requests. Two (FTE)

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			Department Analyst positions were also added. One position has been filled and one is in recruitment.
3B	Data are used to inform management and guide decisions	FC	QM is structured in a way that enables executive management to obtain program information and related data to guide decisions. QM does a good job of data extraction and reporting, but there is a need for more analysis and synthesis.
3C	Evidence of effective communication from MHP administration	PC	A number of stakeholders, both internal and external to the MHP, described communication as uni-directional (from MHP administration/management to them) and lacking transparency. Among the different levels of staff (e.g., supervisors to line staff), communication was bidirectional. Emails and meetings were the primary means of communication. Training for new employees was not standard and perhaps contributed to safety issues at the CSU. Staff reported little time to learn and understand the system and their programs. Consumers identified their case managers, psychiatric providers, or staff at the wellness center as their sources of information. Family members reported few means of communication and receiving information from the MHP.
3D	Evidence of stakeholder input and involvement in system planning and implementation	NC	There was a sense that MHP administration/ management withheld information and did not involve relevant stakeholders in decision making. The co-location/division of adult case management was cited several times as an example of a unilateral decision that continues to have an impact on many stakeholders, including staff. Another example of minimal stakeholder input was the exclusion of contract providers in policy and procedure meetings (and mentioned previously, regular meetings with contract providers do not take place). Conversely, family members felt involved in system planning. A family member reported his/her participation in Marin County Mental Health Board.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	The MHP has a number of partnerships that promote quality and facilitate integrated services. The MHP has partnered with MCC on a CIBHS-sponsored Care Coordination Collaborative project to improve coordination and outcomes for consumers with high needs. The MHP appears to have strong collaborations with schools and criminal justice (e.g., probation and courts) to improve services for shared consumers.
3F	Evidence of a systematic	PC	The MHP has prioritized services through a continuum of care. They are beginning to capture pre-consumer

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
	clinical Continuum of Care		information and can eventually link that to care once individuals are enrolled. Staff integrate evidenced-based practices in their work (e.g., motivational interviewing) to engage consumers. The MHP does not use systemically outcome tools or level of care tools. MHP appears to face challenges in moving certain consumers (e.g., those at the CSU and monolingual Vietnamese adults),) to another level of care when they no longer meet criteria.
3G	Evidence of individualized, client-driven treatment and recovery	PC	MHP staff use measurement tools to determine outcomes and course of treatment. Support groups are available to consumers through community providers and NAMI. Consumers had mixed responses regarding the degree to which they were involved in developing their own treatment plans.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	While the majority of consumer and family member/peer positions are employed through contract providers, they peers are very integrated into many programs. The MHP is working with Marin Health and Human Services (HHS) Human Resources to develop Peer Counselor and Peer Supervisor classifications. Peers were represented in different levels of the MHP.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	While there are no peers in management, peers are present in other parts of the MHP. The Enterprise Resource Center staff are all consumers, including four supervisors. The Center offers an extensive peer counseling training program. Two of the seven employees were full-time with benefits. The Center also has 25 volunteers to assist. 169 individuals were trained in Mental Health First Aid in 2016 and WISE trainings were made available (and attended) by several peers.
3J	Measures clinical and/or functional outcomes of consumers served	FC	Different programs of the MHP use outcome tools (e.g., CANS and MORS). The use is not geared toward system-wide evaluation, but for direct consumer outcomes. The tools are paper/pencil and do not enable aggregation.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP and their partners (e.g., WISE) have conducted a number of surveys. Stakeholders were aware of and participated in the surveys; however, most stakeholders reported that the findings and outcomes were not communicated to them.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP has made a number of changes to improve access to mental health services, particularly through integration of programs such as Access and Crisis/Urgent services, which are primary entry points for consumers.
  - While the MHP has attempted to mitigate psychiatric provider shortage, the strategies have not enabled stable coverage. Continuing their efforts to stabilize psychiatric coverage, the MHP intends to execute a contract with an organization that employs a large of psychiatric providers in February 2017.
  - The MHP has added more bilingual (Spanish) and bicultural Latino staff to a number of programs, which has the potential to not only increase access, but facilitate engagement of consumers in care.
- Timeliness of Services
  - The MHP's current shortage of psychiatric providers is experienced by consumers as delays in receipt of ongoing appointments and in renewal of medications.
  - The MHP has developed a web-based tracking that will enable field-based staff (e.g., Mobile Treatment) to capture and include their times to services for various calculations related to timeliness.
- Quality of Care
  - The MHP appears to have sufficient staff to report and analyze data, but the MHP may require more staff in the QM department to better synthesize and make the data meaningful so as to be understood and useable by more stakeholders.
  - The MHP does not appear to engage stakeholders in system planning and decision making. The MHP administration risks alienating and disaffecting stakeholders, particularly staff, which may trigger more turnover at an inopportune time.
  - The MHP recognizes the benefit of peers in engaging and connecting consumers. Peers are integrated into many programs, though infrequently not employed directly by the MHP.
- Consumer Outcomes
  - The MHP may be discouraging future participation and input from consumers by not disseminating results of surveys and other feedback timely.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was at the MHP's Wellness Center Campus (3240 Kerner Boulevard).

Number of participants – 6

For the four participants *who entered services within the past year*, they described their experience as supportive, but needing better collaboration between the schools (i.e., for those participants with children were being served).

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

- Uncertainty about the degree to which they were involved in treatment planning.
- Lack of stability in psychiatric provider coverage. Participants reported change of providers without any notification and having gone two months without seeing a provider.
- Need for collaboration between the clinicians and the schools. MHP therapists need to connect with school therapists and, more generally, teachers would benefit from education about the mental illness.
- General ease in receiving services in Spanish.

Recommendations for improving care included the following:

- Educate the community and the schools (i.e., teachers) about mental illness, including signs, symptoms, and treatment options.
- Have permanent psychiatrists/psychiatric providers available.

- Improve/increase access to beds when hospital beds/stay are no longer available.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a culturally diverse group of adult beneficiaries and transitional age youth, including 1) Latino beneficiaries and 2) a mix of existing and new clients all who have initiated and utilized services within the past 12 months. The focus group was held at the MHP's Wellness Center Campus (3240 Kerner Boulevard). Number of participants – 9

None of the participants had *entered services within the past year*.

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

- Case managers were helpful in coordinating services, including providing transportation.
- The relocation of case managers with the therapist (presumably at the Bon Air campus) has improved coordination of services.
- The frequent change of psychiatric providers was disruptive.

Recommendations for improving care included the following:

- Maintain the same psychiatric providers.
- Expand the hours of the warm line to the evenings.

Interpreter used for focus group 2: ☐ No ☒ Yes Language(s): Spanish and Vietnamese

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Participants indicated that co-location of adult case management with medication services and clinicians has improved access. Participants reported that coordination of services was better.
    - The MHP's shortage of and frequent change in psychiatric providers has had a negative impact on consumer access. In addition to the disruption in services, some participants linked their missed appointments to their uncertainty about being assigned a new psychiatric provider or not.

  - The MHP has a number of staff who are multi- or bi-lingual in Spanish and Vietnamese. Participants remarked on the ease of and availability of services in their preferred language.

- Timeliness of Services
  - Participants reported long wait times to see psychiatric providers. For one consumer, a protracted wait contributed to discontinuation of his/her child's medications.

- Quality of Care
  - Participants look to the MHP to educate and provide information on mental illness and treatment for themselves and their communities, particularly schools.
  - Participants felt that quality of care for their school-aged children receiving services could be improved through outreach, coordination, and regular communication between the MHP (i.e., by clinicians and case managers) and school-based therapists and schools themselves.

- Consumer Outcomes
  - Treatment plan and related goal setting is a means for consumers to gauge outcomes. One focus group participant recalled a discussion of his/her child's goals. However, most of the focus group participants could not recall whether or not they were involved in the development of their Wellness Recovery Action Plan or their children's treatment plan. Particularly for consumers whose primary language is not English, clinicians may need to be more explicit with consumers or their family members about developing the treatment or client plan as it was not salient for them.

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	30%
Contract providers	67%
Network providers	3%
Total	100%

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

  3%

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

  ☐ Yes ☐ In Testing/Pilot Phase ☒ No

- MHP currently provides services to consumers using a telepsychiatry application:

  ☐ Yes ☐ In Testing/Pilot Phase ☒ No

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

    N/A

MHP self-reported technology staff changes since the previous CalEQRO review (FTE): Two System Technology Specialist positions were vacated in October 2015 and summer 2016, these positions were filled in September and November 2016.

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
3	2	2	1

MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE): Both analyst positions were newly allocated to QM in 2016.

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
2.5	1	1	1

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

- Behavioral Health and Recovery Services IT (BHRS IT) staffing consists of one supervisor and two System Technology Specialists. BHRS IT was significantly understaffed in the last year with the loss of both System Technology Specialist positions, one was vacated in October 2015 and the other in summer 2016. These positions were filled in September and November 2016. The staffing deficit significantly impacted the MHP's ability to achieve IT related initiatives over the past year.

- With the planned retirement of the IT supervisor in March 2017, BHRS IT will have lost significant historic knowledge and be in a rebuilding phase. The MHP hopes to mitigate some of this knowledge loss by hiring the replacement supervisor prior to the departure of the current supervisor in order temporarily double fill the position to allow for training and knowledge transfer.

- The Supervising Technology Specialist will retire in March 2017. The position will be filled with a Technology Services Coordinator. This newly titled position is more closely aligned with County IT positions and will allow the supervisor to have more administrative activities as well as contract management with vendors. The MHP plans to have the new Technology Services Coordinator hired prior to the departure of the existing supervisor in order to allow for training and knowledge transfer.

- A QM Department Analyst was hired in July 2016. There was an additional Department Analyst position in recruitment at the time of the review.

CURRENT OPERATIONS

- The MHP continues to utilize the ShareCare/Clinicians Gateway system.
- The HHS Technical Services staff contribute to the BHRS IT support, by providing management of hardware resources and desktop support, as well as by sharing responsibility for after-hours support of the Crisis Stabilization Unit's technology needs.
- The MHP reports that 30% of services are provided by county operated/staffed clinics, 67% by contract providers and 3% network providers. Approximately 45% of services are claimed to Short Doyle/Medi-Cal (SD/MC).
- The MHP does not currently utilize telepsychiatry services.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide 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 12— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
ShareCare	Practice Management	The Echo Group	5	Marin BHRS-IT
Clinician's Gateway	EHR	Krassons	10	Marin BHRS-IT
RxNT	eRx	RxNT	7	Marin BHRS-IT
Teleform/POQI	Customer Satisfaction Survey	State/HP	7	Marin BHRS-IT
MySQL PES Tracking	PES Medication Tracking, PES Access Log	Marin HHS Technical Services	2	Marin HHS Technical Services
ImaVisor	Document Imaging	Marin HHS Technical Services	1	Marin HHS Technical Services

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP is considering a new system.
- The MHP is in the very early stage of considering a new system. A target date has not been established and work groups have not been formed. Initial discussions are expected to continue into the next fiscal year.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts				X	
Assessments	Clinician's Gateway	X			
Document imaging/storage	ImaVisor		X		
Electronic signature—consumer	Clinician's Gateway	X			
Laboratory results (eLab)	Quest			X	
Level of Care/Level of Service	Clinician's Gateway	X			
Outcomes	Clinician's Gateway		X		
Prescriptions (eRx)	Rx/NT	X			
Progress notes	Clinician's Gateway	X			
Treatment plans	Clinician's Gateway	X			
Summary Totals for EHR Functionality		6	2	2	0

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

- ImaVisor scanning is being utilized in the test system by medical records staff. Due to BHRS IT staff vacancies, no other EHR initiatives were achieved in the past year.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- ImaVisor scanning is being utilized in the test system by medical records staff.
- HHS Technical Services staff developed web-based applications for Crisis Stabilization Unit and Access tracking needs and have been key partners in the Health Information Exchange implementation.

- BHRS IT is in a rebuilding phase. The two System Technology Specialist positions which were vacated in October 2015 and summer 2016 were filled in September and November 2016. The Supervising Technology Specialist will retire in March 2017. The MHP plans to have the newly reclassified Technology Services Coordinator hired prior to the departure of the existing supervisor in order to allow for training and knowledge transfer for the new supervisor.

PRIORITIES FOR THE COMING YEAR

- Hire the new Technology Services Coordinator who will replace the current BHRS IT supervisor, who is retiring in March 2017. Double filling of the position will allow for training and knowledge transfer. Continue training of the two newly hired System Technology Specialists.
- The interim Medical Director is in conversation with a telepsychiatry provider regarding on-demand psychiatric evaluations in the Crisis Stabilization Unit as needed to augment existing psychiatry staffing.
- Detention Health and Mental Health Services are preparing for implementation of an electronic health record. Implementation will include interoperability with the MHP's EHR.
- Implement the Suicide Behavior Questionnaire-Revised (SBQ-R), Ask-Suicide-Screening Questions (ASQ) per Meaningful Use requirements.
- Continue working with HHS and Redwood MedNet in the implementation of the Marin Health Gateway Health Information Exchange.
- Implement a web based CANS product by Advanced Metrics.
- Upgrade EHR to DSM-V
- Upgrade EHR to support mobile teams and CSU.
- Implement new CANS web based reporting system by Advanced Metrics.
- Complete implementation of ImaVisor medical records scanning system.

OTHER SIGNIFICANT ISSUES

- While CANS use began in November 2015, a paper format continues to be utilized and scanning into the EHR has not yet occurred.
- The Marin County Health and Human Services is the lead entity for Marin County in the creation of a local HIE ("Marin Health Gateway"). Participants will include BHRS, the four local Federally Qualified Health Centers (FQHCs), HHS public health clinics,

Emergency Medical Services and Marin General Hospital. Initial work is currently focused on refining use cases and conducting discovery for interface development.

MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

Dimensions Reports, T-SQL ShareCare database queries

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 14—Summary of CY15 Processed SDMC Claims—Marin

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
47,477	$15,250,990	$573,590	3.76%	2,152	$14,677,400	$453,376	$14,224,024

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

- The August 2016 claim was submitted in January 2017. The MHP reported a FY15-16 denied claims rate of 3.3% with the top two reasons for denial as Other Health Coverage must be billed before submission of this claim and beneficiary not eligible.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The interim Medical Director is in conversation with a telepsychiatry provider regarding on-demand psychiatric evaluations in the CSU as needed to augment existing psychiatry staffing.
- Timeliness of Services

- Web-based tracking applications for the CSU and Access were developed.

- Quality of Care
  - A Quality Management Department Analyst was hired in July 2016. There was an additional Department Analyst position in recruitment at the time of the review.
  - With the two allocated System Technology Specialist positions being filled in September and November 2016 and the planned retirement of the IT supervisor in March 2017, BHRS IT will have lost significant historic knowledge and will be in a rebuilding phase.
  - Detention Health and Mental Health Services are preparing for implementation of an electronic health record. Implementation will include interoperability with the MHP's EHR.
  - The Marin County Health and Human Services is the lead entity for Marin County in the creation of a local HIE ("Marin Health Gateway"). Participants will include BHRS, the four local FQHCs, HHS public health clinics, Emergency Medical Services and Marin General Hospital.

- Consumer Outcomes
  - Use of the CANS began in November 2015; however, the tool continues to be utilized in a paper format and the paper documents are not scanned into the electronic health record.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers to the site review.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP relocated the Access team to the Bon Air Campus, which was already the site of the CSU, mobile teams, and inpatient psychiatric unit (operated by Marin General Hospital). This move facilitates entry into services as well as coordination of services for existing consumers.
  - The MHP is able to adapt programs to improve access to services. The addition of twice weekly walk-in appointments at Access and the co-location of Adult Case Management at the Kerner and Bon Air campus, demonstrate the MHP's commitment to integration and coordination of services.
  - The MHP is also adopting an integrated approach between mental health and physical health. The MHP's PIP on integrated care with Marin Community Clinic exemplifies this focus.
- Opportunities:
  - The MHP does not have sufficient and stable psychiatric provider coverage, which adversely affects access and continuity of services. The MHP should examine all opportunities to provide more consistent psychiatric providers in the year ahead.
  - While the MHP has a standard and formal orientation for new staff, there are opportunities to provide training and more information on the larger system of care. Staff reported that because they were not aware of the larger system of care and services within the MHP (even months after their employment), they were unable to connect consumers to appropriate and available services.

Timeliness of Services

- Strengths:
  - The MHP's ability to adapt programs to meet demand has had a positive effect on timeliness of services. By centralizing referrals and entry to services through

the Access department, consumers have been able to connect to services faster. By co-locating Adult Case management, consumers can more quickly access therapy and medication support.

- Opportunities:
  - The MHP does not have sufficient and stable psychiatric provider coverage, which adversely affects time to psychiatric assessments and routine medication management and monitoring. The MHP should examine all opportunities to provide more consistent psychiatric providers in the year ahead, including expanding telepsychiatry.

Quality of Care

- Strengths:
  - The MHP has an EHR that can capture pre-consumer information. The MHP is taking advantage of this by acquiring/developing a pre-consumer electronic system that can be integrated into their EHR. The MHP will be able to coordinate services for consumers who move through the continuum of care.
  - Web-based tracking applications for the CSU and Access were developed.
  - The MHP appears to have sufficient staff, particularly in adult case management, who are committed to and able to prioritize the needs of the clients. Staff are attempting to strike the right balance between maintaining quality of services, with increased caseloads and the same productivity requirements.
  - The MHP has a strong, data-focused QM department that enables data-driven decision making.
- Opportunities:
  - IT staffing continues to be under-resourced, even with all positions filled. Most planned IT initiatives were not met over the past year due the vacancy of the two System Technology Specialist positions for much of the past year.
  - . That staff have a very different perception of what the MHP administration is doing/has done to engage them in system-planning indicates an issue with communication and perhaps transparency within the MHP. Despite the MHP's efforts to involve staff in the planning of recent move and the integration of services, the perception among staff at various levels was that they were not involved and that there was little communication to/from them about these changes
  - While the MHP has multi- and bi-lingual staff, it may not be sufficient to meet the needs of consumers in various programs. Staff who are multi-lingual reported higher caseloads and greater demand on their time, they facilitate services for consumers beyond their roles and, sometimes, they are also asked to fill in when translators are unavailable.

Consumer Outcomes

- Strengths:
  - The MHP recognizes their deficits in opportunities for peers. Accordingly, the MHP has partnered with contract providers and other organizations (e.g., WISE) to strengthen their ability to incorporate peers.
- Opportunities:
  - The MHP uses the CANS in paper format and does not scan them into the EHR. The MHP cannot provide aggregate and system-level data with this means of tracking.
  - The MHP serves consumers who no longer meet criteria for their care. Consumers may not be receiving services at a level that is appropriate to their current functioning.

RECOMMENDATIONS

- Conduct an analysis of the current options to provide stable psychiatric coverage (e.g., increased telepsychiatry, utilization of nurse practitioners, and smaller caseloads of locum tenens) and implement the strategies that are most feasible and promising.
- Establish a designated forum with representation by staff and peers at each level of the MHP, and/or ensure attendance by staff and peers at system planning meetings conducted by MHP administration.
- Hire a project manager to oversee project tracking and assignment of Information Technology staff to those projects, ensuring that limited staff can focus on completing of initiatives that will support the department.
- Conduct a program-by-program analysis of consumers' needs for ongoing services through the mental health plan; identify those consumers who no longer meet criteria; and develop and execute a plan to move those consumers to the most appropriate provider or placement.

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

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

Table A1—EQRO Review Sessions - Marin MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Acute Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview –Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
Tele Mental Health
Access Call Center Site Visit
Wellness Center Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Ewurama Shaw - Taylor, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Rama Khalsa, PhD, Director, Drug Medi-Cal
Walter Shwe, Consumer/Family Member Consultant
Mei Chung, BHC Office Manager, Review Observer

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

Behavioral Health and Recovery Services, 20 N. San Pedro Road, San Rafael, CA 94903
Wellness Center Campus, 3240 Kerner Boulevard, San Rafael, CA 94901
Bon Air Campus, 250 Bon Air Road, Greenbrae, CA 94904

CONTRACT PROVIDER SITES

Enterprise Resource Center, 3270 Kerner Blvd., Suite C, San Rafael, CA 94901

Participants Representing the MHP

Name	Position	Agency
Abaci, Maria	Mental Health Practitioner	Health & Human Services (HHS)
Astalis, Paula	Mental Health Unit Supervisor	HHS
Ballinger, Katie	Acting Medical Director/Staff Psychiatrist	HHS
Bates, Jennifer	Program Manager	HHS
Bender, Joanne	Utilization Management Coordinator	HHS
Cain, Sarah	Utilization Review Specialist	HHS
Clarke, Kasey	Administrative Services Manager	HHS
Condon, Catherine	Program Manager	HHS
Dang, Huy	Office Services Supervisor	HHS

Name	Position	Agency
DeVido, Jeff	SUD Medical Director	HHS
Duvall, Cammie	Utilization Review Specialist	HHS
Flores, Marta	Utilization Review Specialist	HHS
Gardner, Kristen	Sr. Program Coordinator	HHS
Jang, Richard	Division Director/BHRS IT	HHS
Kaiser, Dawn	Division Director/Quality Mgmt.	HHS
Kwok, Kristine	Mental Health Unit Supervisor	HHS
Lagleva, Cesar	Program Manager	HHS
Pierce, D.J.	Division Director/Alcohol & Drug Programs	HHS
Swift, Eric	Administrative Services Associate	HHS
Tavano, Suzanne	Assistant Director/BHRS	HHS
Tognotti, Angela	Mental Health Unit Supervisor	HHS
Herrera, Veronica	Administrative Services Associate	HHS
Martin, Keely	Administrative Services Associate	HHS
Hall, Jordan	Senior Program Coordinator	HHS
Milner, Cody	Administrative Service Assistant	HHS
DeVido, Jeffrey	Chief, Addiction Services	HHS
Jaragosky, Darby	Senior Program Coordinator	HHS
Davis, Susan	BHRS IT	HHS
Chao, Chua	Social Service Program Manager	HHS—Child Welfare Services
Linda Noonis	LRAC Program Supervisor	Community Action Marin
Lisa Y. Peacock-Compton	Manager ERC	Community Action Marin
Pring, Ann	Division Director/YFS	HHS
Robinson, Brian	Mental Health Unit Supervisor/YFS	HHS
Hirschfield, Sandra	Licensed Mental Health Practitioner/YFS	HHS
Nightingale, Vicki	Administrative Services Associate	HHS
Norris-Alvarez, Shelley	Social Services Worker II	HHS
Fleck, Catherine	Mental Health Practitioner/Access Team	HHS
Steffy, Leigh	Department Analyst II	HHS
Dang, Alex	Mental Health Practitioner Acting Supervisor	HHS
Dunnigan, Ryan	Mental Health Practitioner Supervisor	HHS
Carrier, Kila	Mental Health Practitioner	HHS
Saucedo, Maritza	Behavioral Health Coordinator	Marin Community Clinic

Name	Position	Agency
Howard, Peggy	Licensed Crisis Specialist	HHS
Paler, Todd	Program Manager	HHS
Roomian, Rachel	Mental Health Registered Nurse	HHS
Rossi, Jennifer	Mental Health Unit Supervisor	HHS
Stein, Rebecca	Mental Health Unit Supervisor	HHS
Watson, Nicole	Mental Health Practitioner	HHS
Beebe, Alexis	Mental Health Practitioner	HHS
Hansen, Paul	Mental Health Practitioner	HHS
Ireland, Jane	Mental Health Practitioner	HHS
Nguyen, Tran	Mental Health Practitioner	HHS
Popplewell, Michael	Mental Health Practitioner	HHS
Gray, Erin	Mental Health Practitioner	HHS
Tellez, Rafael	Support Service Worker II/Access Team	HHS
Murotake, David	Technology Systems Specialist II/BHRS IT	HHS
Ongwongsakul, Walter	Department Analyst II/Quality Mgmt.	HHS
Wells, Janice	Division Director, Adult Services	HHS
Srinivasan, Soma	Technology Systems Specialist III/BHRS IT	HHS
Zvanovec, Denise	Assistant Chief Fiscal Officer	HHS
Zane, Cathy	Mental Health Unit Supervisor/YFS	HHS
Allen-Willis, Iris	Peer Provider-Odyssey	Community Action Marin
Learson, Connie	Peer Provider- Outreach & Engagement	Community Action Marin
Scuitti, Linsey	Adult Family Partner	Community Action Marin
Carrol, Kimberly	Deputy Executive Director	Marin Housing Authority – Shelter Plus
Clayman, Alyse	Clinical & Site Director	Jewish Family & Children's Services
Mensing, James	Senior Director	Buckelew
Player, Tamara	Chief Executive Officer	Buckelew
Conboy, Titus	Clinical Supervisor, Wraparound Program	Seneca - Marin
Sweeney, Mary Kay	Executive Director	Homeward Bound/Voyager Carmel
Henriques, Erik	Supervising Peer Provider	Mental Health Association of San Francisco (MHASF)
Leavitt, Corrina	Peer Provider, Transition Team	MHASF

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing n ≤11.

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

Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary
Marin

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Medium	272,209	17,965	6.60%	$79,457,048	$4,423
Marin	7,885	488	6.19%	$3,751,602	$7,688

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

Table C2—CY15 Distribution of Beneficiaries by ACB Range
Marin

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	1,430	85.12%	94.46%	$7,140,278	$4,993	$3,553	44.96%	61.20%
>$20K - $30K	134	7.98%	2.67%	$3,292,845	$24,573	$24,306	20.73%	11.85%
>$30K	116	6.90%	2.86%	$5,447,493	$46,961	$51,635	34.30%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 CLINICAL PIP

GENERAL INFORMATION

MHP: Marin

PIP Title: Care Coordination in the Integrated Clinic

Start Date (MM/DD/YY): 02/29/16

Completion Date (MM/DD/YY): Ongoing

Projected Study Period (#of Months): 10

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 01/11-12/2017

Name of Reviewer: Ewurama Shaw - Taylor

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

Rated

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): For several years, the MHP has partnered with Marin Community Clinic (MCC) to operate a clinic for mental health consumers with chronic and complex medical and substance use needs. The integrated clinic enabled consumers with high needs, including some social challenges, to access health services in a familiar setting, with smaller waiting rooms, less wait times and longer appointments. An evaluation of current operations indicated that the clinic had become less integrated and more like a satellite location for physical health services. The MHP and MCC developed this PIP to improve collaboration and integration of health services. The PIP team's goal is to

maximize the utilization of the integrated clinic, improve processes for sharing clinical information and coordinating care, and develop strategies to address the whole health of shared clients.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team has a cross-section of staff stakeholders from both behavioral health and physical health (i.e., MCC) who can speak to the integration of services. However, the PIP team lacks membership by consumers or their family members who have used or would benefit from the integrated clinic.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team provided some data related to current status (e.g., that 80% of clinic consumers had a coordinator and 86% had 2^+ visits within a year), but did not provide enough or relevant data for other aspects of their project (e.g., % consumers that are appropriate for the panel; % consumers with active and current medications; etc.).
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions		*Non-Clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is part of a larger project, the Learning Collaborative, which will address other aspects of consumer care. This PIP will address consumer access and consumer outcomes from an integrated and physical health approach.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP targets all enrolled populations and its aim is to connect those with high mental and physical health needs, per the Jarvis model of need, with integrated health care services. The current consumers of the clinic were not identified/categorized by demographics.
	Totals	**2** Met **2** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* If we improve processes related to coordination of care, will it improve system capacity and outcomes for consumers with complex medical, mental health, and substance use issues?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the study question is stated clearly, the impact—and measurable outcome—for consumers is not specific. The study question does not suggest how the PIP team will assess system capacity and consumer outcomes. The measures that the PIP team outlined (further in the study) relate more to improving the *process* of coordination, rather than the effect of the coordination on consumers. With regard to the consumer outcomes, the measures are related to physical health and less so on mental health and none on substance use. (N.B. The previous version of the document had mental health measures—CSU and hospital admissions).
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study is applicable to all consumers who require integrated health care, many of whom are Medi-Cal enrollees. Given the finite number of the consumers that are currently served by the clinic, the PIP team should provide demographics of the consumers at the start of the project.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: Text if checked	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team's data collection approach does not capture all the consumers to whom the question is applicable. Presently, the PIP targets consumers who are already receiving integrated services at the clinic. The PIP team did not articulate how they will include consumers who meet criteria for integrated services but are <u>*not*</u> currently accessing the integrated clinic. At presents, all the interventions appear to affect coordination of consumers already being served.
	Totals	**1** Met **1** Partially Met **1** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. % consumers in integrated clinic with an assigned BHRS contact 2. % consumers whose BHRS communicated with clinic in past 6 months 3. % consumers with medication reconciliation within the past 6 months 4. % consumers with newly established exclusion criteria 5. % consumers with 2^{+} clinic visits within last 12 months 6. Number of slots made available by applying inclusion/exclusion criteria	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators 1 and 5 are clearly defined and measurable. Indicator 1 relates to a process change and Indicator 5 relates to a functional change. Indicator 2 appears to measure the *intervention* of the PIP (i.e., the care coordination form), rather than actual communication. In order to measure communication, the PIP team should audit health records for evidence of any communication between BHRS and the clinic, prior to the implementation of this PIP. Indicator 3 has a similar issue, in that it is a measure of the *intervention* rather than a measure of appropriate medication usage. The PIP team mentions that consumers were using discontinued medications or were not taking their medications appropriately. Thus a more precise indicator would be the number/percentage of consumers who only possess/present active medications and know how to use their medications. Indicator 4 and 6 are corollaries of each other—by applying an exclusion criteria, the clinic will necessarily eliminate some slots and make available other slots. There only needs to be one indicator and it should address whether or not the existing consumers are appropriate for the clinic. The indicator should be some measure related to % of the consumers (or a sample) who meet criteria for the clinic.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators primarily measure changes related to the process of coordination and not changes in consumer outcomes and system capacity. The one measure of consumer outcome (% of consumers with 2^+ clinic visit) is more of a physical health outcome and not a mental health or substance use outcome. (N.B. In the previous version of the PIP document, there *were* measures of mental health and substance use outcomes). It may also be difficult for the PIP team to determine change because some of the indicators (e.g., 2, 3, 4, and 6) do not have true baselines. The long-term outcome of this PIP (and the larger project) is that care coordination/integration improves the overall health of individuals with severe mental illness and comorbid physical conditions.
	Totals	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP team does not use sampling; however, they should consider sampling for some of their indicators (e.g., 2 and 3).
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* Text	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP team does not use sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP team does not use sampling.
	Totals	**0** Met **0** Partially Met **0** Not Met **0** UTD **3** NA

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team specifies data elements to be collected related to utilization of the care coordination form and numbers of current and referred consumers to the clinic. But, the data section does not specify the data collection for the medication reconciliation, collaboration, and exclusion/inclusion criteria and need for integrated clinic. Quite a number of the other data measure or track the team's own internal processes of implementing this PIP.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Electronic Health Record (EHR) and Referral Log	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	For the data elements listed, the sources of data are indicated.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP team does not articulate a systematic method of collecting valid and reliable data that represent the relevant population. The team does not provide data to address capacity—what is the overall need for integrated care versus the number that are presently being served. Of those that are referred, the PIP team will log referrals, but ostensibly only conducts a bi-annual review of referred consumers. This suggests that either consumers have to wait for the bi-annual review before they become part of the integrated clinic or that some consumers are enrolled in and access integrated services, but then after the bi-annual review are determined not to meet criteria. The data collection also includes a quarterly review; it is unclear if and how the quarterly review relates to the ongoing referrals and increasing capacity of the clinic. As stated (see 6.1), some data or detail on data collection are missing (e.g., medication reconciliation and efficacy of collaboration). Whereas other data (e.g., satisfaction) are included that did not appear to be part of the project.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Referral Log	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Some of the instruments permit consistent and accurate data collection (e.g., EHR to track assignment of a care coordinator; EHR to track number and frequency of clinic visits; log to track referrals to the clinic); but other instrument do not. There is little detail on the exclusion criteria (besides the twice yearly visit) to determine the need for enrollment and continued inclusion in the clinic.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team provides data collection/analysis plan; however the plan needs more detail and elaboration. The frequencies of data collection, for example 6-month review of CCF and referrals, are too infrequent to affect change or permit modifications if untoward events or result are found.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Joanne Bender Title: Utilization Management Coordinator Role: Project Lead *Other team members:* Names: Please see PIP	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team is primarily responsible for the data collection, with oversight and analysis of data by the QM department. Some data are to be provided by a staff person (Tess McCartney); however, her credentials and role in the project are not articulated.
	Totals	**2** Met **3** Partially Met **1** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *1.* Assign a care coordinator to each consumer *2.* Facilitate bi-directional communication between clinic and BHRS by creating a care coordination form *3.* Provide a medication review with all clinic visits *4.* Create clear criteria for clinic inclusion/exclusion	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team reports a number of barriers and deficiencies with the integration of MCC and BHRS; however, not all of the interventions are easily linked to the identified barriers. As an example, one deficit is a lack of knowledge of the integrated clinic by referring providers, but no intervention specifically relates to increasing knowledge or awareness by providers (if so, it is not explicit). Similarly, another problem is a lack of space for new clients, but the PIP does not actually address increasing the space (rather ensuring that existing space is occupied by consumers who meet criteria).
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP provided interim/preliminary data for some of their indicators, but the MHP is still in the process of implementing and collecting data.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP provided interim/preliminary data for some of their indicators, but on the whole, the MHP is still in the process of implementing and collecting data.

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

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

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Text		
Recommendations: Text		
Check one:	☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Confidence in PIP results cannot be determined at this time	☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 NON- CLINICAL PIP

GENERAL INFORMATION

MHP: Marin

PIP Title: Improving Access to Outpatient Services

Start Date (MM/DD/YY): 10/01/2015

Completion Date (MM/DD/YY): Ongoing

Projected Study Period (#of Months):

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 01/11-12/2017

Name of Reviewer: Ewurama Shaw - Taylor

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

Rated

☒ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

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

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

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP's Access team is staffed by clinicians and non-clinicians who perform three functions: staffing the Access Line (during business hours), conducting face-to-face assessments, and completing treatment authorizations. Upon evaluation of workflow, the MHP realized that staffing the call line and fielding inquiries were performed by both the clinicians and no-clinicians. Recognizing an ever increasing demand for services, particularly assessments, the MHP identified a need to modify the workflow in the Access team such that the administrative functions were performed by administrative staff and less so by clinical staff. The MHP's project is to reconfigure the staffing structure of the Access team (with the addition of support personnel) and establish walk-in appointments at Access. Ultimately, the goal of this PIP is to enable clinical staff to conduct (more) assessments. While the PIP team references time to appointments (routine, post-hospital, and two-day urgent standards) and no-shows as being influenced by Access team workflow and ability to conduct assessments, these were not

measured.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP has multi-functional team of stakeholders who are involved in Access. The stakeholders on the PIP team can speak to various components of Access (i.e., administrative vs. clinical vs. operational). The team includes an MHP staff who identifies as a family member.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP reflects forethought and planning for an increased demand for services, rather than an effort to address a problem or deficiency. The only data that PIP team provides is on the sources of calls to the access line. There is no data showing: an increase in the number of calls; an inability to meet the demand with their current staffing structure; an increase in no-shows; or an increase in time to assessment.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-Clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP can improve access to services and has the potential to affect broad components of access, including timeliness of assessments, consumer interface/contact with mental health services, and engagement/continuity of services. However, as the project is presented, it appears more to maintain current level of services.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes all enrollees (and potentially enrollees) who contact the MHP's Access Line or come in to the Access clinic.
Totals		**2** Met **1** Partially Met **1** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will changing the staffing mix for the Access Team improve the capacity to provide face-to-face assessments without decreasing the current level of service to the Access Line? Will adding Walk-in days increase the overall capacity of Access to provide assessments?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the study question is stated clearly, it does not fully indicate what the measurable impact will be. It is unclear if the PIP team intends to affect capacity (which would be a related to the numbers needing assessments relative to the number of staff) or access (which would be the number of assessments) or both.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study will affect all those who contact the Access line or go to Access department, including Medi-Cal enrollees, existing beneficiaries, pre-consumers, and individuals who have yet to enroll in Medi-Cal, but are eligible.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: Access Line call center data, Access call log, and the Electronic Health Record (EHR)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team's data collection approach will capture the population that the project is intended to affect. The PIP will track calls to the Access call line and walk-ins to the Access clinic.
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. % calls handled by Non-Clinical staff monthly 2. Call handling metrics (3 variables) 3. Number of completed assessments monthly 4. Latino demographics 5. Access consumer satisfaction	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators 1, 2, and 3 are objective, measurable, and directly relate to the project. Indicator 4, Latino demographics, is not clearly defined and there was no previous mention of access for Latino consumers as a problem. While barriers for Latino consumers is part of a larger project, the PIP team has not adequately incorporated it into this PIP. Similarly, Indicator 5, satisfaction, was not presented as an issue or concern related to access, so measuring it at the conclusion does not seem to be that informative. The PIP team did not include indicators for time-to-assessments and no-shows which were mentioned as components of access that are affected by Access workflow.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Three of the indicators measure change in functional status, but the other two do not. The indicators measure access (through assessments) rather than capacity. The PIP team makes a correlation between access/treatment on demand (i.e., walk-ins) and its potential to improve consumer engagement and ongoing access to mental health, but the PIP does not provide indicators that relate to this longer-term outcome.
	Totals	**0** Met **2** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP does not include sampling.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* Text	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP does not include sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The PIP does not include sampling.
	Totals	**0** Met **0** Partially Met **0** Not Met **0** UTD **0** NA

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study design specifies the data to be collected. One data element that is not captured, and should be, is the walk-ins to the clinic. Also, the PIP team reports on much more data (e.g., type of call, time of day of call, incoming vs. outgoing calls, number of behavioral health screenings vs. substance use screenings, etc.) than they initially indicated. Including these other data elements suggests that these variables are a component of/affected by the workflow within the Access team. For example, was the time of day of the call (and the number of incoming calls) affected by the change in staffing of the Access team or the use of a different calling system? It is unclear why the MHP reported this data, but not present them as variables.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: Call log, EHR, and walk-in	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	With the exception of the walk-in information, the study design specifies the sources of data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the PIP team indicate the sources of data—the Access Phone Line Call center, the Access Call Logging Application, and Assessment data, they do not elaborate on the frequency of data collection or times to analyses.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Access Phone Line Call Center data, Access Call Logging Application, and the EHR	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team indicates the need for unit supervisors and IT analysts to "monitory entry closely" and to correct data entry errors, which suggests that the Access Call logging application may not error-free and reliable data.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP team did not articulate a data analysis plan, prospective or otherwise.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Jenny Bates Title: Access Unit Supervisor Role: Project Lead *Other team members:* Names: Not named specifically.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team has data/information system analysts to support data collection. Staff and supervisors of the Access Team will review logs and the EHR.
	Totals	**1** Met **4** Partially Met **1** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *1.* Change staffing pattern—add support workers *2.* Change to a call center *3.* Latino Access Meetings *4.* Move Access to 250 Bon Air *5.* Change staffing pattern—add support worker *6.* Initiate Uniform Method of Determining Ability to Pay in Access *7.* Pilot Walk-in Access 2x week *8.* Access Satisfaction Survey	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	Five of the barriers that the PIP team identifies are not actual barriers to access, but rather are purposes/objectives of the intervention (e.g., ensuring that quality of Access Line service remains constant or improves). There is no clear correlation between some of the interventions and barriers.
	Totals	**0** Met **0** Partially Met **1** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	See 6.5

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team provides preliminary/interim data. As the PIP team provided much more data than was originally planned, it is difficult to tell which data elements are related to which interventions. For example, the change to call center was implemented in February 2016. There is no pre-intervention (i.e., prior to 2/2016) data and of the post-intervention data, it is unclear which elements would have been affected by the intervention (e.g., number of incoming calls, time of day of the calls, incoming vs. outgoing, etc.).

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	While the PIP team did not articulate an analysis plan, with time frames and frequencies for data collection and analysis, they have collected quite a bit of data and have conducted some analyses. To continue the PIP, the team should examine their interventions and identify which data elements are specifically related and can capture both pre- and post-intervention results. (There is an intervention that dates back to November 2015, but it is unclear which of the numerous data elements are specifically related to pre- and post-results for this intervention).
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Text *Conclusions regarding the success of the interpretation:* Text *Recommendations for follow-up:* Text	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team provided preliminary data analysis, but ongoing tracking and measurements (and refining of the data to collect) are needed. The study is not yet completed.
	Totals	**1** Met **2** Partially Met **1** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The PIP team did not articulate an analysis plan or specify repeated measures. Different data elements are collected than were reported and certain data elements are not reported but should have been (e.g., number of assessments clinicians conducted). The PIP team would do well to collect the relevant pre- and post-intervention data for each indicator and articulate a plan for (and carry out) repeated measures.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	At present, the results show improvements in Call Handling Metrics, but the study is not yet completed.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The study is not yet completed.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The study is not yet completed.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **4** NA **1** UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Text		
Recommendations: Text		
Check one:	☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Confidence in PIP results cannot be determined at this time	☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible