FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Marin MHP

Conducted on

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INTRODUCTION

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

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

- MHP information:
  - Beneficiaries served in CY14—1,832
  - MHP Size—Medium
  - MHP Region—Bay Area
  - MHP Threshold Languages—Spanish
  - MHP Location—San Rafael

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Marin mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

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

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

CalEQRO also conducted three 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:

[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.

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

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

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO report made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below.

Assignment of Ratings

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

Key Recommendations from FY14-15

- Recommendation #1: Continue the current data collection endeavors and schedule routine reporting of timeliness indicators, analyze for effectiveness and improvements.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - In the course of the prior year the MHP reports continued expansion of data usage for system-monitoring and decision-making. This focus has included improved data collection, data quality and data reporting.
  - Initial timeliness of access was reported on a quarterly basis, enabling continual monitoring of capacity and service issues.
  - Tracking of timeliness indicators has faced a number of challenges: developing mechanisms for tracking service requests; tracking responses,

tracking across reporting units; and a need to track pre-consumer contacts that establish the basis for timeliness for initial contact.

- Other improvements include: Increased use of the urgent conditions flag by Access Team; improved utilization of urgent psychiatry appointments; and initiating timeliness tracking for mobile services - Mobile Crisis Response, Transitions and Outreach and Engagement teams.
- The MHP is working with the EHR vendor (Krassons) to incorporate initial contact, pre-consumer information with the EHR, an improvement over the current methodology that captures this information in logs external to the EHR.
- The MHP is developing a QI Capacity and Flow Dashboard to incorporate a mechanism that will accurately track timeliness of network provider services, and is scheduled to be released in April 2016. Initially, the information will be reviewed by management for several months before full MHP distribution occurs.
- The MHP made the decision to use the scheduler function in ShareCare for the tracking of medication support services within Children's Services.

- Recommendation #2: Create measurable goals within the QI work plan to measure its progress; establish baselines and timeline indicators.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has created an FY15-16 QI Work Plan that contains significant granularity in tracked parameters relating to access, timeliness and quality. A number of tracked areas will be using current FY15-16 data for the establishment of baselines.
- The methodology designed by the MHP to evaluate results of the prior FY14-15 QI Work Plan, and going forward, incorporates data reporting and conclusions of the progress made summarizing results in categories of "met/partially met/not met."

- Recommendation #3: Select and implement use of a system wide outcome tool to measure consumer progress and treatment effectiveness with routine reporting of the results.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The Patient Health Questionnaire (PHQ-9), which was developed for a primary care environment and targets identification of depression symptoms, is utilized by the MHP with all adult consumers for whom depression is relevant.
- The MHP began the rollout of the Child and Adolescent Needs and Strengths (CANS) assessment system-wide in November 2015, and is utilizing this

instrument with all children/youth served by both directly operated and contracted providers. Remaining to be finalized is the selection of software which supports data capture, aggregation and analysis. The MHP is evaluating the proposals of several vendors which provide this functionality.

- The MHP utilizes the Milestones of Recovery (MORS) universally with all consumers 18 years and older and served by a Full Service Partnership (FSP) program.
- The MHP has contracted with UC San Diego Health Services Research Center to implement a pilot Outcome Management System (mHOMS), to provide improved analysis of the available data. The target for this activity is the subset of consumers who receive non-FSP CSS services.

- Recommendation #4: Consider extending psychiatric availability via telepsychiatry.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP's Medical Director assumed his role fairly recently and is in the process of reviewing authorized prescriber strength (psychiatric nurse practitioners (PNP) and psychiatrists), and existing vacancies. The MHP is aware of the after-hours/weekend and holiday coverage need, with special focus on Psychiatric Emergency Services (PES), which is currently handled by an on-call rotation. The main utilization of psychiatrists and PNPs is at the central San Rafael clinic site and PES services.
- The MHP is participating in conversations with telepsychiatry venders to evaluate available resources, particularly after-hours, weekend and emergency coverage. Other considerations for coverage include increased permanent and locum tenens on-site medical staffing.
- While telepsychiatry could prove beneficial, the MHP believes its chief need is to be able to offer competitive salary and fill the 2.9 FTE of psychiatry and the 1.5 FTE of PNP slots that are now vacant.

- Recommendation #5: Continue to identify barriers to creating peer employee positions and begin classification process.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has modified an existing current classification position for use with individuals having lived experience – peer/family members. With the assistance of the Human Resources, specifications were reviewed, supplemental questions created, and a job announcement was issued. The related position was filled August 2015. The resultant employee is hired to work in the Odyssey Step-Down program.

- The MHP has expanded its use of contracted peer employees, with both Community Action Marin (CAM) and MHA SF (Mental Health Association of San Francisco).

- The MHP is a partner entity to the Bay Area Workforce Co-Learning Collaborative (WCC), which was funded by the Office of Statewide Health Planning and Development (OSHPD). The WCC's goal is to provide trainings, technical assistance and resources to Bay Area Public Mental Health Systems (PHMS) that currently (or will in the future) employ a workforce with lived experience. Key MHP personnel will participate in a WCC training in February 2016.
- The MHP is awaiting the outcome of SB614: Mental Health Peer Provider Certification bill (Leno), a bill offering training and certification for peers and allowing for federal funding of these positions, to support further movement towards creation of peer provider positions.

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 launched three new mobile teams: Mobile Crisis Response Team, Transitions Team, Outreach and Engagement Team. These teams are staffed by clinicians and peer providers and designed to reduce gaps in services and enhance the "Crisis of Continuum of Care."
  - Full Service Partnership (FSP) services were expanded within two programs, and added bilingual capability within the Helping Older People Excel (HOPE) FSP. Also important was the development of a step-down element for the Odyssey FSP (homeless), in effect expanding capacity of that program by transitioning 12 consumers to a lower level of service.
  - The MHP created the Mental Health Wellness Clinic, a clinic operated under contract with Beacon Health Strategies to provide services for the "mild to moderate" population.
  - The Access Team added 2 FTEs, including 1 FTE Supervisor and 1 bilingual FTE Support Services Worker. The team is staffed with 3 bilingual Spanish speaking staff.

- Substance use treatment screening and referral functions were integrated into the operations of the Access Line in October 2015.
- Expansion of services into the Novato area is under active discussion and consideration, pending the identification of a compatible physical site.

- Timeliness of Services
  - The MHP increased collaboration with adult medication clinics to utilize urgent psychiatry appointments.
  - Enhancements were made to the Access Log system features to allow centralized data capture for timeliness.

- Quality of Care
  - The MHP expanded a contract with Independent Community Services (ICS), a program to teach vocational and independent living skills for individuals with SPMI, which created an "employment on demand" component for FSP clients.
  - Mental Health Services (MHSA) Workforce, Education and Training (WET) allocated approximately $65,000 towards a "Grow Your Own Workforce" Initiative. This program awards scholarships for peers and family members to participate in peer provider, substance use counselor and /or domestic violence, vocational programs. The WET coordinator is working to secure internship placements for graduates of the program.
  - Children's mental health hired two additional bilingual/bicultural clinicians, increasing to 50% the portion of Youth and Family Services staff that are bilingual Spanish speakers.

- Consumer Outcomes
  - The MHP has contracted with UC San Diego Research Center to implement the pilot for Mental Health Outcomes Management Systems (mHOMS). The contract is in effect from November 2015 through July 2016. The target population is adult consumers receiving non-FSP CSS services - expanding to all adults. Outcome instruments have been loaded into the EHR.
  - The Child and Adolescent Needs and Strengths (CANS) instrument was implemented in November 2015, accompanied by the training and certification of staff in its use.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

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

Table 1—Marin MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

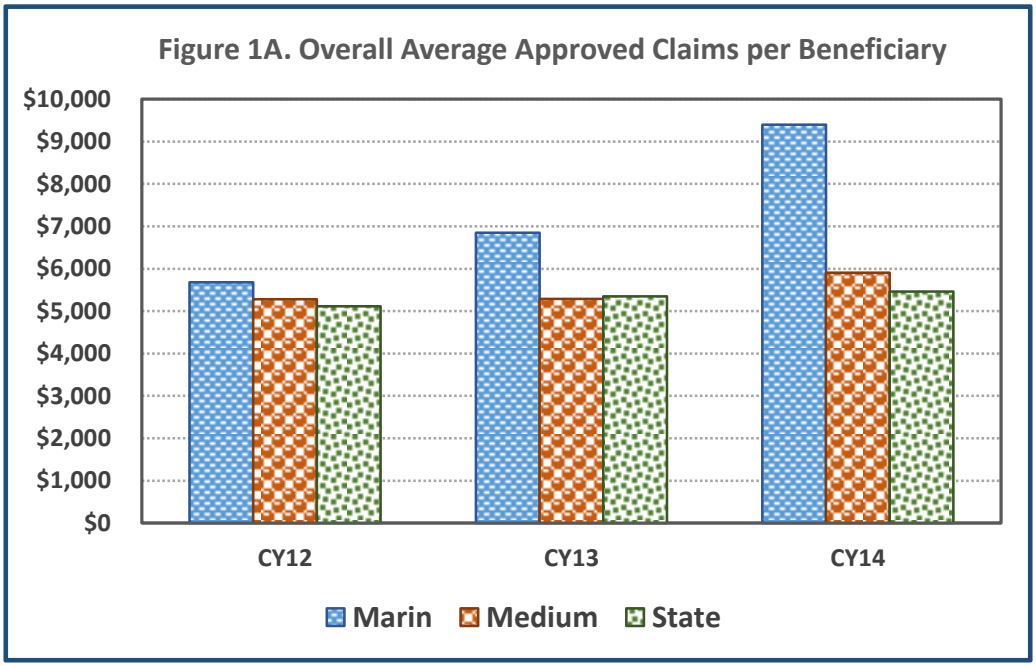
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	9,102	988
Hispanic	15,656	378
African-American	1,624	182
Asian/Pacific Islander	1,789	83
Native American	58	9
Other	2,192	192
Total	30,419	1,832

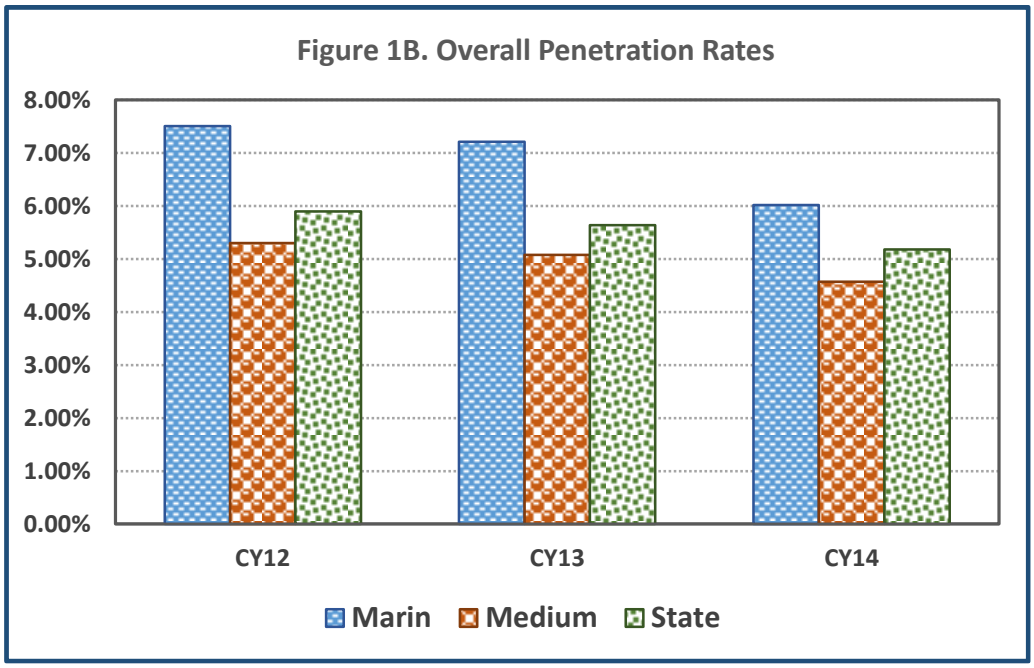
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

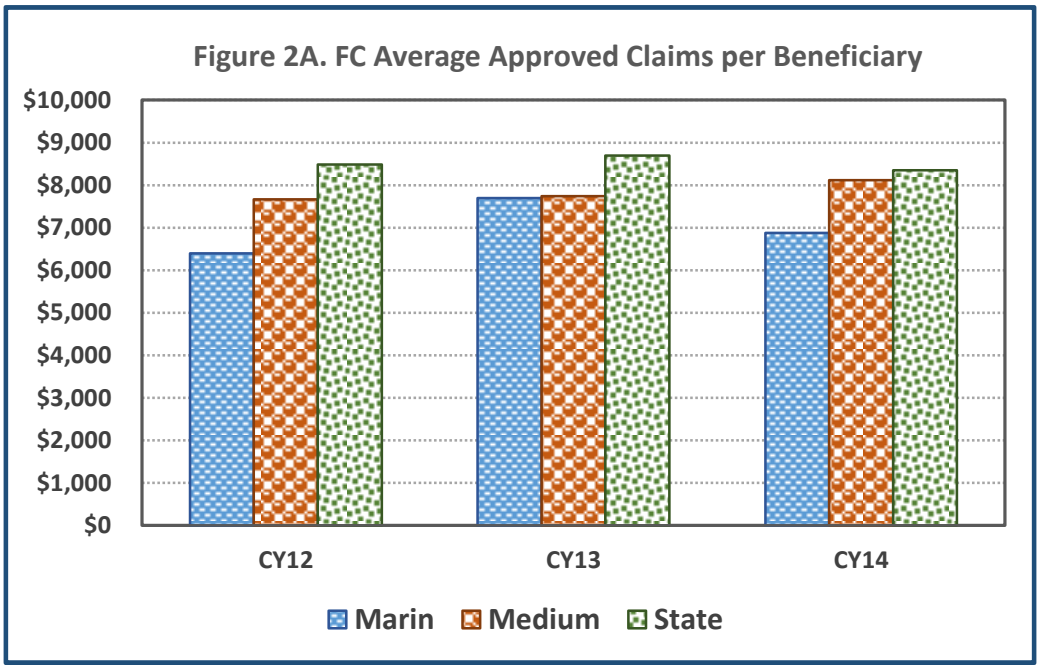
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

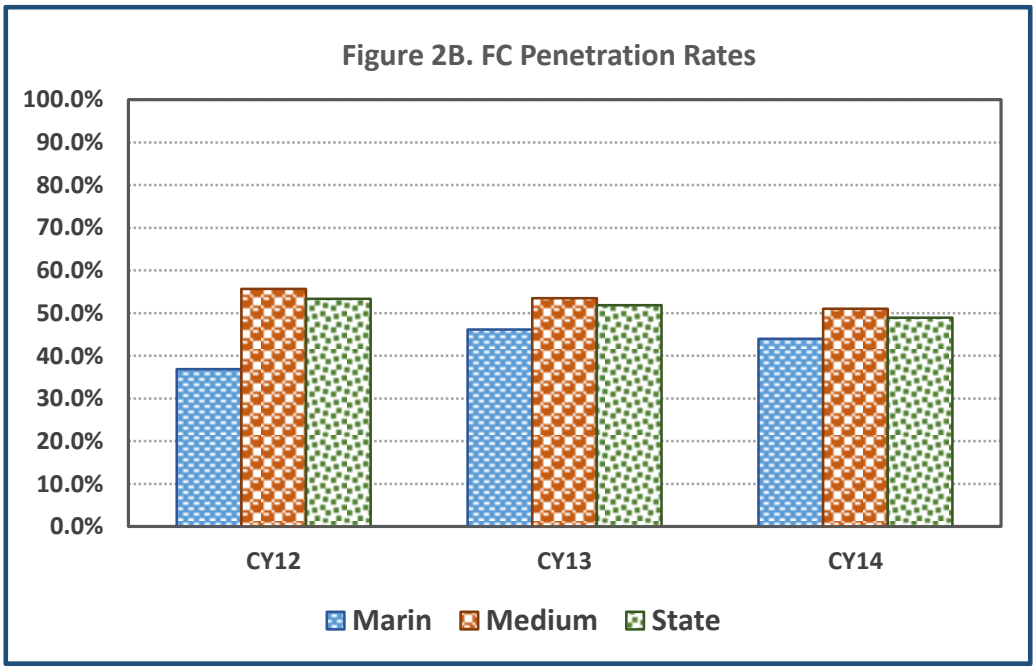
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for size category MHPs.



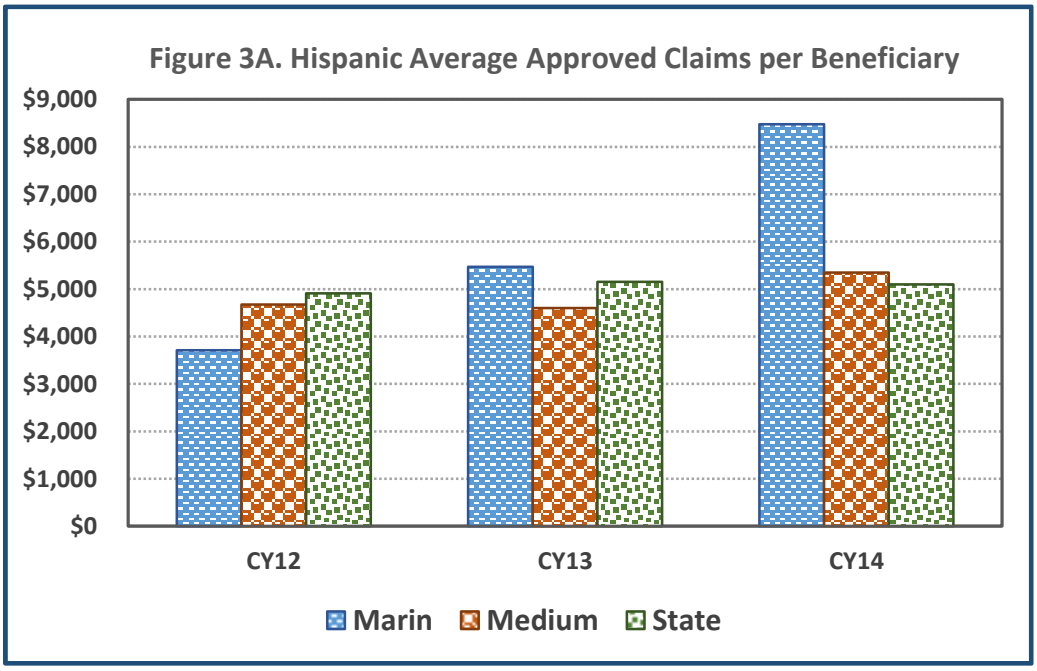


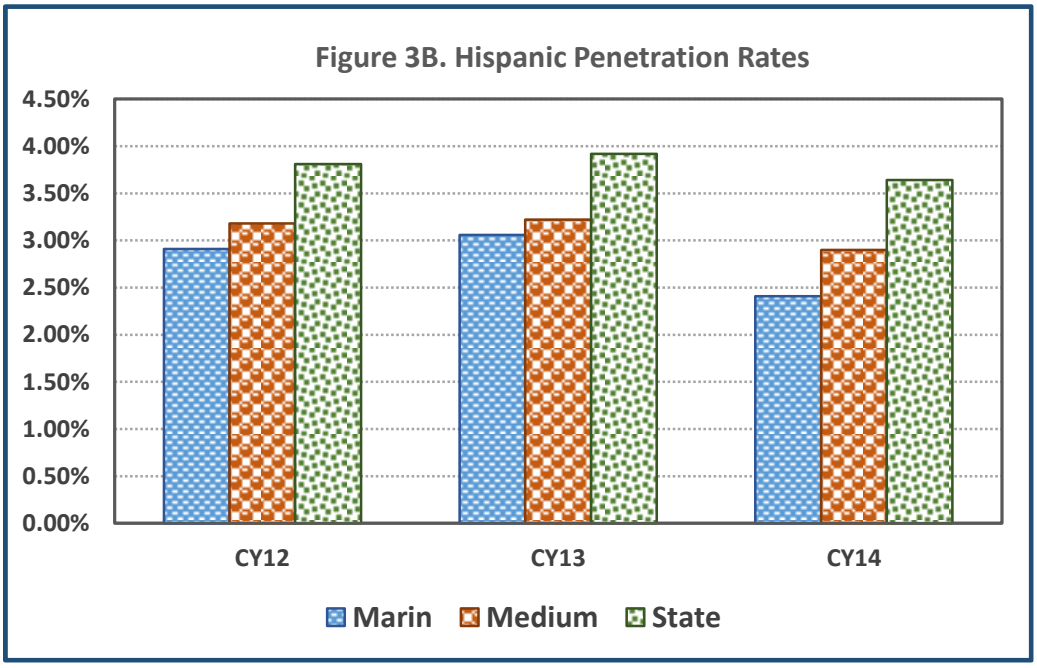
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for size category MHPs.





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 size category MHPs.





HIGH-COST BENEFICIARIES

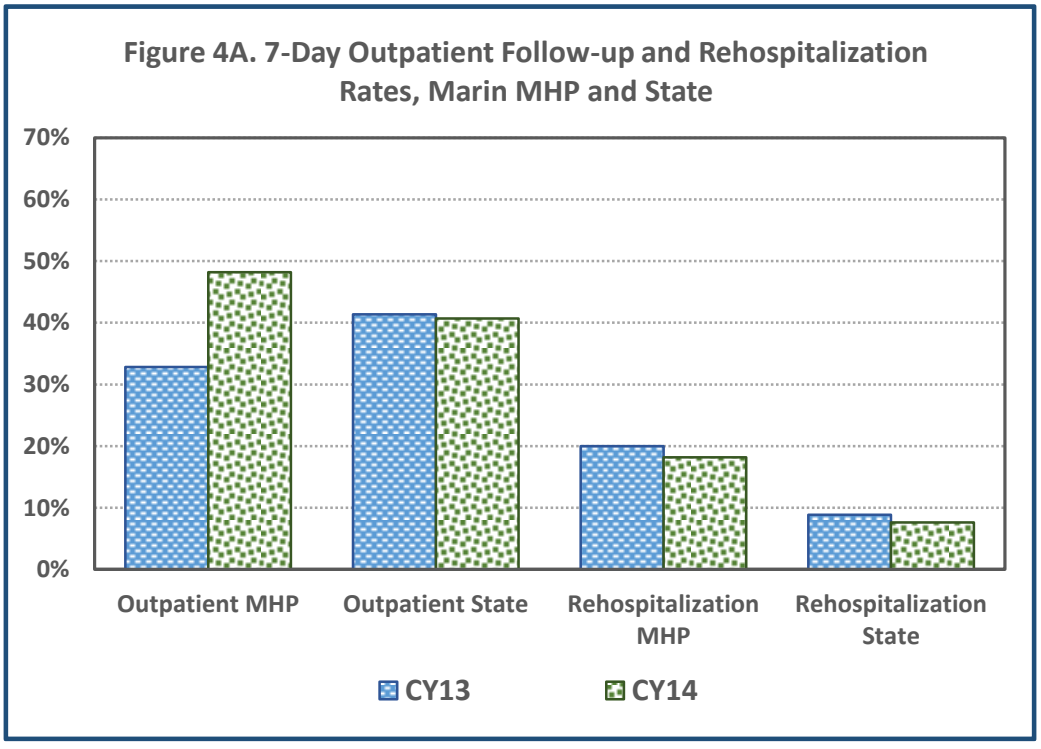
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

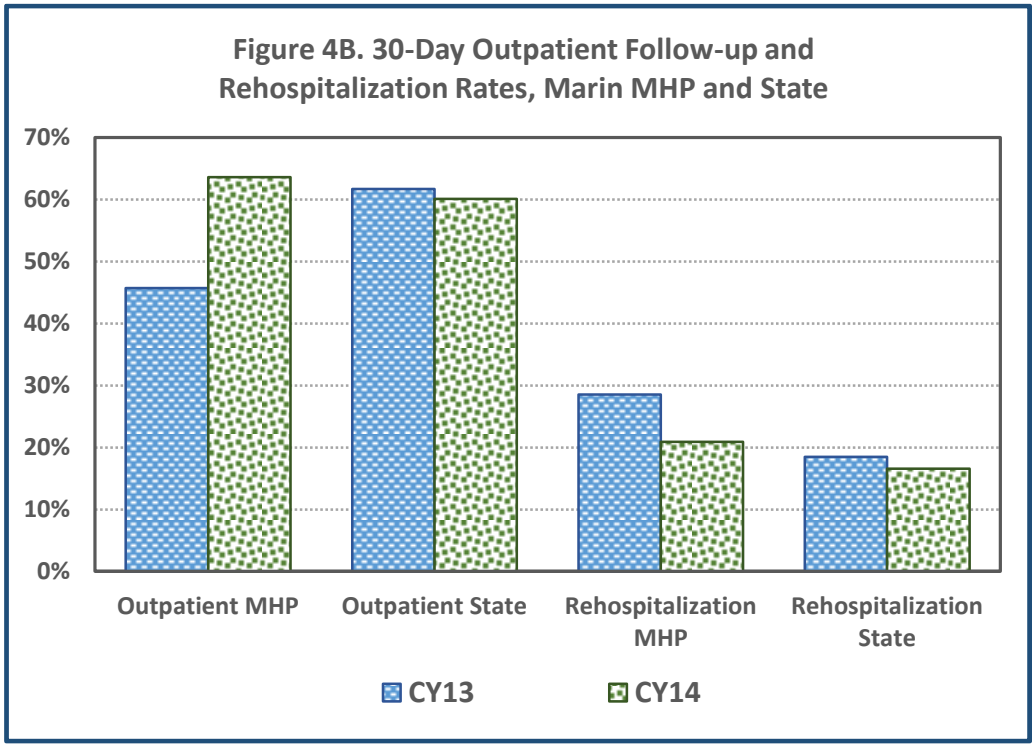
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Marin	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%
	CY12	51	1,802	2.83%	$41,919	$2,137,847	20.89%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

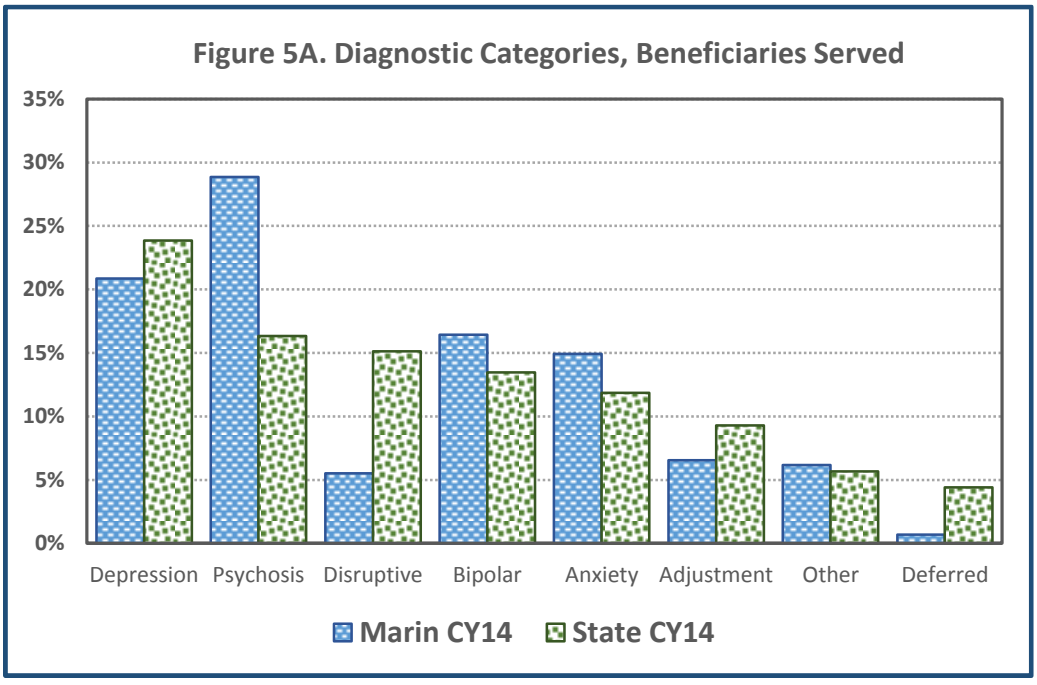
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.

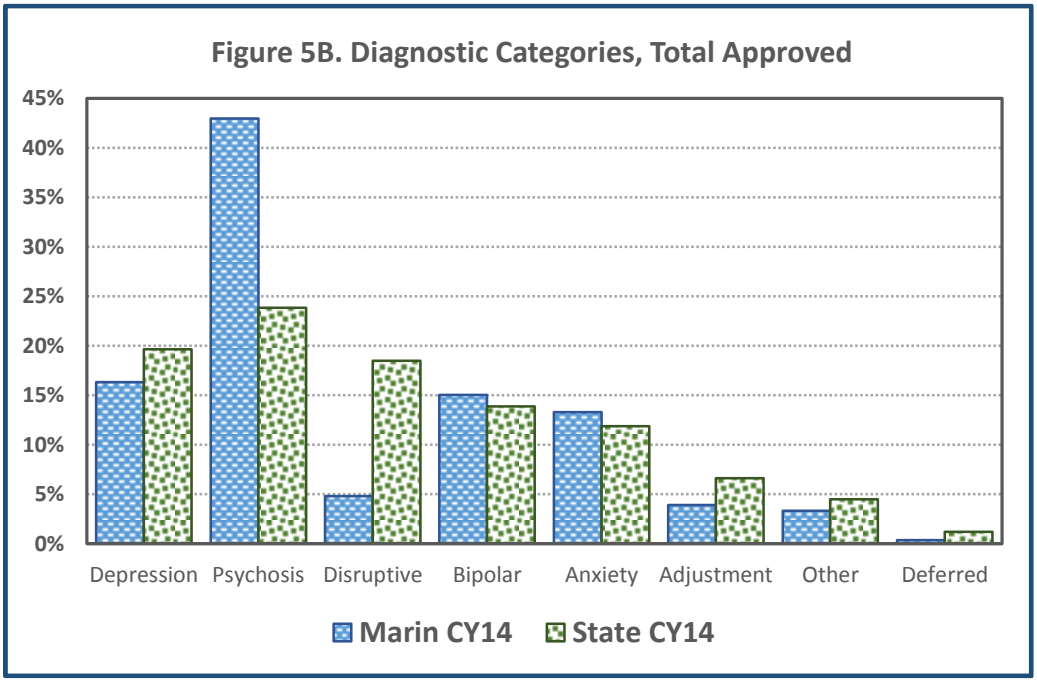




DIAGNOSTIC CATEGORIES

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 CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's penetration rate has declined steadily between CY12 and CY14, although the MHP's rates have been consistently and significantly higher than both medium size counties and statewide rates through the same period.
  - The MHP's Foster Care penetration rate has slightly declined since CY13 but has consistently remained lower than both medium size and overall statewide averages between CY12 and CY14.
  - The MHP's Hispanic penetration rate has declined since CY13 similar to the decline of both medium size and statewide counties rates since CY13. However, the MHP's rates have been consistently lower than both medium size and overall statewide averages between CY12 and CY14.
- Timeliness of Services
  - The MHP's 7 day and 30-day outpatient follow-up rates after discharge from psychiatric inpatient episodes have increased significantly from CY13 and is higher than statewide. Seven-day re-hospitalization rates for CY14 were similar to CY13 while 30-day re-hospitalization rates increased between CY12 and CY14. Both the 7 day and 30-day re-hospitalization rates are higher than statewide.
- Quality of Care

- The MHP's percentage of high-cost beneficiaries for CY14 is more than double statewide and showed a significant increase over its CY13 percentage. The MHP's percentage of total HCB claim dollars is higher than statewide and also increased over its CY13 percentage.
- The MHP's average approved claims per beneficiary for CY14 served increased significantly from CY13 and is significantly higher than both medium size counties and statewide. While the rates for medium size counties and statewide were similar between CY12 and CY14, the MHP's rates shows a significant upward trend for the same period.
- The MHP's CY14 average approved claims per beneficiary for foster care declined from CY13 and was lower than both medium size counties and statewide.
- The MHP's CY14 average approved claims per beneficiary for Hispanics increased significantly from CY13 and was also remarkably higher than both medium size counties and statewide.
- A primary diagnosis of Psychosis accounted for the largest number of beneficiaries served and was significantly higher than statewide. The diagnosis of Disruptive Disorder was markedly lower than statewide. Other Diagnoses was similar to statewide and Deferred Diagnoses were significantly lower than statewide.
- The MHP's total approved claims for individuals for Deferred Diagnoses were slightly lower than statewide.

- Consumer Outcomes
  - The MHP's 7-day rehospitalization rates have been nearly double the statewide average for CY13 and CY14. The 30-day rehospitalization rates have been above the statewide average for the same period, but are beginning to come down in CY14.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

MARIN MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Improving Psychiatric Emergency Services (PES) Processes
Non-Clinical PIP	Assisted Outpatient Treatment (AOT) Study

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

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

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NM	NM
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NM	NM
		8.3	Threats to comparability, internal and external validity	NM	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NM	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NM	NM
		9.2	Documented, quantitative improvement in processes or outcomes of care	NM	NM
		9.3	Improvement in performance linked to the PIP	NM	NM
		9.4	Statistical evidence of true improvement	NM	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NM	NM

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

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

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	0	9
Number Partially Met	0	4
Number Not Met	0	17
Number Applicable (AP) (Maximum = 30)	30	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	0%	36.6%

CLINICAL PIP— IMPROVING PSYCHIATRIC EMERGENCY SERVICES (PES) PROCESSES

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

- "Will improving the processes informing consumers and collecting financial information in PES result in reduced grievances around invoices?"
- Date PIP began: July, 2015
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☒ Submission determined not to be a PIP

☐ No PIP submitted

The MHP targeted the reduction of grievances from consumers served at the Psychiatric Emergency Services (PES) program who were directly billed for services. These individuals either lacked health insurance coverage or, if covered, the coverage denied payment for PES services. These denials for payment can come from Medicare and a host of other insurances that did not find the program to be an eligible provider or mode of service.

The performance indicator was the reduction of grievances related to PES invoicing. The interventions included training PES staff in the understanding of financial processes and completion of financial forms such as the Uniform Method for Determining Ability to Pay (UMDAP) and Financial Responsibility Form (FRF) document. The baseline data of financially related grievances numbered five in FY14-15, and in FY15-16 (to date) numbered two.

The number of impacted consumers appears to be very small (five or fewer per year) and the interventions are non-clinical; the only Medi-Cal eligibles who are included have Share-of-Cost coverage and are not benefitted until SOC is met. As stated, the impacted consumers remain a very small number, and the MHP should consider identification of a topic which impacts a much large pool of consumers. This topic appears to be one that would have best been approach by a brief process improvement activity that improves the capture of financial data and informing of 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 discussion of the submission not constituting a PIP and potential clinical PIP topics including MH/SUD dually diagnosed individuals.

NON-CLINICAL PIP— ASSISTED OUTPATIENT TREATMENT (AOT) STUDY

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

- "Is there an identified population of people in Marin who would likely meet criteria for AB1421 services that would be effectively served by the implementation of AB1421?"
- Date PIP began: February, 2015
- Status of PIP:

☒ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

This Non-Clinical PIP submission was focused, as stated in the study question, upon determining if there exists a significant population of Assisted Outpatient Treatment (AOT) consumers eligible for AB1421 services. This description more accurately comprises the study element that would occur as part of the identification of a PIP topic, and does not serve as a PIP study question as written.

Revision of the study question might focus on asking if the SB82 programs of Mobile Crisis, Outreach & Engagement, Transitions, in addition to the FSPs are able to serve a significant percentage of potential AB1421 candidates effectively, coupled with a reduction in adverse events such as hospitalization and jail stays/arrests. A derivative of the PIP results might also inform the MHP if adoption of AOT would seem necessary, or not, to serve potential AOT individuals.

The MHPs data analysis would benefit from summarizing the numbers eligible for AOT consideration, and then tracking the results of services to these individuals and whether or not engagement and treatment occurred – as is currently included in the PIP. This review would suggest that the MHP also consider tracking some external data indicators determination of outcomes -- including as arrests and jail stays.

The described study indicators included: 1) Planned Treatment Initiation/Engagement: This is defined by three or more outpatient face-to-face services or three consecutive residential treatment days during the study period (the MHP's internal discussion contemplated increasing these values to six for greater accuracy). 2) Engaged Individuals: The numerator is the number of individuals who do not meet the engagement criteria; the denominator is the total number of individuals meeting this definition of engagement. 3) Retention: Not defined as yet. (The MHP indicates that there may be a redetermination of the criteria used for engagement, indicating that three therapeutic contacts or residential days may be too small a number and that six would be a predictive measure of engagement.)

The MHP provided numerous data tables that reported out Psychiatric Emergency Services (PES) from various perspectives, diagnoses, hospitalization data, and jail mental health data, inclusive of arrests.

In conclusion, it appears that the MHP's initial PIP focus was to determine if the recently started SB82 programs, in conjunction with FSPs, would be able to effectively serve those potentially eligible for AB1421 criteria in the absence of an of a formal 1421/AOT program. As of this current EQRO review the decision of the local board of supervisors was to not implement AB1421/AOT services. The MHP plans to continue this PIP with modification to the study question and indicators, including developing higher standards for engagement and retention targets.

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 discussions of the study question, and also whether or not this could be a clinical PIP, since outcomes were being tracked and various intervention approaches were being tested.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's Non-Clinical PIP has the potential for improving access for those mentally ill individuals who have been unable or unwilling to engage in customary outpatient services.
- Timeliness of Services
  - None identified.
- Quality of Care
  - The Non-Clinical PIP targets provision of service delivery in the field and meeting the needs of the individual, resulting in a type of service that is likely more effective in engaging individuals who are disconnected from many societal resources.

- Consumer Outcomes
    - The Non-Clinical PIP is configured to result in improved outcomes – fewer hospitalizations, arrests, and other adverse events.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	Input gained during this review indicates that the majority of consumers enter services through the Access Team/line, with others engaging through Psychiatric Emergency Services (PES), school referrals and Mobile Crisis. The number of bilingual staff has increased as has outreach into the community on multiple levels. The MHP trained promotores in West Marin in order to improve access for Spanish speakers. Children's Mental Health hired two additional bicultural, bilingual clinicians. Half YFS and YES staff are bilingual Spanish speaking. The Access Team is now staffed by three bilingual Spanish speaking employees. The MHP's efforts to reach ethnic and cultural groups are clearly evident and represented in trainings and other improvement activities. However, focus group input suggested that those with a non-English preferred language often experience longer waits for services. Specifically, the languages of Vietnamese, Portuguese and Spanish were mentioned. Once services have started and a connection made with speaker of the needed language, services are perceived as high-level.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	A key personnel challenge for the MHP has been in the area of prescribers. The MHP has adopted a policy of recruiting both psychiatrists and psychiatric nurse practitioners (PNP), and serving as a training site for UCSF PNP students. This has helped with the prescriber coverage challenge. The MHP currently has approximately 2.9 FTE of psychiatry vacant as well as 1.5 FTE PNP positions. Reported barriers to hiring these categories include salary rates, and costly housing and low vacancy rate in the area. Review feedback indicated concerns exist about service accessibility outside of the central San Rafael area. Marin City, Novato and other non-central locations have little in the way of contract organizational provider programs. Universally, review participants identified the lack of acute inpatient psychiatric/PHF beds as an important matter, with a need for at least four beds dedicated to MHP use at all times.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP engages in a wide spectrum of collaborations, including a partnership with Beacon Health Care, serving the mild to moderate, where the MHP provides the clinician and the space. In addition, the MHP significantly partners with local non-profits, with 66% of services delivered outside of county operated services. The MHP demonstrates significant and apparently effective collaboration with CWS on providing services to Katie A. subclass members. In this area, the only issue identified was the difficulty in tracking out-of-county placed eligibles and then assuring that services are occurring. This was discussed as having the potential for becoming a PIP.

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

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services

	Component	Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP currently utilizes a 14-day initial access standard, for which it measures time to the completed assessment appointment – a standard higher than the first offered appointment minimum. Adult services are reported as averaging 7.7 days (92.5% meeting standard; range: 0-75 days); and children/youth 9.7 days (81.8% meeting standard; range: 0-36 days). The MHP is working with the EHR vendor, Krassons, Inc., to establish a pre-consumer module that will enable, in conjunction with the scheduler, improved tracking of offered appointments.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP utilizes a 30-day standard for initial psychiatry/prescriber access. Adult services averages 20.9 days (81.3% meeting standard; range: 0-91 days); children/youth average 16 days (53.8% meeting standard; range 0-86 days). Increased collaboration with adult medication clinics has focused on the improved utilization of urgent psychiatry appointments. Some review input indicated that psychiatry/prescriber access during recent months, in some instances, has taken as long as 30-45 days for adults.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP utilizes a 3-hour standard for urgent condition access to care. Adults average 18.14 minutes (98% meeting standard); children/youth 6.15 minutes (100% meeting standard). Increased use of the urgent conditions flag by Access teams has improved data collection in this area. The MHP is initiating timeliness tracking for mobile teams.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	The MHP utilizes the 7-day HEDIS standard for post-inpatient aftercare appointment timeliness. Adult services reflect a 17-day average (67% meet standard); children/youth have a 12.5-day average (67% meet standard). The MHP is aware that a number of factors impact this data. Many of the hospitalized individuals are admitted to distant facilities with which the MHP has inconsistent contact, and some of these individuals are not in treatment with the MHP and will not be referred to the MHP at discharge; occasionally the hospitalized are simply passing through and do not return after discharge. The MHP would benefit from study of this issue and determining if there are coordination or follow-up issues to be addressed, and that they are tracking those who will be returning and should receive MHP follow-up, with attention to reduction to the time to follow-up appointment. Some contract organizational providers indicated that they were unaware of the post-hospital follow-up time-frame standard.
2E	Tracks and trends data on rehospitalizations	FC	The MHP identifies an acute inpatient readmission rate of 10% for adults and 5% for children/youth.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2F	Tracks and trends No Shows	FC	The MHP tracks and trends No-Shows for psychiatrists and for non-medical clinicians. The acceptable no-show standard is 10% for both groups. The actual clinician no-show rate for adult services is 2%; children and youth have a 6% no-show rate. Within psychiatry, there is a 5% no-show rate for both adults and children/youth.

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

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP has written a QI Work Plan with measurable goals and objectives. The progress from FY14-15 to FY15-16 is notable, with increased granularity of intended data elements and tracking. For many of these new QI Work Plan additions the MHP is using the current fiscal year as a period for acquisition of baseline data. The MHP plans to report access/capacity on a monthly basis. Initial analysis of MORS and PHQ-9 is completed which provides baseline data for evaluating consumer outcomes. Medication monitoring will be conducted quarterly; for this review the quarterly Med Monitoring data elements were blank in the QI Work Plan (two quarters have elapsed in the FY period). It is not clear if the MHP plans to use the QI Work Plan as a living document which is updated routinely or plans to enter information at the end of the year. The QI/QA staff resources are clearly working towards a totally data driven approach, but it is unclear if the resource allocation is sufficient.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	FC	The MHP focused last year on the expanded use of routine data reports which are intended to support decision-making. This included a survey of staff and resulted in the development of several reports including an inpatient tracking log. This current FY15-16 review indicates ambitious data collection and analysis, but it is not clear if the MHP possesses sufficient analytic capacity to ensure this occurs at the desired level. In a number of areas challenges have arisen in software functionality. Currently, there is an unresolved ability to record pre-consumer information necessary for creation of a start point for consumer access. Examples of the MHP's planned data tracking includes: Compare location of Medi-Cal beneficiary population to MHP treatment population by age, race/ethnicity and city of residence. Establish baseline data. Clearly the MHP is data-focused, with issuing arising in the capacity to perform the work to create, run and analyze.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	FC	The MHP communicates via a number of mechanisms, including informative emails, staff meetings, and one on one supervisor contacts. Communication with organizational providers has recently been revitalized, re-instituting regular meetings that had been reduced. During the course of this review some input identified changes in the communication practices that are experienced by some as less welcoming of feedback; however, these were few and often attributed to department leadership instituting changes in structure and process within the department. A "Be Happy" video was developed for You Tube is about recovery and has been very successful in promoting communication with potential service recipients. A TV series in Spanish will be rolled out in February 2016. The MHP has partnered with a local radio station.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	The MHP includes contract organizational providers in key meetings where information is shared about current or new initiatives. The MHSA Plan Update process in the 2015 year included a broad array of stakeholders who provided input. The MHP's Non-Clinical PIP involved a broad swath of community agencies including law enforcement entities, the courts, and jail representatives, along with consumers and advocates. Review input noted that the change in the process and membership of the group that reviews changes in policy and procedure no longer includes consumer/family members. The MHP may wish to consider development of a forum for this type of input.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP collaborates with Child Welfare Services, the Health Agency, law enforcement entities, the local general hospital, and a broad array of community stakeholders, including the partner CBOs. The MHP includes contract organizational providers in QI program activities (Seneca, Sunny Hill, Homeward Bound, Community Action Marin, Buckalew, e.g.). These providers receive information from the satisfaction survey results by email and through meetings where discussion occurs. The MHP has expanded a contract with Independent Community Services (ICS) to provide vocational training and independent living skills to individuals with serious mental illness.
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	The MHP has successfully completed the implementation of the CANS among child and youth programs. The selection process of software which supports data aggregation and reporting is underway. The MHP also uses the MORS and the PHQ-9, with selected populations. Reporting on these instruments has been regularly performed by the MHP. Additional instruments in selective use include the Child Behavior Checklist and Youth Self Report. The MHP has not identified an outcome instrument for global use in the adult population.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP collects and reports out POQI data by program, enabling relevant discrete analysis. Contract organizational providers have received the satisfaction data relating to their programs. The MHP has also considered how to improve participation in the survey process. Challenges exist in capturing a high number of consumers' input during the survey period.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Peer employees are utilized by the MHP in service delivery through contract organizational provider hires by Community Action of Marin (CAM), the Mental Health Association of San Francisco and direct hires. The types of positions include youth mentor, family partner, peer case manager, support staff and court client peer support. The input of consumer/family member employees indicated that they experience challenges in having their opinions and recommendations accepted and valued by licensed staff. The amount and type of training provided to consumer/family employees is determined by the individual supervisor. However, input from the CAM operated Enterprise Resource Center differed, with these individuals receiving five job training classes. Other training is available via the Relias online training. A common theme emerged: Consumer-family employees believe that MHP staff understand the role of those with lived experience, but respond in ways that raise questions if they value it. Specific recommendation of consumer-family employees includes: uncoupling youth mentor services from therapy, because the mentor role provides benefits beyond the limits of therapy. The consumer-employee role would benefit from the existence of funds to purchase coffee and snacks for consumers. Lastly, additional training and opportunities for professional development would benefit consumer-employees.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP operates the Enterprise Resource Center (ERC) through a contract with Community Action Marin (CAM). All staff are peers, and includes a career ladder – from case aid, case manager to senior case manager. There are two fulltime positions with benefits; four part-time staff without benefits. Consumers determine groups and activities through a community input meeting. The programming focuses upon topics that support recovery and development of coping skills. Consumers learn of the ERC when transitioning out of jail, hospital, case manager referral, Homeward Bound, and Mill Street. The center operates seven days per week; 9am to 4pm, Mon-Fri; 10am-4pm Sat-Sun. Reported 1100-1400 visits occur each month. Consumers run groups at the center, and may attend a weekly "Groups Made Easy" class to help them be more effective. All consumers, both open and closed, are welcomed.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP has been working to improve the effectiveness of the Access Team and line, improving linguistic capacity, recording and tracking of key events, and communication with direct and contracted programs.
  - The MHP's challenges in filling vacant prescriber positions, both psychiatry and psychiatric nurse practitioners, is clearly impacting service delivery, as observed by consumers, family and staff.

- The MHP significantly relies upon contract organizational providers with which long standing relationships exists. These partners provide a significant amount of services (66%) that complement directly operated programs.

- Timeliness of Services
  - The MHP meets its own initial access standard of 14 days (7.7 days, adults; 8.7 days, child/youth).
  - The MHP's standard of 30-days for initial psychiatric care is met, averaging 20.9 days, adults; 16 days, child/youth. The MHP has procedures for expediting services when other risk/acuity factors are identified, of which staff seem universally aware.

- Quality of Care
  - The communication and coordination between PES and outpatient services was remarked upon by a number of individuals during the course of the review. Outpatient prescribers, such as PNPs, will come to the PES unit between sessions when a patient of theirs is in crisis and provide assistance to the consumer and the PES team.
  - Post-hospital discharge follow-up, which follows the 7-day HEDIS standard, is exceeding standard for this review period, including both adults and children. While this is, for this MHP, a complex issue, relating to many out of area hospitalizations that may have irregular coordination contacts, the MHP would be advised to study this area and determine if there is a data issue or an actual coordination/aftercare planning issue that merits attention.

- Consumer Outcomes
  - In the Children/Youth treatment division, the MHP has completed the adoption of the CANS, which is to be used with all child/youth consumers. It is in the process of selecting appropriate software to assist in managing the resultant data and making it useful for program analysis and planning, along with the current individual case planning use.
  - The MHP has not yet identified an adult services instrument for universal use with consumers outside of the FSP environment. Selecting an appropriate instrument will serve not only as an adjunct to the treatment planning process but will also offer aggregate data that may help identify effective practice patterns.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

- Adult consumers including a mix of existing and new clients who initially accessed services within the past 12 months.
- Caregivers/parents of child/youth beneficiaries, including a mix of those who initially accessed care within the prior 12 months.
- Adult Asian-Pacific Islander Consumers (Vietnamese).

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This multi-cultural adult focus group was conducted at the MHP's Kerner Connections campus in Room 110, and included 11 participants. Five participants initiated services within the last year.

For participants who entered services within the past year, the experience was described as:

- Initial access took anywhere from "one week" to "a couple of weeks," and no significant barriers or delays were identified.

Other observations about services include:

- Experience with mental health services are described as: Less demanding, pretty open, understanding.
- Information about accessing care was provided by a number of sources that included: A coworker; CalWorks; following an arrest (2); referral by Ritter Homeless Resource Center; a Nurse Practitioner who provides medications.
- The focus group participants see a therapist on the following schedule: Monthly (3), weekly (3), every two weeks (4).
- As to whether the frequency of treatment is sufficient, the participants indicated a range of responses: the majority, if needed, believe they could be seen more frequently. One participant leaves it up to the therapist to decide when to return.

- Several have been offered group therapy. The majority would not want family therapy, nor family members involved in their treatment.
- All participants are seen by a psychiatrist, with the frequency varying: monthly (2), weekly (2), three weeks to one month (2). All are seen at least monthly.
- Some focus group members participate in support groups conducted by Alliance and Recovery.
- In a crisis or stressful circumstances all participants know how to get help and who to contact.
- Two participants have either changed therapists or are in the process of changing. One noted it can be awkward at first, but has worked out.
- Several are attending the Enterprise Resource Center. Others have tried it and did not go back. And some went, instead, to the TAY center which has more appropriate activities for the youth population.
- Consumers report obtaining information about events from a number of sources: The TAY center calendar, the NAMI newsletter, and information at the Enterprise Resource Center.
- The majority of the focus group participants reported to have participated in the MHP's survey process.
- None of the participants experienced difficulties with transportation to appointments.
- Evaluative comments of this focus group were overwhelmingly positive, and included: "My experience has been so amazing, everyone has been supportive and could not have done more. ""They have helped me in every possible way." "The NP and case manager and the head of the program are all so involved and communicative." "Everyone has been really nice, there are no barriers to services." "I was helped in every way I can think of."

Recommendations arising from this group include:

- Would like for more groups for TAY who are transitioning to adulthood, including learning how to live independently, how to balance a checkbook, and other life skills.
- Would like to not have to sign so many release of information forms, which seem to occur with SSI, the therapist and the case manager.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		**11**
Number/Type of Participants	Consumer Only	10
	Consumer and Family Member	1
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	3
	Adult (25–59)	8
	Older Adult (60+)	0
Preferred Languages	English	11
	Spanish	0
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	6
	Hispanic/Latino	1
	African American/Black	3
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	1
Gender	Male	9
	Female	2
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 1: ☒ No ☐ Yes Language(s): N/A

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The second focus group was also conducted at the Kerner Connections campus, and included five parents/caregivers of children and youth in treatment. Participants were evenly distributed between Caucasian/white and Hispanic/Latino participants.

For participants who entered services within the past year, the experience was described as:

- Four modes of referral were identified: CalWorks, domestic violence advocates, referral after a crisis event, and a needs assessment.
- The time from first contact to starting therapy was approximately one month for participants. If needed, access to a psychiatrist/prescriber was described as fairly quick.
- Participants felt there was not enough information provided initially about services, programs, and also rights and responsibilities. They did not know how to change therapists, if the need was felt. They did not know the total scope of available services, such as wraparound.
- The foster child Katie A collaboration was identified as problematic for one caregiver/parent, who felt the therapist interaction was rote and stilted.
- A common theme emerged that participants felt MHP staff would "take over" when invited into the home. At times, this reached the extent of the parent feeling disrespected. There were several instances cited by participants in which staff were perceived as not offering a collaborative approach, making communication difficult.
- All participants felt the frequency of services was appropriate and adequate, initially receiving weekly sessions and with improvement, tapering down. There were no issues with obtaining supplemental support, contact or sessions from the therapist.
- An observation was made that the MHP should be more flexible in the treatment modality utilized, and that in some instances CBT was thought by caregivers as no longer be effective. When that occurs, it would be helpful to consider, in conjunction with parental discussions, alternate approaches. In some instances, parents would question "Play Therapy," which seemed to them emphasizing play over treatment. The parents were looking for specific results which may not have been occurring.
- All parents had participated in Family Therapy sessions, and as well have been offered collateral sessions with the therapist individually. Telephone contact with the therapist is another supportive intervention that is offered.
- Psychiatry is offered monthly, with the availability limited to one day of the month. This limitation is considered by the parent/caregiver group as insufficient, in that changes in medications or response to medications may indicate for a session that occurs before the monthly psychiatry day. If medications run out, the psychiatrist will act on calls and renew the prescription. However, all other issues directed to the psychiatrist must wait until the next scheduled appointment.
- Case management services are sometimes provided by the therapist, and in other instances by others, such as family partners. These contacts may either be in the home or out of the home. There were no concerns about the frequency or adequacy of case management services. However, since case managers do not have an office,

sometimes space for confidential conversations is problematic when the home setting is not suitable.

- In the event of a crisis, participants understand that the therapist will usually meet them at the emergency room.
- In the event that a need to change therapists arises, these participants did not know in advance who should be contacted with the request. Once this was known, the process was easy.
- An interpreter was provided in those instances in which non-English speakers need services.
- Information about services is conveyed through flyers posted in the office, and through the therapist.
- Other than the prior year's EQRO focus group, none of these consumers could recall being asked to provide feedback on services.
- These participants are aware of the existence of support groups but have not found any to fit their needs or be appropriate for them.

Recommendations arising from this group include:

- Increase the number and availability of youth mentors.
- The MHP should utilized email to notify consumers of system changes, new services, and other information.
- Provide more flexibility in the scheduling of psychiatry visits.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants*		5
Number/Type of Participants	Consumer Only	0
	Consumer and Family Member	0
	Family Member	5
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	5
	Older Adult (60+)	0

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Preferred Languages	English	5
	Spanish	0
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	2
	Hispanic/Latino	3
	African American/Black	0
	Asian American/Pacific Islander	0
	Native American	0
	Other(s)_____	0
Gender	Male	1
	Female	4
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 2: ☒ No ☐ Yes Language(s): N/A

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The third consumer focus group consisted of seven adult participants who were Vietnamese or Cambodian in origin, and utilized an interpreter to assist with the process. The focus group was conducted at the Kerner Connections Center, in Room 110. This segment of Asian/Pacific Islander population is not a threshold language for the MHP but presents a clear need which the MHP has sought to address.

All participants were direct receivers of services.

Only one participant had initiated services within the last year, and that individual was scheduled to be seen by a psychiatrist for the first time on the day of this focus group.

Other observations about services included:

- All but one participant had received psychiatry services from the MHP for 2 to 17 years.
- Psychiatry is provided with the assistance of an interpreter, with a monthly visits common for these participants.

- The referral process was related to the social worker of similar heritage who had referred individuals for evaluation.
- Those who felt they were improving were seen monthly, and those who felt they were not improving were being seen three times a month.
- Approximately 50% of the group have experienced a crisis event and gone to an emergency room within the last three years. The emergency services were quick and effective, and participants were usually accompanied by their social worker who facilitated and interpreted.
- The difficulties identified in services relates to the language barrier when conversing about rescheduling or cancellations of psychiatric appointments, with the call being delivered without advance awareness that interpreting would be required. If the consumer says "No English," in five minutes an interpreter is provided.
- These participants attend the Wellness Center, which is a non-MHP older adult center, where the social worker who speaks Vietnamese is located. The program teaches English and they talk about issues.
- None of the participants experience any transportation issues.
- Focus group participants receive information about programming from the older adult center via a newsletter.

Recommendations arising from this group include:

- Increase the presence of Vietnamese speaking doctors and nurses.
- Add a Vietnamese speaking front desk/support staff to the clinic.
- Provide reminder calls in the preferred language for community meetings and appointments.
- Notifications of events and appointments should also be copied to the social worker.

Table 7C displays demographic information for the participants in group 3:

Table 7C—Consumer/Family Member Focus Group 3		
Category		Number
Total Number of Participants*		**7**
Number/Type of Participants	Consumer Only	7
	Consumer and Family Member	0
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	0
	Older Adult (60+)	6
Preferred Languages	English	0
	Spanish	0
	Bilingual_____/_____	0
	Other(s) Vietnamese (6)/Cambodian (1)	7
Race/Ethnicity	Caucasian/White	0
	Hispanic/Latino	0
	African American/Black	0
	Asian American/Pacific Islander	7
	Native American	0
	Other(s) Vietnamese (6) Chinese (1)	0
Gender	Male	1
	Female	6
	Transgender	0
	Other	0
	Decline to state	0

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 3: ☐ No ☒ Yes Language(s): Vietnamese/Cambodian

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - The impact of limited child psychiatry time is experienced by parents/caregivers who need a timely response, particularly to a response or reaction to medications, between scheduled appointments.

- The language barrier for non-English speakers is significant. Even though the MHP has aligned services with speakers of the needed non-English language, there is clearly a need to provide front office telephone calls of appointment reminders and cancellations in the consumer's preferred language. This should be known at the time the call is made and provided by a person with the correct language skills. Ideally, the language ability is present in among front office staff.
- Broader availability of TAY mentor services is considered essential by parents/caregivers, who see this connection with peers of high importance.
- Focus group feedback indicates significant limitations exist in making psychiatry appointment changes and obtaining non-routine/urgent additional appointments.

- Timeliness of Services
  - Participants reported reasonable – and equally important, meeting their needs – timeliness of initial access to services. There were no significant delays in service reported by any of the three focus groups for any of the service types required.
- Quality of Care
  - A significant number of consumers felt unsure as how to change a clinician, particularly when they felt uncomfortable with the current provider. Providing written information about how to contact the supervisor and that person's name at initial entry to services would better equip consumers should the need arise.
  - The negative reactions of parents/caregivers to the presence of therapists in the home and their conduct indicates that satisfaction surveys, parent/caregiver input sessions, and training may be useful to improving rapport. Perhaps greater attention to inclusion of parent partners would be another element to see if that presence improves the response.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	32%
Contract providers	66%
Network providers	2%
Total	100%

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

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

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

33%

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

4%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- The MHP uses the MIS system of unduplicated open consumers and the MMEF file.
- The MHP annually utilizes local data to calculate penetration rate by ethnicity for all MHP consumers regardless of payor source.
- The MHP utilizes the EQRO penetration rate data for the Medi-Cal population.
- The penetration rate data is used to assess service needs by language, cultural groups and geographical catchment area.

CURRENT OPERATIONS

- MHSUS IT has three staff: one Unit Supervisor and two Technology Systems Specialists. QM staff provide analytics and data visualization.
- The MHP states there were some software issues with the ICD 10 transition, but have since been fixed and claims are being paid. Currently the MHP's billing lag days for Medi-Cal consumers are 90 days out (date of service to bill submission).
- The MHP is using EDI transactions, billing Medicare-Medi-Cal claims, and validating current and retroactive eligibility.
- The MHP has an IS Committee meeting which meets biweekly with a formal agenda. While there is no IS internal written strategic plan, there is a Human Health Services and County IS overarching plan. The MHP's management team is actively participating in the HHS IT Strategic planning process.
- The MHP has finalized a contract in January 2016 with a locum tenens vendor to expand psychiatric capacity, also on an as needed basis.

MAJOR CHANGES SINCE LAST YEAR

- Dimensions Reports software, a web-based application, was installed and testing was done in December 2015. Training is pending the vendor's availability for scheduling. The software provides on-demand dashboard data reports of 837 and 835 transactions.

- A formal structured training program has been implemented in 2015. New employees are trained individually, there are scheduled periodic refresher classes and additional monthly classes.

PRIORITIES FOR THE COMING YEAR

- A county Health Information Exchange (HIE) project was begun in January 2016 for project management activity. Redwood Med Net has been chosen as vendor; two consultants are leading the implementation. The project has been named the Safety Net Hub Project. Local FQHCs, and FQHC operated dental clinics are scheduled to provide data to HIE in year one. Substance use services may also be incorporated in the HIE if and when confidentiality issues are resolved.
- The MHP has submitted an application to participate in the California Institute for Behavioral Health Solutions (CIBHS) sponsored "Care Coordination Collaborative" in partnership with Marin Community Clinic, one of four FQHCs in Marin County. The application was accepted in January 2016 and the kick-off date has been scheduled for late February 2016.
- The MHP is installing and implementing both the Suicide Behavior Questionnaire-Revised (SBQ-R), Ask-Suicide-Screening Questions (ASQ), and Ages and Stages Questionnaire (ASQ) per Meaningful Use requirements, however, training needs to take place.
- The MHP is interviewing several telepsychiatry vendors for after-hours and emergency coverage, to bolster services as needed. The MHP is developing a Quality Improvement (QI) dashboard, Capacity and Flow Dashboard – to accurately monitor timeliness to network providers' services. It is expected to be released by April 2016. Initially it will be presented to senior management for several months and then distributed throughout the MHP.

OTHER SIGNIFICANT ISSUES

- Consultants have recommended that MHSUS IT possibly be reconfigured and aligned with Health and Human Services (HHS) to provide further collaboration and integration with HHS and the County.
- The percentage of High Cost Beneficiaries (HCB) rose in CY14 to 6.32%, which was over double the statewide experience – 2.48%. Total percentage of approved claims dollars at 33.32% was almost 9 points higher than the statewide figure at 24.41%.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record

(EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
ShareCare	Practice Management	The Echo Group	5	MHP
Clinician's Gateway	EHR	Krassons	9	MHP
RxNT	eRx	RxNT	6	MHP
Analytics	Data Analysis/ Teleform/POQI	Prins-Williams Group	7	MHP
Marin HHS Tech Services	PES Medication Tracking, PES Access Log	MYSQL	>1	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- There are no plans for an information systems change.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Clinician's Gateway	X			
Clinical decision support				X	
Document imaging	Imavisor		X		
Electronic signature—client	Clinician's Gateway	X			
Electronic signature—provider	Clinician's Gateway	X			
Laboratory results (eLab)	Quest & Bio Reference			X	
Outcomes	Clinician's Gateway	X			
Prescriptions (eRx)	RxNT		X		
Progress notes	Clinician's Gateway	X			

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Treatment plans	Clinician's Gateway	X			
Summary Totals for EHR Functionality		6	2	2	

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

- The MHP is implementing the Krassons product Imavisor scanning to convert paper chart components into EHR accessible format. The project is still in test, the MHP received a new version late in January 2016. The MHP will begin the project by April 2016.
- The MHP is working with Quest and Bio Reference to install eLab. Quest provides lab services for 90% of the consumers for who labs are ordered. The installation requires 60 days of testing. Installation is targeted for May 2016.
- The prescription software, RxNT, is utilized for electronic prescribing and medication look-up. Providers cannot prescribe through Clinician's Gateway. The MHP is collaborating with the vendor for resolution.
- The MHP continues to rely on a hybrid (paper and electronic forms) medical record system for clinical records use.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP's average monthly percentage of missed appointments has decreased from FY14 at 7% to 4% for FY15.
- Timeliness of Services
  - The MHP does not have wait lists.
  - In December 2015 the Brief Clinical Assessment template was integrated into Clinician's Gateway allowing immediate access for urgent medication management appointments.
- Quality of Care
  - Administrative and clinical staff were surveyed regarding the use of the Inpatient Tracking Log. The results were used in development of several

reports, both in terms of data elements and format. The project served as a pilot for subsequent data surveys.

- To improve bilateral communication between management, staff, contractors monthly contract provider meetings resumed. A QI newsletter is provided, the HHS Insider which includes Marin Health Services and Substance Use Services (MHSUS) news and information.
- In September 2015 the MHSUS Documentation Guide was posted on the marinhhs.org website which included an electronic feedback form to management creating a venue for interchange between QI and providers.

- Consumer Outcomes
  - The MHP examines trends quarterly in quality and completion of their Milestones of Recovery Scale (MORS) reports. The findings indicate that data quality is insufficient for accurate reporting. Meetings with the QI Manager and case managers are scheduled to discuss remedial action.
  - The MHP has contracted with UC San Diego Research Center to implement the pilot for Mental Health Outcomes Management Systems (mHOMS). The contract is in effect from November 2015 through July 2016. The target population is adult consumers receiving non-FSP CSS services - expanding to all adults. Outcome instruments have been loaded into the EHR.

SITE REVIEW PROCESS BARRIERS

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

- There were no site review barriers experienced.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP's newly developed programs of Mobile Crisis, Outreach and Engagement and Transitions Team offer accessible services to individuals who are reluctant or unable to initiate treatment, and provide support during the engagement process.
  - To improve quality of the 24/7 Access Line, feedback is provided to Access clinicians monthly and the clinicians are continuously trained on service requirements on test calls. Access line resource materials have been updated in an electronic format.
  - To accurately track and improve penetration rates of underserved, in particular Latinos, the MHP is partnering with West Marin Clinic with new outreach approach. They trained five promotores in West Marin who provided education and support to 156 consumers.
- Opportunities:
  - The impact of unfilled prescriber positions – psychiatry and PNPs – is felt throughout the department, and was mentioned in many sessions. Development of solutions to this issue is key to assuring quality care.
  - The MHP is aware of the importance of tracking preferred language of service requests, ensure adequate interpreter services and track related wait times. Plans are underway to make this happen and also to revise Access Line protocols.

- The MHP has received approval to initiate a feasibility study for greater access to psychiatric inpatient beds, which is a need that was identified by many stakeholders throughout the course of this review.
- While solutions are being considered, the MHP's Kerner main campus presents significant access challenges for consumers and staff due to limited parking. Anecdotal feedback during the review indicated an awareness that some consumers had missed appointments due to lack of parking.

Timeliness of Services

- Strengths:
  - The MHP is working on improving the referral process between Access and treatment services, which includes a goal of extensive automation to provide improved tracking of timeliness metrics.
  - The MHP has under development the creation of a Capacity and Flow Dashboard to centralize timeliness elements, which will be released monthly. This endeavor will provide valuable insight to enhance performance in this area.
- Opportunities:
  - Hospital aftercare follow-up exceeds the seven-day standard (adults average 17 days, with 67% meeting the standard; children/youth average 12.5 days, 67% meeting standard). The MHP understands this as related to the frequent use of out-of-area contracted hospitals and the irregular communication between these facilities and the MHP.

Quality of Care

- Strengths:
  - The MHP is making strides in identification of data elements that are key to the focus on quality and efficiency in service delivery.
  - The MHP QI Work Plan structure has the promise of becoming a living document that tracks important service data elements and presents them on a regular basis throughout the year to inform decision-making.
- Opportunities:
  - The concepts of wellness and recovery are well-supported in some areas of the MHP, particularly with partner agencies. However, core directly operated

programs have experienced a focus on many other newer initiatives and changes that may have diluted the extent to which wellness and recovery permeates departmental operations.

- The MHP's capacity to identify and resolve data and reporting issues as well as the staff capacity to attend to quality monitoring throughout the year would appear to merit re-evaluation of the adequacy of current resources involved in both IT and QI programs.
- The Kerner campus has one shared adult/child waiting room, which occasionally has agitated adult consumers present – who are then directed to an adjacent waiting room. However infrequent, this situation impacts the parents/caregivers of children and youth who expressed concerns over their personal safety and that of their children.
- The Kerner building has space challenges for clinical sessions, and in addition distributes the access staff in non-contiguous locations, which can impede effectiveness and efficiency of its operations.
- A planning process with primary healthcare providers who also serve Medi-Cal beneficiaries to identify viable data sharing strategies between disparate EHR systems is an indicated need.

Consumer Outcomes

- Strengths:
  - CANS training, certification and implementation was accomplished with direct and partner staff, in November 2015.
  - The Non-Clinical PIP shows the promise of demonstrating outcomes from the SB82 Mobile Crisis, Outreach and Engagement and Transitions programs, in serving individuals who might be otherwise considered for an AB1421/AOT program.
- Opportunities:
  - The MHP needs to acquire software and or services that assist in managing aggregate data from the CANS and other outcome instruments.

RECOMMENDATIONS

- 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.
- 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.
- 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.
- 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.
- 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.

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

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

Marin County MHP CalEQRO Agenda

February 3-4, 2016

Location: 3240 Kerner Blvd, Connection Center, San Rafael, CA 94901

Day 1 – Wednesday, February 3

Time	Activity		
9:00 – 9:30	**Opening Session** • Introduction to BHC • MHP Team Introductions *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Location: Room 109/110		
9:30 – 10:20	**Review of Past Year** • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • New Uses of Data in the Past Year *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Location: Room 109/110		
10:30 – 12:00	**Clinical Line Staff** Group interview of 6-8 clinical line staff, (no supervisors), representing various aspects of the service delivery system. • Quality • Access • Timeliness Location: Room 109 EQRO: Rob/SSG	**Consumer Focus Group** • 8-10 adult beneficiaries including a mix of existing and new clients who have utilized services with the past 12 months. Hispanic/English/Spanish Location: Room 110 EQRO: Deb/Judy	
12:00 pm – 1:00 pm	BHC Cal-EQRO Working Lunch		
1pm – 2:30 pm	**Clinical Supervisors** Group interview of 6-8 supervising clinical staff, (no managers), representing various aspects of the service delivery system, contract and directly employed. • Quality • Access • Timeliness Location: Breezeway 40-133 EQRO: Rob	**ISCA/Fiscal & Billing** • FY14-15 IS Recommendations • EHR Implementation • IT Strat Plan • Timeliness • Contract Providers • Claim process – denied, replaced transactions • Tele-psychiatry • Primary Care Collab • Meaningful Use Location: Breezeway 40-134 EQRO: Judy	**Family Member Focus Group –** caregivers/parents of child/youth beneficiaries • 8-10 culturally diverse, including a mix of those who initially accessed care within the prior 12 months. Hispanic/Eng/Sp Location: Room 110 EQRO: Deb /SSG

2:45-3:45pm	**Timeliness Performance Measures** • Timeliness Self-Assessment Document • MHP Timeliness Metrics and Procedures Location: Room 109 EQRO: Rob/SSG	**Contract Providers – ED/COO/Administrator** • Quality • Access • Timeliness Location: Room 110 EQRO: Judith/Deb
3:50-5:00pm	**Katie A. Implementation** • Collaboration between MHP and CWS • Implementation and provision of services, i.e. - numbers served, Core Practice Model, CFT, claiming • Policies and procedures • Current challenges • Next steps Location: Room 109 EQRO: SSG	**Consumer/Family Member Line Staff** Group interview of 6-8 staff employed because of their lived experience, (no supervisors), representing various aspects of the service delivery system. • Quality • Access • Timeliness Location: Room 110 EQRO: Deb/Judy

Day 2 – Thursday, February 4

<table>
<tr><th>Time</th><th colspan="2">Activity</th></tr>
<tr><td>9:00-10:00am</td><td colspan="2">Disparities and Performance Measures

• Access, Threshold Languages, Engagement, (Timeliness, Outcomes)

Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff

Location: Room 109/110
EQRO: All</td></tr>
<tr><td rowspan="2">10:00-11:00am</td><td>Performance Improvement Projects - Clinical PIP

• Technical Assistance
Requested Participants: MHP Leadership, Quality Management Staff, Key PIP Participants

Location: Room 109
EQRO: Rob</td><td>10:00-10:30
Wellness Center Visit
The Enterprise Resource Center
3270 Kerner Blvd
Bldg. A, Suite C

30 minutes
EQRO: Deb/Judy</td></tr>
<tr><td></td><td>10:30-12:00
Adult Consumer Focus Group
Vietnamese Consumers
Location: Room 110
EQRO: Deb/Judy</td></tr>
<tr><td>12:00 pm – 1:00 pm</td><td colspan="2">BHC CalEQRO Working Lunch</td></tr>
<tr><td>1:00-2:00pm</td><td colspan="2">Performance Improvement Projects – Non-Clinical PIP
• Technical Assistance
Requested Participants: MHP Leadership, Quality Management Staff, Key PIP Participants
Location: Room 109/110
EQRO: All</td></tr>
<tr><td>2:00-3:00pm</td><td colspan="2">Quality Management Activities
Quality, Access, Outcomes
Location: Room 109/110
EQRO: All</td></tr>
<tr><td>3:15-3:45 pm</td><td colspan="2">BHC CalEQRO Team Meeting</td></tr>
<tr><td>3:45-4:15pm</td><td colspan="2">Exit Interview
• Summary of Findings
• Collection of Requested Documentation
• Next Steps
Location: Room 109/110</td></tr>
</table>

BHC California EQRO Team Members:

Saumitra SenGupta, Ph.D. - Executive Director, BHC CalEQRO
Rob Walton, RN, MPA, Lead Quality Reviewer Consultant
Ewurama Shaw-Taylor, Ph.D., Quality Reviewer
Judith Toomasson - Information Systems Reviewer
Deb Strong - Consumer/Family Member Consultant
www.CalEQRO.com

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, RN, MPA, Lead Quality Reviewer, Consultant
Saumitra Sengupta, PhD, Executive Director, BHC EQRO
Ewurama Shaw-Taylor, PhD, Quality Reviewer
Judith Toomasson, Information Systems Reviewer
Deb Strong, Consumer-Family Member, Consultant

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

Sites of MHP Review

MHP SITES

Marin County Mental Health and Substance Use Services Connection Center,
3240 Kerner Blvd., San Rafael, CA 94901

CONTRACT PROVIDER SITES

Community Action Marin, Enterprise Resource Center,
3270 Kerner Blvd, San Rafael, CA 94901

Participants Representing the MHP

Name	Position	Agency
Alexis Padilla-Gonzales	MH Practitioner – Bilingual	MHSUS-YFS
Allison Adcock	MH Practitioner	MHSUS-ACMK
Amanda Davis	Utilization Review Specialist	QI- MHSUS
Amber Mayfield	MH Practitioner – STAR	MHSUS-Adult
Angela Tognotti	MH Unit Supervisor	MHSUS
Ann Pring	Division Director	MHSUS
Anne Lauver	Family Partner/PES	CAM/PES
Barbara Coley	Dir. CAM MH Programs	CAM
Bianca Bustos	MH Practitioner-bilingual	MHSUS-HOPE
Bob Brown	Dir. Community Support Svcs.	Buckelew Programs
Brian G. Robinson	Unit Supervisor	MHSUS
Cammie Duvall	Utilization Review Specialist	MHSUS
Cassandra Gabriel	MH Practitioner-Transition Team	MHSUS-Adult

Name	Position	Agency
Catherine Condon	Resource Development Admin.	MHSUS
Cathy Zane	MH Unit Supervisor	MHSUS
Cesar Lagleva	ESM	MHSUS
Charles Saldanha	Medical Director	MHSUS
Chua Chao	Manager	CFS
Cody Milner	Accounting Technician	County of Marin, H&HS
Darcy Woodall	Sr.Peer Case Manager	CAM/Odyssey
David Busby	Sr. Peer Case Manager	CAM
David Rothery	Privacy & Compliance Program	MHSUS
Dawn Kaiser	Division Director	MHSUS
Debi Moss	Child Welfare Dir	Children & Family Services
Denise Zvanovec	Assistant CFO	Marin County
Eileen Becker	Support Services Worker II	MHSUS
Eric Swift	Office Supervisor	MHSUS
Esmeralda Garcia	Patients' Rights	Community Action Marin
Janice Wells	ASOC/Crisis Chief	MHSUS
Jeanne Scott	Director of Behavioral Programs	Sunny Hills Services
Jennifer Rossi	Jail/Mobile Crisis/O&E/Supervisor	MHSUS
Jenny Bates	Access Unit Supervisor	MHSUS
Joanne Bender	Utilization Mgmt Coor	MHSUS
John Bhambra	HIM Administrator	MHSUS
Jordan Hall	Planner/Evaluator	MHSUS
Juanita Zuniga	Clinical Psychologist	MHSUS-YFS
Karl Hackert	Administrative Services Assoc	MHSUS
Kasey Clarke	MHSA Coordinator	MHSUS
Kathy Chestnut	MH Unit Supervisor	MHSUS
Kerry Peirson	Client Advocate	Community Member
Kristen A. Brock	Exec. Director	Community Action Commission
Kristen Gardner	PEI Coordinator	MHSUS
Kristine Kwok	Unit Supervisor	MHSUS
Kristine Kwok	Unit Supervisor-Bilingual	MHSUS
Larkin Scaly	Program Director	Seneca Center
Larry Jacobs	MH Unit Supervisor	MHSUS
Leigh Steffy	Resource Development Coord.	MHSUS

Name	Position	Agency
Leigh Steffy	Resource Development	MHSUS
Leticia McCoy	Family Partner	CAM
Lillian Jang	Office Supervisor	MHSUS
Linsey Maldonado Scinitti	Family Partner	CAM
Lisa Ballard	PES Unit Supervisor	MHSUS
Lydia Villanueva	IT	MHSUS
Marisol Munoz-Kiehne	Clinical Psychologist	MHSUS
Marta Flores	MH Practitioner – Bilingual	Access
Mary Kay Sweeney	Executive Director	Homeword Bound
Nancy Masters	Assoc. Exec Director	JFCS
Pamela Roman	Unit Supervisor	Marin MHSUS
Patty Lyons	MH Unit Sup	MHSUS
Richard Jang	IT Supervisor	MHSUS
Sean Holcombe	Licensed Crisis Specialist-PES	MHSUS-PES
Suzanne Tavano	Director	MHSUS
Todd Paler	Program Manager	MHSUS
Tran Nguyen	MH Practitioner-bilingual	MHSUS-ACM
Vicki Nightingale	Admin. Svc. Assoc.	MHSUS
Walter Onguongsabul	Admin. Service Tech	MHSUS

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

Clinical PIP:

The MHP's submission was not considered to be a PIP.

Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 446, South San Francisco, CA 94080 *(855) 385-3776*
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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Marin	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Assisted Outpatient Treatment (AOT) Study		
Dates in Study Period: Feb 2015 -		

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	While the MHP has included a diverse team of participants, the PIP is conspicuously absent of consumers, family members, and consumer advocacy representation. Significant presence of local leadership and multi-agency participation is evident, however.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	SB1421/AOT provides a mechanism for engaging those who met the criteria with more effective services. The MHP's data analysis examines this topic from multiple data aspects, and has identified a number of individuals who are potential AOT candidates.

Component/Standard	Score	Comments
1.3 Did the Plan's PIPs, 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	It is not clear precisely what element of services each program/intervention is intended to improve.
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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**2** Met **1** Partially Met **0** Not Met **1** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? *Include study question as stated in narrative:* Is there an identified population of people in Marin who would likely meet criteria for AB1421 services that would be effectively served by the implementation of AB1421?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	A PIP and the related study question must pose an issue that, as validated by data, is determined to exist and also include what is being tested out to remedy the problem. In this case, it would appear that the MHP would eventually intend to improve the outcomes – engagement and treatment - of SB1421 eligible. But at this point, it is limited the PIP to determining if a problem exists. This is not an adequate study question. More likely, the MHP is asking if its existing FSP programs and new Mobile Crisis, Outreach and Engagement and Transitions Services will serve to engage (95%?) of individuals who would meet AOT eligibility criteria. If so, adoption of AOT would not be beneficial.
Totals		**0** Met **0** Partially Met **1** 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population was defined as all Marin County residents age 18 and older who, subsequent to 2+ PES visits, had two or more hospitalizations within a 36 month period. Or, two or more treatment episodes with a forensic psychiatrist while in custody in the Marin County Jail or one of each (hospitalization plus Jail Mental Health) within the past 36 months.

Component/Standard	Score	Comments
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: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	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:* • Planned Treatment Initiation/Engagement • Engaged Individuals • Retention	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Retention, the third indicator is yet to be adequately defined at the time of this review. There was also discussion about what would constitute engagement, if the consultant's recommendation of 3 sessions in six months or three consecutive residential treatment days were adequate. This reviewer agrees that a stronger value, such as six, would provide a superior indicator and would serve better as a floor on engagement.
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? Are long-term outcomes implied or stated? ☒ Yes ☐ No ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	These indicators should result in improved outcomes for the consumers, and fewer adverse events – such as incarcerations, acute hospitalizations, and crisis events. It would, however, be useful to also include as indicators hospitalizations, crisis events, arrests and jail days as indicators for those individuals identified as the AOT candidate population.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Assess Improvement Strategies		
5.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes? *Describe interventions:* • FSP Teams • Outreach and Engagement Team • Transition Team • Mobile Crisis Team	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	It would appear that the MHP is targeting the use of newly funded programs as the PIP interventions (SB82 programs), which have missions that would seem as potentially inclusive of AOT eligible individuals. The MHP has not undertaken a root cause analysis of why individuals fail to engage in services, and thereby have the foundation for development of interventions specific to AOT/1421 individuals. There may be common and specific factors – such as co-occurring disorders – that might indicate for changes in approach with the targeted AOT/1421 eligibles within each of the program elements, in order to test out a specific approach.

Component/Standard	Score	Comments
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Retention and engagement indicators merit further review and a determination of what the parameters should be that are tested. In addition, it would likely be useful to adopt indicators such as arrest/jail stays, hospitalization and crisis events as "real world" outcome data for these individuals.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	MHP system data is indicated as the source.
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	System data is first identified. If targeting the AOT candidates as defined, the MHP may need to seek outside data from law enforcement as well.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☒ Other: EHR	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP is using the data collection process to determine if there is a problem, not following the implementation of specific interventions that are targeting the relevant issues of non-engagement for this population. In addition, its reporting out is confined to annual/fiscal year reporting. When tracking results of interventions, quarterly or semi-annual data reporting is necessary in order to provide feedback to the PIP team. No data is presented for the period from July 1, 2015 until January 2016.
6.5 Did the study design specify a prospective data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	

Component/Standard	Score	Comments
6.6 Were qualified staff and personnel used to collect the data? Did the documentation include contractual, temporary, or consultative personnel? *Project leader:* Dawn Kaiser, LCSW, Lead Walter Ongwongsakul Richard Jang	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**3** Met **1** Partially Met **2** Not Met **0** UTD
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Did the analysis process occur as planned? *This element is "Not Met" if study is complete and there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
7.2 Did results obtained through interim data review trigger modifications to the project or its interventions when appropriate?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The data is collected and reported on fiscal year basis. No specific modifications are articulated in the PIP at this time. The data is not being reported out monthly, quarterly, semi-annually, customary minimums for PIPs.
7.3 Were the results presented in adherence to the statistical analysis defined in the data analysis plan?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Statistical analysis has not yet occurred.
7.4 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: <Text> Indicate statistical analysis used: <Text> Indicate statistical significance level or confidence level if available/known: ☐ 99% ☐ 95% ☐ Unable to determine	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	

Component/Standard	Score	Comments
7.5 Did the analysis of study data include an interpretation of the extent to which its PIP was successful, and 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 **5** Not Met **0** Not Applicable **0** Unable to Determine
STEP 8: Review Assessment of PIP Outcomes		
8.1 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 did report data for the last three fiscal years.
8.2 Were any issues identified through the data analysis? Did the data cycles identify when measurement occurred? Were results presented in terms of statistical significance?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 What factors influenced comparability What factors threatened the internal or external validity of the outcomes? Indicate the time periods of measurements: <Text> Indicate statistical analysis used: <Text> Indicate statistical significance level or confidence level if available/known: ☐ 99% ☐ 95% ☐ Unable to determine	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	

Component/Standard	Score	Comments
8.4 Did the analysis of the study data include an interpretation of the extent to which its 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 **4** Not Met **0** Not Applicable **0** Unable to Determine	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used, when measurement was repeated? *Ask: 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: ☐ Increase ☐ Decrease 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 "face" 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	

Component/Standard	Score	Comments
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 **5** Not Met **0** Not Applicable **0** Unable to Determine

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified upon repeat measurement?	☐ Yes ☐ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Revision of the study question might focus on asking if the SB82 programs of Mobile Crisis, Outreach & Engagement, Transitions, in addition to the FSPs are able to serve a significant percentage of potential AB1421 candidates effectively, coupled with a reduction in adverse events such as hospitalization and jail stays/arrests. A derivative of the PIP results might also inform the MHP if adoption of AOT would seem necessary, or not, to serve potential AOT individuals. The MHPs data analysis would benefit from summarizing the numbers eligible for AOT consideration, and then tracking the results of services to these individuals and whether or not engagement and treatment occurred – as is currently included in the PIP. This review would suggest that the MHP also consider tracking some external data indicators determination of outcomes -- including as arrests and jail stays.		
Recommendations: Revise study question. Refine the data analysis plan.		
Check one:	☐ High confidence in reported Plan PIP results	☒ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible