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FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

FRESNO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

MARCH 20-22, 2018

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FRESNO MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 19,044

MHP Threshold Language(s) — Spanish and Hmong

MHP Size — Large

MHP Region — Central

MHP Location — Fresno

MHP County Seat — Fresno

Introduction

Fresno County's Mental Health Plan (MHP) is categorized as a Large, Central region MHP. The MHP's official name is the Department of Behavioral Health, which includes mental health and substance abuse services. The MHP provides adult, children's, and transitional age youth (TAY) outpatient services, adult and youth inpatient services, crisis stabilization services, and school-based services. The majority of the MHP's consumer population are in the Fresno metropolitan area. The MHP's service sites are in Fresno at three campuses, termed Metro, Heritage, and Sierra; Heritage was the site of the MHP's administrative offices at the time of the review. The MHP has commissioned a space needs assessment on use and improvements to their facilities, which includes potential renovations to the Sierra building to enable direct services.

During the fiscal year 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the MHP and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The MHP has continued to experience staff departures and vacancies in clinical positions, most recently in staff who facilitated Katie A. services. Since the last review, the MHP has expanded contracted services to improve availability of services in rural areas outside metropolitan Fresno. The expanded contracts included increased capacity and scope, enabling contract providers to provide more services to consumers. While the MHP has worked to recruit staff and offer higher salaries, they recognize that the costs of employee benefits (both to the department and to the employee) diminish the impact of increased salaries. The MHP is in the second year of the Multi-Agency Access Program (MAP), which is a partnership with Kings View, Poverello House, and

Centro La Familia to facilitate multiple points of access to a variety of health and supportive services, including mental health. MAP uses a screening tool to determine consumers' needs for linkage to services or resources; the screening tool has gained interest among other community providers, which would further streamline and facilitate access. The MHP has made some internal changes to facilitate access, including restructuring of the school-based programs and development of a medium intensity program to address a gap in services for high-need consumers.

Timeliness

The MHP has improved their timeliness in some areas (e.g., first appointment), but has experienced further delays in others (e.g., urgent conditions for children and rehospitalization rates for adults). Both the 7-day and 30-day outpatient follow-up rates post-hospitalization improved in calendar year 2016 (CY16); however, both remain below the State average. The MHP cited limited staffing, of both clinicians and psychiatrists, and providers as primary contributors to increased times to services. To understand better the changes in timeliness, the MHP would benefit from closer review of all timeliness metrics and analysis of extremes or outliers.

Quality

The MHP provides a variety of services that meet the needs of consumers with diverse linguistic, cultural/ethnic, and racial backgrounds. However, stigma is a particular barrier for some consumers of different ethnic and cultural groups. The MHP conducted a survey of employees that showed 52 percent of employees were consumers of mental health services at some point and that 72 percent of employees had a family member who was a consumer, affirming that individuals with lived experienced are represented within the MHP.

The MHP has implemented its Sisense dashboard and made it available to managers and supervisors. Sisense is easy to use and provides daily updates on service utilization and clinic caseloads that can be used to guide MHP decision making. There are a number of positive and progressive improvements happening, sometimes driven by particular individuals, with support from mid-management.

Outcomes

The MHP has continued the use of Reaching Recovery as an outcome tool and level of care instrument. Reaching Recovery includes multiple measures that provide a comprehensive picture of consumer outcomes. The MHP intends to expand training for and use of Reaching Recovery by contract providers. The MHP also uses the Child and Adolescent Needs and Strengths (CANS) assessment.

INTRODUCTION

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

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

This report presents the FY17-18 findings of an EQR of the Fresno MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);

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

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

- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

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

MHP Health Information System Capabilities[4]

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

Validation of State and County Consumer Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY16-17

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

Status of FY16–17 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY16-17

Recommendation #1: Review all of the timeliness metrics in greater depth, investigate: (1) extreme times and (2) when the percentage of appointments/metric does not meet a predetermined minimum standard, and implement corrective action.

Status: Partially Met

- The MHP examined their timeliness metrics and chose to focus their performance improvement efforts on the county-operated children's outpatient program. The MHP convened process meetings to strategize the best interventions to increase timeliness and, from this, developed a non-clinical PIP.
- The MHP made changes to Avatar (e.g., including a field to track time from initial request to first offered appointment) and their reporting systems to better capture some timeliness metrics.
- The MHP allocated some of their FY 17-18 budget to 32 new positions, many of them clinical, intended to improve timeliness of service delivery. As an example, there are now three new clinical positions for initial assessment for youth post-hospitalization. There is

also a new streamlined referral process for TAY and a short-term treatment option of four to six sessions for youth discharged from a psychiatric health facility (PHF) and awaiting assignment to a clinician for ongoing therapy.

- The MHP identified several forums, including the Access Committee, Outcomes Committee, and an Ad-Hoc Data Workgroup where timeliness to services was reviewed.
- However, the MHP's monitoring of timeliness (or the frequency of these meetings) did not appear to permit for contemporaneous review of timeliness that would identify and resolve aberrant times. The MHP reported reviewing the detailed timeliness data only twice yearly with their Access Committee.
- The MHP has implemented corrective action for some timeliness metrics that did not meet timeliness standards (e.g., initial appointments), but for others (i.e., urgent conditions) no corrective action were identified.
- The MHP is still working on consistency in their gathering of timeliness data, including incorporating contract providers' measurements in reporting of no-shows.

Recommendation #2: Develop and implement a plan for monitoring penetration rate and other indicators of access in the rural areas of the county related to the new initiatives to increase access to services (e.g., Multi-Agency Access Program Point).

Status: Partially Met

- The MHP provided a list of various indicators that they are using or will use to evaluate the outcomes and impact of their efforts to increase access. These indicators address wait times for assessments; screening processes; clinician and provider caseloads; and improved accuracy of triage for urgent conditions.
- The MHP had data on the numbers of beneficiaries served; the number of open cases in Avatar; average days to assessments; and, range of days to assessment of Turning Point programs. The MHP did not have data from other providers that were facilitating access in rural communities
- The MHP uses a Sisense software-based dashboard to provide managers and supervisors with daily updates that can assist with routine monitoring of penetration rates, clinic workloads, and service backlogs.
- The MHP expanded telepsychiatry to facilitate better services in rural communities. Use of telepsychiatry is yet another indicator that the MHP can use to measure access in rural areas of the county.

Recommendation #3: Create a stakeholder work group to develop a comprehensive plan for electronic data exchange with organizational providers and hospitals. Begin tracking wait-times and waiting list status for all providers.

Status: Partially Met

- A stakeholder group was not convened, but the MHP has expanded Avatar use by contract providers when Exodus Recovery and Kings View began using Avatar.
- The MHP collaborates with a few contract providers (e.g., California Psychological Institute; Central Star Community Services Program; and, Uplift Family Services) for direct data entry into the EHR, which enables the tracking of wait times. Not all contract providers are submitting timeliness data to the MHP. The MHP's goal is to collect timeliness data from all contract providers by August 2018.
- MHP does not yet have a comprehensive plan for electronic data exchange with organizational providers and hospitals, but the MHP is working with the hospitals for a direct messaging from Epic, the hospital's EHR system, to Avatar for transitional care documents.

Recommendation #4: Conduct a new staff survey on lived experience that specifically identifies the level or classification of the respondent's position and ensure that at least 70% of the MHP staff participate.

Status: Met

- The MHP conducted a staff survey of lived experience. The MHP achieved a 67 percent response rate, just slightly below the target of 70 percent; 329 staff responded out of the 494.
- The survey included the level or classification of the staff. Of the 329 respondents, 60 (18 percent) indicated that they were in supervisory positions.
- Just over half of the respondents (52 percent) indicated that they had lived experience with mental illness. More respondents (72 percent) reported having a family member who has (had) a mental illness.
- The MHP reported that a number of staff, well known within the system of care and in supervisory positions, have informally shared their experiences with recovery in mental illness. The MHP can use the survey results to further demonstrate this with an analysis of only those 60 in supervisory positions and their responses to the question on self-reported lived experience.

Recommendation #5: Review and update resource information including MHP website.

Status: Met

- The MHP made several updates and changes to their website, including addition of appropriate links to other service providers and updated resource information.
- The MHP launched a new website in October 2017. The MHP has also provided trainings to contract providers on developing user-friendly websites.

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

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

Access to Care

- The MHP expanded contracts with several adult and youth contract providers. These expansions and amendments of/to contracts enabled the contract providers to serve more consumers, through increased number of staff and increased hours of service. Some contract providers increased their scope of service. For example, in addition to providing Assertive Community Treatment, Uplift Family Services (and two other contract providers) now provide the program Bright Beginnings for Families.
- The MHP has continued with the MAP, with Kings View and Turning Point as the primary contract providers to facilitate access to mental health services in rural areas. The MAP also includes mobile services for communities with emergent, but not necessarily regular, needs.
- The MHP has leveraged their existing partnerships to facilitate improved access to the appropriate mental health services. Two such examples of these enhanced partnerships include: a co-response model for crisis intervention with the Fresno Police Department and re-organized school-based services wherein the Fresno County Superintendent of Schools, with its own dedicated clinicians, is a contracted provider to the MHP.
- The MHP's Outpatient Intensive Treatment program, which opened in March 2018, facilitates transition support for consumers discharged from hospitals or crisis services.

Timeliness of Services

- Between August and November 2017, the MHP added or reallocated clinical staff to the Youth Wellness Center to increase access, timeliness of initial assessments, and ongoing treatment for youth discharged from the Central Star Youth Psychiatric Health Facility.
- One of the MHP's primary contract providers, Turning Point, has extended their service hours to later in the day, which enables more consumers to receive services in a timely manner.
- The children's mental health (CMH) has implemented a cancellation list for appointments. CMH maintains a list of consumers who are willing to consider an appointment on short notice in the event of a cancellation by another consumer. The use of a cancellation list provides more timely appointments for initial assessments and post-hospitalization follow-ups.

- The MHP has streamlined the process for ongoing services at their Metro Outpatient Clinic. The MHP now accepts assessments completed at the Urgent Care Wellness Center rather than requiring a new assessment, thereby decreasing the time for consumers to begin treatment at the lower level of care.

- In October 2017, the Fresno Board of Supervisors approved a master agreement for primary care integration with mental health and substance use disorder (SUD) services at federally qualified health clinics.

- The MHP has explored contracting options for psychiatry, the impact of which will be felt in the upcoming year and will be revisited in the next EQR.

Quality of Care

- In the past year, the MHP has conducted, initiated, or participated in projects related to a holistic view of services. The MHP convened a housing workgroup from which a housing needs assessment was commissioned. The MHP partnered with law enforcement and emergency medical services to conduct Stepping Up, a program to divert consumers from detention and the criminal justice system, and to find the most appropriate services available to them.

- The MHP's Contracted Services Division was very thorough, over the past year, in involving contract providers in program development, contract negotiations, and new campaigns and initiatives. Contract providers endorsed being active stakeholders and that the MHP sought their input and participation.

- In July 2017, the MHP integrated the Access form into Avatar to consistently track requests for services and better track timeliness of service delivery.

- Over the past year, the MHP has implemented staff trainings, inclusive of contract provider staff, on a number of topics to increase staff's skill and ability in serving a diverse consumer population with varied mental health needs. The trainings have included dialectical behavioral therapy (DBT), triage accuracy, health equity and multi-cultural diversity trainings, and motivational interviewing.

- The MHP reported that they were in a rebuilding and foundational stage with their cultural competency program. The MHP's focus in the past year has been on establishing a baseline of their understanding of cultural competency and related topics of health equity, health disparity, and culture, beyond race and ethnicity. The MHP conducted a staff and client survey on cultural equity and intends to re-issue the surveys later this year, the results of which will inform staff training, workforce development, and outreach to the community.

Consumer Outcomes

- The MHP continues to invest in Reaching Recovery as way of assessing and managing level of care and documenting individual outcomes. The MHP has embedded the Reaching Recovery tools into Avatar.
- The MHP extended use of Reaching Recovery to two contract providers, Turning Point and Mental Health Systems. To further support continued implementation of the Recovery tools, in February 2018, the MHP sent a team of eight staff, including both county and contractor staff, to the Mental Health Center of Denver, where this outcome tool was developed.
- MHP will implement CANS in the summer of 2018 to provide a common outcome measure for children.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of TBS Beneficiaries Served Compared to the 4% Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS);
- Total psychiatric inpatient hospital episodes, costs, and average LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

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

Total Beneficiaries Served

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

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

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	68,713	13.9%	4,398	23.1%
Latino/Hispanic	259,629	52.5%	6,989	36.7%
African-American	31,165	6.3%	1,943	10.2%
Asian/Pacific Islander	82,367	16.7%	2,098	11.0%
Native American	2,959	0.6%	225	1.2%
Other	49,288	10.0%	3,391	17.8%
Total	**494,119**	**100%**	**19,044**	**100%**

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

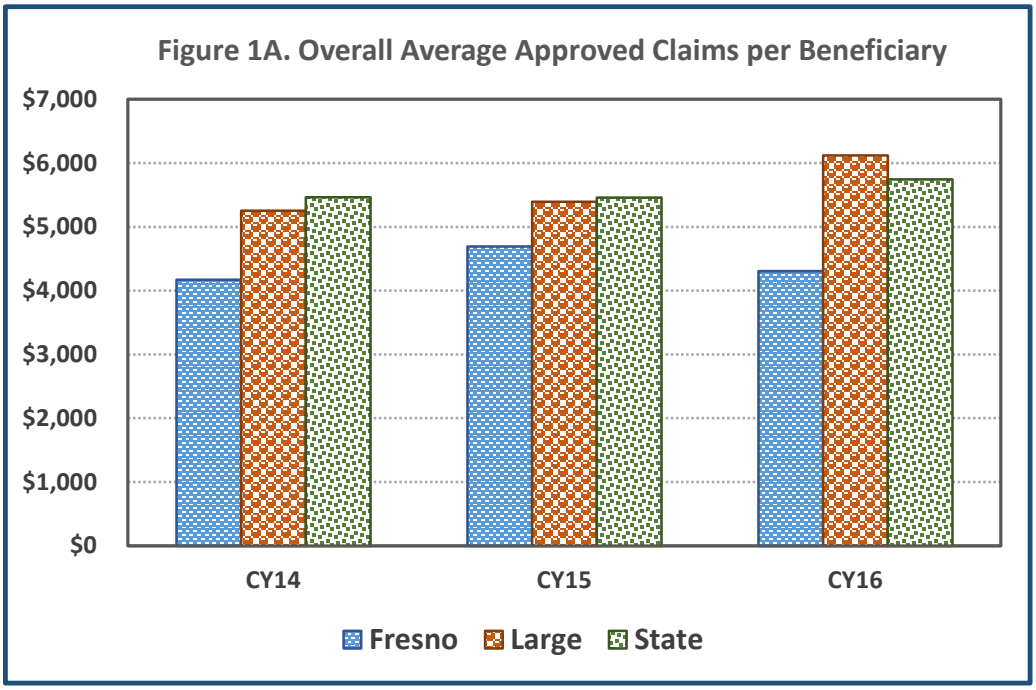
Starting with CY16 performance measures, CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved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

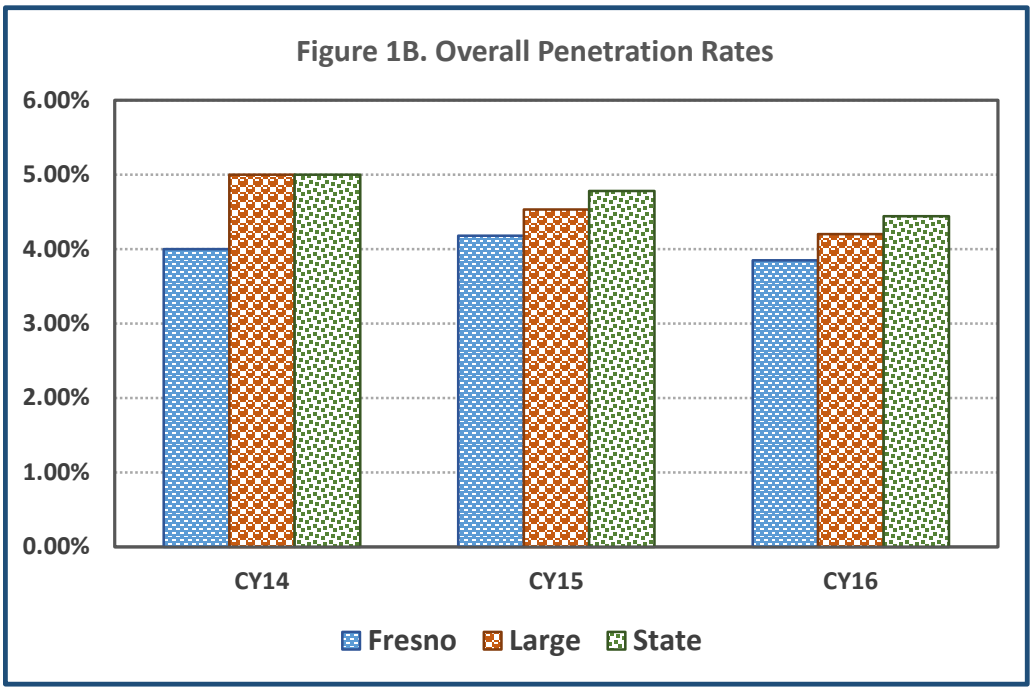
Penetration Rates and Approved Claim Dollars per Beneficiary

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

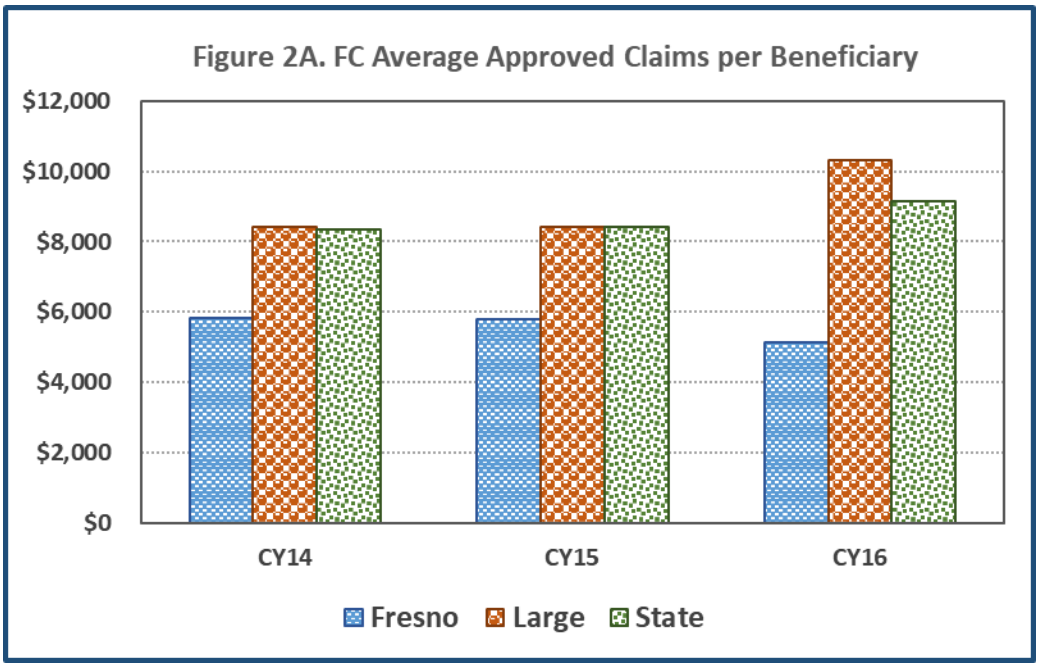
Regarding calculation of penetration rates, the Fresno MHP uses the same method used by CalEQRO.

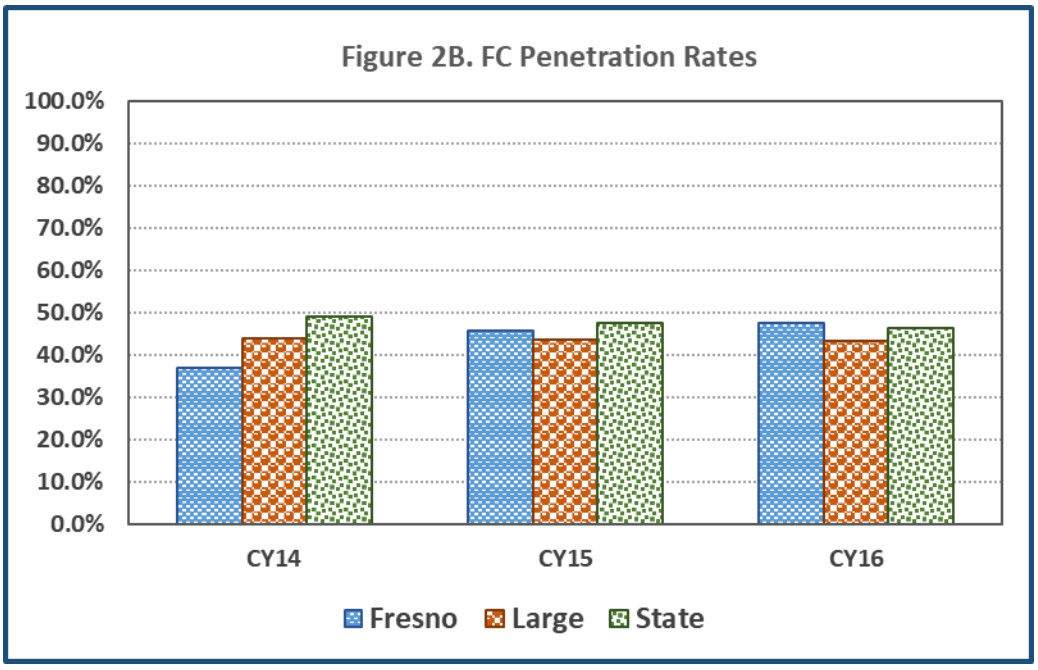
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



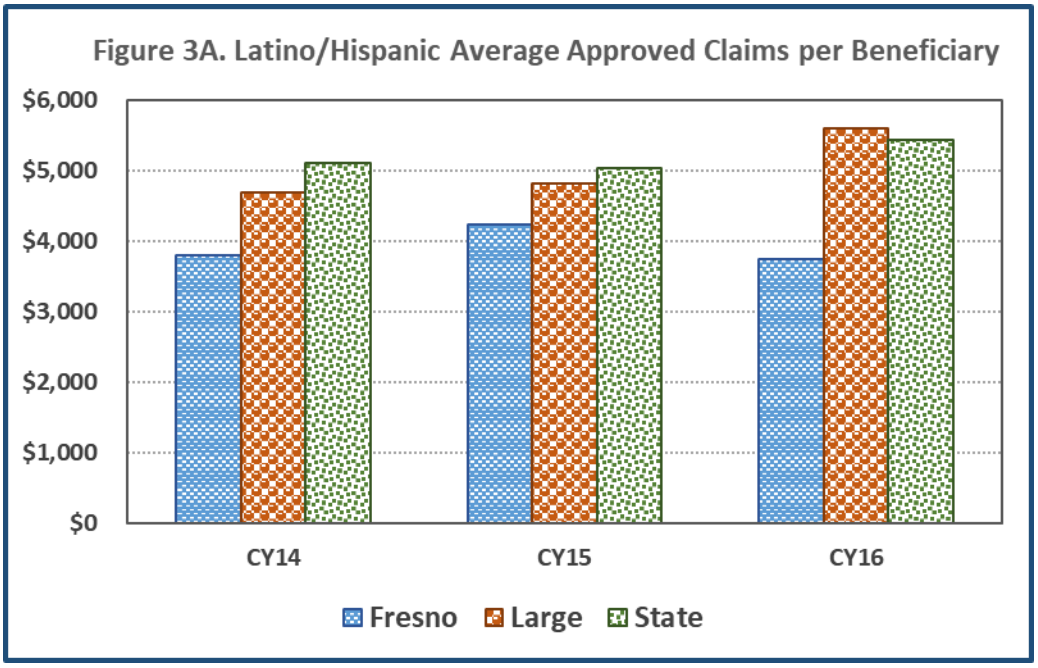


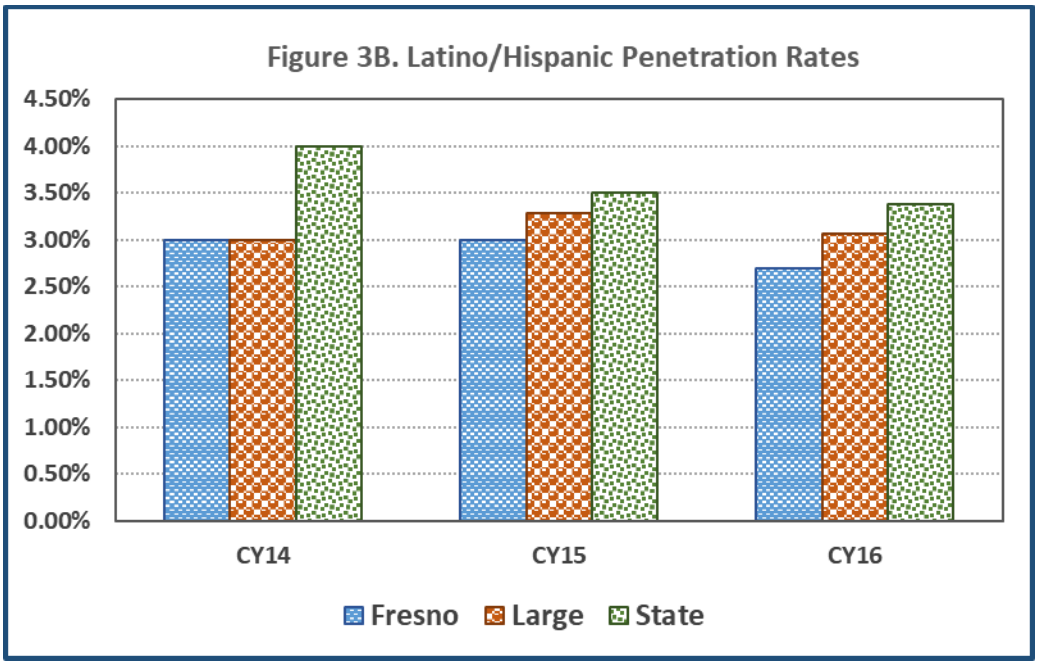
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

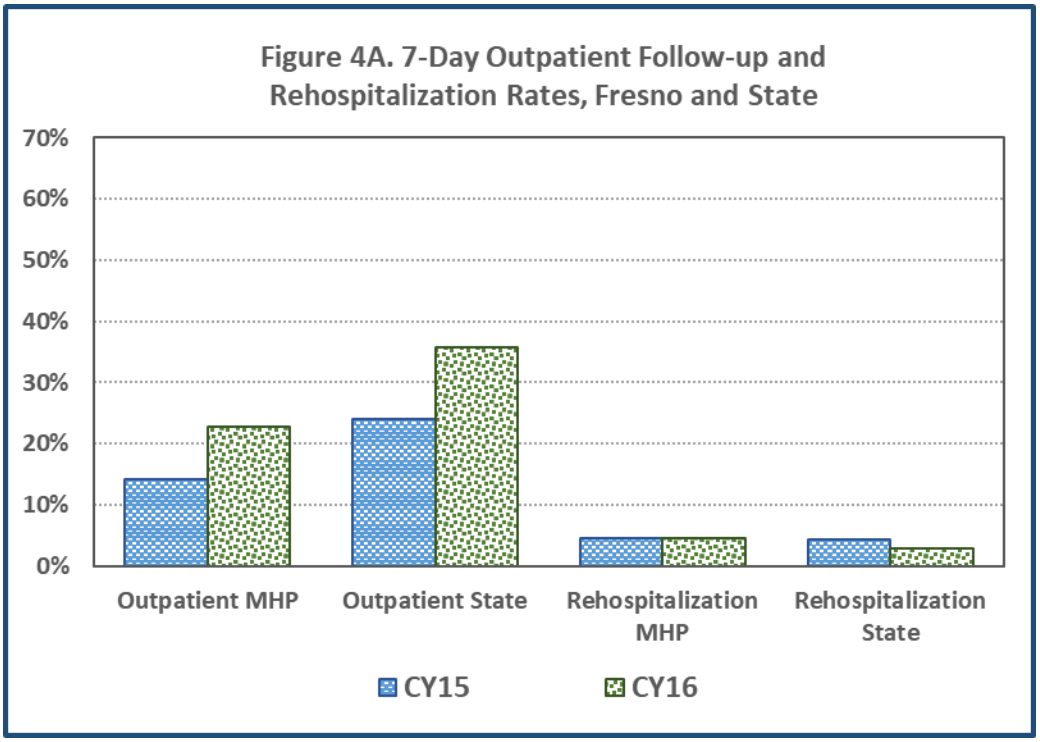
Table 2: Fresno MHP High-Cost Beneficiaries

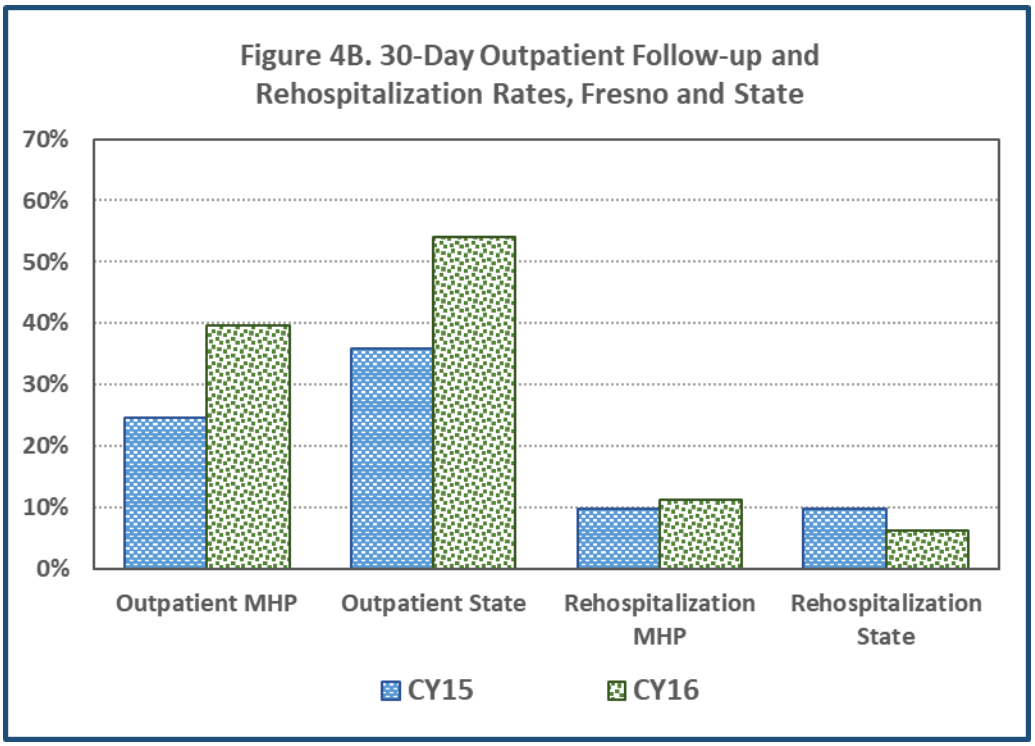
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Fresno	CY16	392	19,044	2.06%	$51,420	$20,156,834	24.57%
	CY15	489	19,769	2.47%	$54,072	$26,441,425	28.51%
	CY14	178	14,028	1.27%	$47,025	$8,370,499	17.29%

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

Timely Follow-up After Psychiatric Inpatient Discharge

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

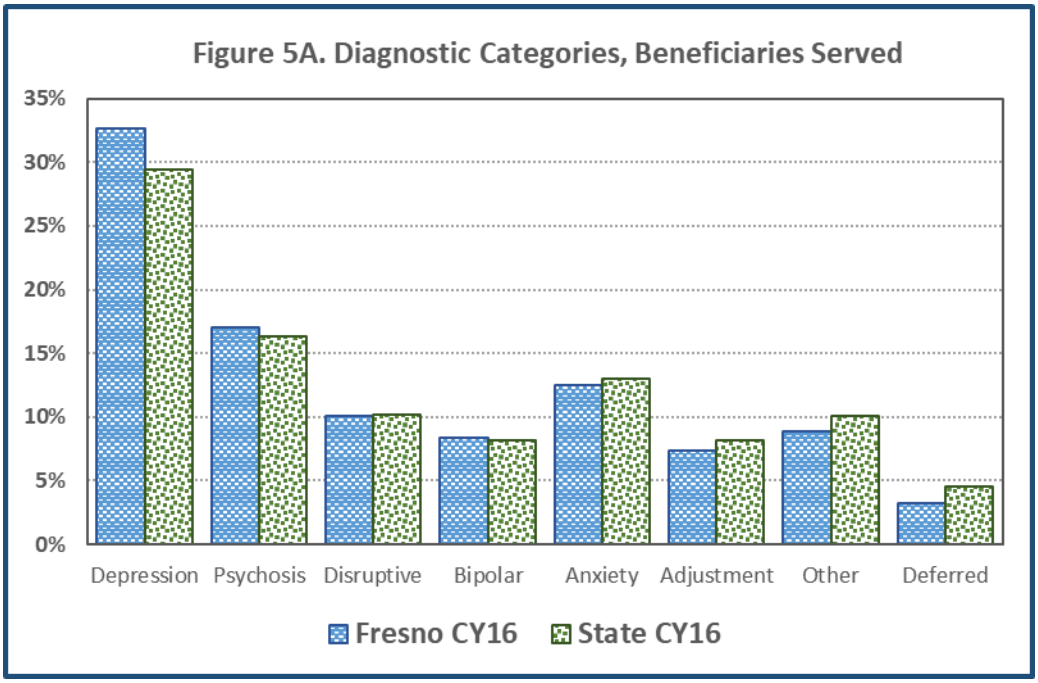


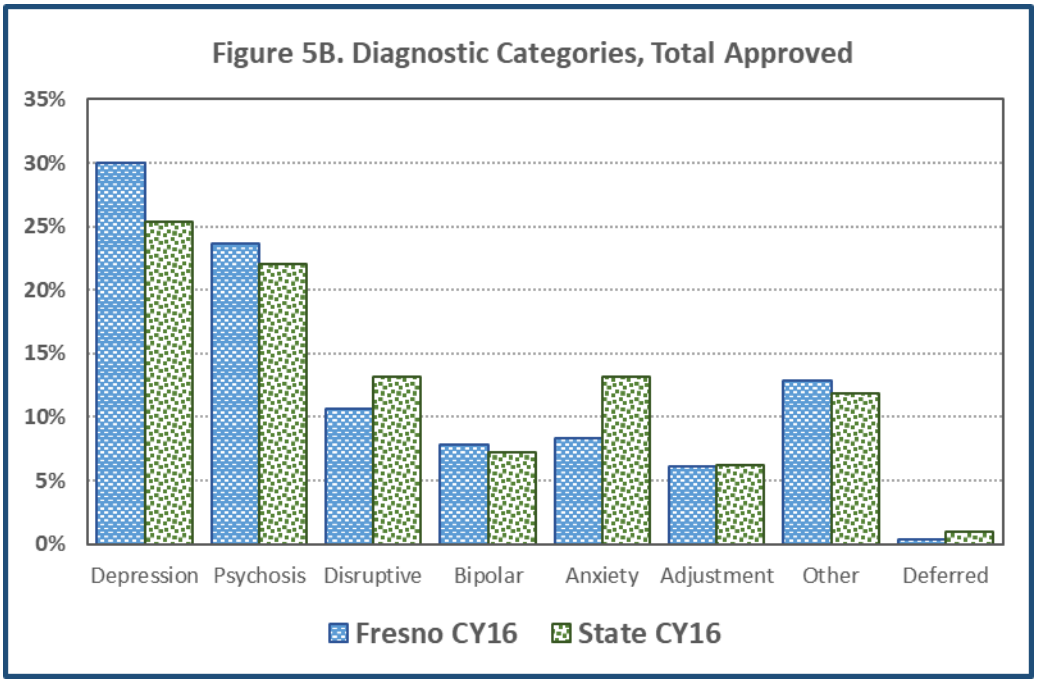


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 12 percent





Performance Measures Findings—Impact and Implications

Access to Care

- The total number of Medi-Cal eligibles increased from 434,204 in CY15 to 494,119 in CY16 while the number of beneficiaries served also increased from 16,771 to 19,044. The increase was almost entirely from adding 61,846 eligibles through the ACA.
- The overall penetration rate remains below the state and large MHP averages. The MHP has concluded, based on data analysis of penetration by zip code, that very low penetration rates in the rural areas of the county were a significant factor. Accordingly, the MHP has continued to focus efforts on rural access (e.g., MAP).
- The average ACB was well below other large MHP and the state averages. The number of services delivered per beneficiary skewed significantly lower in the MHP than the statewide average. This might, in part, explain the low ACB.
- The MHP's ACA eligibles for CY16 total was 116,979, and the beneficiaries served was 4,667, resulting in a penetration rate of 3.99 percent for this sub-group (see Table C1 in Appendix C), which is greater than the statewide average and less than other large MHPs.
- The MHP average claims per beneficiary served of $4,307 was lower than the statewide average of $5,746 and the $6,121 average for similar sized MHPs. For children in FC, the MHP's average claims per beneficiary was s $5,138, compared to the statewide average of $9,147 and the $10,301 average for large MHPs.
- All FC children are screened for mental health service needs. This results in a higher than usual number of people receiving only one service.

Timeliness of Services

- The MHP has improved its post-hospital discharge performance over last year, but the current outpatient follow-up rate of 23 percent at seven days remains substantially lower than the statewide average of 36 percent. The 30-day follow-up rate of 40 percent was also well below the statewide average of 54 percent.
- Rehospitalization rates for the MHP were slightly above the 7-day statewide average rehospitalization rate. At 11 percent, the MHP's 30-day rehospitalization rate was substantially above the statewide average of 6 percent.

Quality of Care

- The number of HCBs in CY16 decreased from 489 in CY15 to 392 in CY16. Also, HCB percent of total approved claims decreased from 28.51 percent in CY15 to 24.57 percent in CY16.

- The MHP acknowledges that the co-occurring disorders rate is above the reported 12 percent. The low number is the result of an outdated practice regarding co-occurring disorders documentation.
- The statewide average for the percentage of beneficiaries receiving more than 15 services in a year was 39.57 percent; for the MHP, it was 28.42 percent. The MHP delivers a lower average number of services per beneficiary than the statewide average, and consequently spends less per beneficiary than the statewide average.

Consumer Outcomes

- The MHP has made many changes in the last year to improve access, timeliness, and quality of services. One of the changes includes the system-wide adoption of Reaching Recovery as an outcome and level of care measurement.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Fresno MHP PIPs Identified for Validation

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

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

Table 3: PIPs Submitted by Fresno MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	"Improving Care Coordination and Timeliness of Post-Hospital Follow-up"
Non-clinical PIP	1	"Children Mental Health Outpatient Intake Process Re-design"

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

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

Table 4: PIP Validation Review

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

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	10	8
Number Partially Met	7	7
Number Not Met	2	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	20	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**67.50%**	**71.88%**

Clinical PIP—Improving Care Coordination and Timeliness of Post-Hospital Follow-up

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

"Will the 30-day readmission rate decrease with improved care coordination, communication, and more timely post CSYPHF follow-up on the youth not linked to treatment prior to the CSYPHF admission by Fresno FMHP's outpatient program managed by Fresno County DBH?"

Date PIP began: October 2016

Status of PIP: Active and ongoing

This is the second year of the MHP's PIP, with the goal of reducing the readmission rate of youth admitted to Central Star PHF. Central Star receives the majority of the MHP's youth who require inpatient services. The MHP has focused on readmission rate because it is a standard measure of quality of care. The MHP believed that there was room to decrease the readmission rate by targeting youth who were unlinked (i.e., were not otherwise receiving mental health care prior to admission to the facility). The 30-day readmission rate for unlinked youth was 19.5 percent. In the first year, the MHP implemented two interventions: daily conference calls between Central Star (i.e., their discharge coordination team) and the children's mental health division (i.e., their case managers and clinicians) and home visits subsequent to a missed follow-up appointment by the youth. After no improvement in the readmission rate—and in fact an increase (to 22.1percent), the MHP revised the interventions. In the second year of the PIP, the MHP (1) used email communication for coordination between the Central Star social worker and a CMH case manager, rather than a call between many stakeholders, and (2) added a 7-day follow-up assessment and a short-term therapy (of four to six weeks) until transition to ongoing treatment with a designated

clinician. After four months of these two interventions (August 2017 – November 2017), the MHP has begun to realize a decrease in the readmission rate of unlinked youth (16.7 percent). The MHP credits the decrease to a warmer hand-off and connecting youth with services during the first week post discharge. The MHP continued the study for another five months (through March 2018), but the most recent data were not available at the time of the onsite review.

As the MHP continues the project, they should focus on fidelity and consistency in applying the interventions. The MHP changed the initial interventions because they were presumed not to be effective; however, the MHP did not consider the team's consistency in applying them. Did the daily coordination calls occur? Were all youth scheduled for an appointment within 14 days? Did all youth who no-showed receive home visits? Part of the efficacy of an intervention rests on regular application. The issue of consistency in implementation was discussed with the MHP as part of onsite technical assistance. This issue is presented, here, as an area of caution for the MHP. Per the discussion during the review, the MHP is using brief short therapy as an interim treatment for those awaiting ongoing service, however not all applicable youth are receiving it.

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 a review of their interventions and recommendation to include other indicators of outcomes, for example, (number/rate of) entry into care and retention in services. The MHP has invested in stabilizing access for youth such that acute services such as the hospitalizations are not as necessary. The MHP ought to capture the impact of this effort, which would be reflected in increased entry to services and increased number of youth who remain in care after a certain amount of time. The MHP was advised to also determine their benchmark for an acceptable readmission rate for unlinked youth.

Non-clinical PIP—Children Mental Health Outpatient Intake Process Re-design

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

"Will the intake process re-design and associated interventions increase initial mental health service request to first service within 14 calendar days by January 2019?"

Date PIP began: March 2018

Status of PIP: Active and ongoing

The purpose of this PIP is to decrease the time-to-initial assessment for youth (and families) who enter and seek MHP services. The MHP reported an average time of 40 days from first request for services to subsequent initial assessment, which exceeds their standard of 14 days. The MHP suspects that delayed intake causes some families to forego services (or drop off) and others to receive mismatched services. While foregoing services is a likely consequence for protracted wait

times, the MHP did not explain how delayed access contributed to mismatched services. The MHP identified a number of factors, labelled 'drivers', of delayed intake, including: the time or ease of completing required forms; flow of existing clients out of the system (thereby creating openings for new clients); and timing and ability to match services to families' needs. However, the MHP neither speculated on how much of an influence each driver had on the intake process nor presented evidence to substantiate their claim that these are drivers of delayed intake. This evidence would be helpful in determining where the MHP should direct their PIP efforts and what interventions to implement. The MHP presented four interventions and, as of the onsite review, had initiated two of them: 1) simplify the intake paperwork and 2) conduct same-day triage. The MHP's other two interventions were not actionable and require more detail and planning to implement. 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 (a discussion on) how to move the project forward. CalEQRO suggested that the MHP quantify (i.e., in days) the relationship between the drivers and the intake process. For example, if the MHP is suggesting that paperwork delays intake, the MHP should be able to articulate how many days it takes (for clients or staff) to complete the current documents. Per the MHP, insufficient number of staff to conduct assessments is an ongoing concern. CalEQRO suggested that the MHP consider flexible hours as a way to optimize the time of existing staff to enable more assessments.

PIP Findings—Impact and Implications

Access to Care

- The MHP recognizes that long wait times discourage entry into services. If successful, the non-clinical PIP will go a long way to increasing consumer access and retention in services.
- By coordinating post-hospitalization services, the MHP has increased access to services for youth who were previously unlinked to care.

Timeliness of Services

- The MHP has a considerable way to go to decrease the current average of 40 days to 14 days for initial assessments in CMH.
- The MHP has implemented brief therapy as a means to provide more timely services to youth who are discharged and awaiting ongoing clinical care.

Quality of Care

- The MHP believes that the non-clinical PIP will improve matching of services to consumer's' needs, but "matching" of services was not operationalized and was not monitored or measured.
- The MHP intimated that staffing played a significant role in timely intake; however, the MHP has yet to address staffing in the non-clinical PIP.
- When possible, the same clinician providing the brief therapy remains the youth's clinician. This facilitates continuity of care, which benefits youth who may experience instability and are sensitive to change.

Consumer Outcomes

- When consumers can rely on the MHP to consistently provide timely services, as is the aim for both the clinical and non-clinical PIPs, there is an increased potential for consumers to become more actively engaged in their own care.
- Neither of the PIPs had consumers or their representatives on the PIP teams. The MHP missed opportunities to receive input and feedback from those who experience delays in services or fragmented services, which contribute to consumer drop off.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 6: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PM
The MHP has focused on improving their capacity to provide culturally competent and culturally sensitive services to their consumer population. The MHP has invested in staff training, on topics such as cultural humility, gender identity, aging, and health equity among others, with the aim of establishing core standards for a culturally competent workforce. Staff were attuned to their underserved populations (e.g., the Hmong and African-American) and communities (e.g., Coalinga) and provided examples of MHP's efforts to outreach and increase access. The MHP's efforts have met with some challenges, and perceived stigma was cited as a barrier in ethnic communities. The MHP demonstrated use of data and improvement in data collection related to their consumer population; however, the MHP has not had the capacity to analyze what has been collected to then determine the effectiveness of some of the strategies used to improve accessibility.		
1B	Manages and adapts its capacity to meet consumer service needs	M
The MHP has monitored caseload numbers and flow to assess the types and numbers of practitioners and providers necessary to meet the needs of beneficiaries. It was this type of monitoring that led to expanded contracts with their contract providers, particularly those who serve rural areas of the County. The MHP has mitigated their shortage of psychiatric providers through increased use of telepsychiatry, and the MHP has explored privatization of existing psychiatrist services via potential agreement with the Central California Faculty Medical Group.		

In addition, the MHP has collaborated with University of California San Francisco-Fresno's forensic residency program as a pipeline for providers, and the MHP sponsored 15 primary care providers to attend a one-year training program on primary care psychiatry. The MHP also has made more use of tools, such as the Sisense dashboard, to capture and provide data on utilization and flow through their system of care. That said, the MHP has had more issues with access to services than they can solve with current resources and policies. Over the past year, the MHP experienced departure of a number of staff including the supervisor of Katie A. services and also ended a contract with one of their four service providers. The three remaining contract providers assumed care for the children and families, but staffing has not stabilized. The MHP reported that strategies like extra help staff or flexible hours were generally unavailable to them.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has developed a number of strong collaborative relationships with many county and community organizations. The MHP participated in several countywide initiatives, including a Housing Task Force, a Central Valley Opioid Safety Coalition, and the Suicide Prevention Collaborative. The MHP has leveraged the relationships from these collaboratives to facilitate other services for consumers. The fact that the Fresno Police Department took a unit that had been devoted to homeless issues and reassigned them to work with the MHP directly on a co-response crisis model affirms the collaboration and the importance of the program. The partnership with the school districts was another example of a robust collaboration. Over time, the MHP intends to embed clinicians in the schools; the clinicians will be hired by the school district and will have more access and availability to travel to other schools in the district. One type of collaboration that some stakeholders felt was lacking were those that would support consumers with co-occurring substance use disorders.		

Timeliness of Services

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

Table 7: Timeliness of Services Components

Component		Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	M
The MHP's standard was 30 days, which exceeds the standard used by most MHPs, but the MHP is moving toward the new standard of 14 days, and has used 14 days as their standard in the non-clinical PIP. Nevertheless, the MHP met their standard 96 percent of the time for adults and		

80 percent of the time for children, both an improvement from last year. The MHP has concentrated their efforts on initial access in the children's system of care, where they were more challenge with timely first appointments. School-based programs reported that they have a waiting list for individuals not yet receiving services. The MHP evaluated performance, but regular reporting and review did not appear to generate more timely corrective action or improvement activities.		
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PM
The MHP has set a 30-day standard for first psychiatric appointment and has met this 55 percent of the time for adults and 39 percent of the time for children. The MHP had some extremely long wait times, which the MPH explained were due to cases remaining open after consumers left the system and then returned, thus artificially increasing the average length of time. The difficulty the MHP has had in recruiting and retaining psychiatric providers remains the fundamental contributor to protracted time to first psychiatry appointment. The MHP has increased the use of telepsychiatry with contracted psychiatrists to increase access to psychiatric providers. While the MHP gathers and reports data on this metric, the frequency or depth of analysis did not permit them to identify and resolve outliers in the moment.		
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
The MHP set a reasonable standard of three days or less to an urgent appointment. They met this standard 98 percent of the time for adults and only 54 percent of the time for children, with a maximum range of 26 days compared to 13 days last year. The MHP is acutely aware of the need to improve access to urgent appointments for children and cited lack of child psychiatrists as a factor in poor showing for children's urgent appointment timeliness. It was not clear what the MHP had done specifically to address timely response to urgent conditions for children. The MHP referenced increased use of contract providers more generally.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP has tracked post-hospitalization appointments, but the standard of 30 days is high. The MHP's standard was met less than 50 percent of the time for adults and 66 percent for children. The MHP has a team that goes to hospitals weekly to consult on discharges, but this process was limited to certain hospitals. Communication with one local hospital was purported to be challenging and did not facilitate continuity of care after hospitalization. For children, the MHP added three clinicians to assist with assessment for youth post-PHF. The MHP also implemented a short-term treatment option of four to six sessions for youth discharged from Central Star PHF, as an interim service while awaiting assignment to a clinician for continuing services.		
2E	Tracks and trends data on rehospitalizations	M

The MHP reported rehospitalization rates of 24 percent for adults and 17 percent for children, respectively. As stated above, the MHP has focused on strategies to reduce rehospitalization of youth from the Central Star PHF, the primary PHF for youth.		
2F	Tracks and trends no-shows	M
The MHP has tracked no-shows over the past year for psychiatric providers (12 percent) and for clinicians (18 percent), both of which were below their standard of 20 percent. The MHP has developed a process in CMH to fill cancellations/no-shows, which enables them to optimize available time. The cancellation list is not captured in Avatar, which makes tracking more difficult and time consuming. (The clients on the list for filling cancelled appointments are kept in a spreadsheet). The MHP does not capture no-show data from all contract providers, but they stated that they intend to do so beginning in August 2018.		

Quality of Care

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

Table 8: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
MHP has been challenged with a long-term vacancy (four years) in the Quality Management (QM) Coordinator position. Although the functions of the coordinator have been assigned to others, this long-term vacancy has limited the coordination of QM with programs of the MHP. As an example, there are staff doing excellent quality improvement (QI) work in CMH, but they are not connected to the QM team who could support their work. Nevertheless, the QM team has an updated annual QI Work Plan that has measurable goals, an evaluation of the previous year's QI program, reporting requirements, improvement projects, and data collection and analysis. The MHP has established a foundation for QM and has continued to build the QM infrastructure. The MHP's focus is on strengthening the capacity of QM to become a value-driven organization by learning and deploying QI techniques (i.e., run-chart, flow chart, control charts, etc.). In July 2017, the MHP began training and receiving technical assistance on QM from the California Institute for Behavioral Health Solutions.		
3B	Data are used to inform management and guide decisions	M
The MHP's QM function collects, reports on, and uses data to monitor services and output. Managers and supervisors regularly used the Sisense dashboard and made decisions based on that information. The MHP has highly competent and creative staff who are interested in maximizing use of data. The changes in MHP's data capture and reporting seemed to rely on the force of a particular staff member's interests or passion, as opposed to a clear strategic direction reflecting system improvement goals. Because of this, there are some gaps in the data analytics capability.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
The MHP demonstrated inclusion and participation of their stakeholders in system planning, committees, and other initiatives. Of special note was the involvement of contract providers in all aspects of coordination, planning, problem-solving, and particularly the EQR itself. Supervisors felt that the MHP had made an effort to engage mid-level staff in decision-making. Line staff reported ongoing changes in the MHP and the need to re-adjust continuously, but they also reported hopefulness and belief in change for the better. The optimistic view was attributed in large part to feeling that they were part of the change and understanding why changes were happening. The MHP has made efforts to increase consumer representation at stakeholder meetings. Some focus group participants expressed difficulty in getting information about available services, particularly those without case managers.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
3D	Evidence of a systematic clinical continuum of care	M
The MHP evaluates their continuum of care and several examples were evidenced. The MHP has an initiative to educate and provide guidelines for board and care operators (and consumers) on providing safe and quality housing for vulnerable populations. The MHP sponsored training of primary care providers on primary care psychiatry. They have instituted several transition strategies to facilitate successful engagement in subsequent levels of care. For example, the MHP established the Outpatient Intensive Treatment program, a step-down program to receive consumers being discharged from inpatient or crisis services, to fill an identified gap in their continuum of care. In addition to measuring output and numbers served, the MHP's evaluations of programs would benefit from an analysis of outcomes and impact of the programs.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The MHP has begun a recovery-oriented approach with Reaching Recovery, which provides a client centered approach and a way to measure outcomes. The MHP conducted a survey last year to validate that they have staff at all levels of the organization who have lived experience of mental illness, either themselves or family members. Based on this completed survey, individuals with lived experience are represented in supervisory levels. Peer support staff reported that they feel supported in their roles. Peers expressed limited opportunities for advancement; the career ladder included only two levels and peers were doubtful that they would be hired into other positions within the department even if they were qualified. There continues to be a push for a greater number of positions that require or acknowledge lived experience and not just relying on an individual's self-identifying lived experience in their day-to-day interactions.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
The Blue Sky Wellness Center for TAY was described by youth participants as very helpful for their recovery. The programs and offerings at the Blue Sky Wellness Center for adults, which existed as a model for recovery, appears to have been curtailed partly due to political pressure—to not have so many consumers in the area where the center operates. Stakeholders reported a decrease in consumer involvement and consumer-run programs, and disappointment from reduced participation in beneficial programs.		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP has trained all staff on Reaching Recovery, a client oriented system designed to improve the consumer experience and improve outcomes. Reaching Recovery involves using		

Table 8: Quality of Care Components		
Component		**Quality Rating**
data collected as part of clinical documentation to inform decisions about level of care. The involvement of QM in Reaching Recovery was not apparent.		
3H	Utilizes information from Consumer Satisfaction Surveys	M
The MHP has participated in the statewide survey. Participants in the consumer/family member focus groups acknowledged receiving the satisfaction survey. They did not recall discussing the results. The MHP's analysis of the May 2017 survey showed 1980 consumers (10 percent of their consumer population) completed the survey. The MHP compared 2015 and 2016 finding to 2017, but not always the same months (i.e., March or November). As of May 2017, staff in QM incorporated the quality of life measures in their analysis of the consumer perception survey as a way to provide context and make meaning of the survey results. The MHP has also conducted their own Employment Engagement survey for staff; leadership has left follow-up and corrective action from the findings of this survey to managers/supervisors to resolve with their staff.		

Key Components Findings—Impact and Implications

Access to Care

- The MHP recognizes that there are multiple entries—and opportunities for entry—into the system of care and has established several partnerships (e.g., with governmental agencies, community collaboratives, and task forces) and fostered relationships to facilitate access.
- Sisense has provided the MHP with data on their consumer population and services, which the MHP did not have before, and the reporting capabilities of Sisense are likely to improve in the coming years.
- The MHP has not been able to utilize strategies such as extra help or flexible hours to increase their capacity, which would prove beneficial to providing access to children (and their caregivers), whose schedules may not permit appointments during the regular work day.

Timeliness of Services

- The MHP has improved their timeliness in some areas (e.g., first appointment), but has experienced further delays in others (e.g., urgent conditions for children and post-hospitalization follow-up for adults).

- As the MHP prepares to apply the more conservative standards for network adequacy, the MHP will need to be more vigilant with monitoring and evaluating their timeliness metrics along with implementing concurrent improvement activities.
- Delays in initial access to psychiatry have implications for refilling prescriptions, which have serious negative outcomes for consumers.
- As the strategy to decrease rehospitalization for unlinked youth is proving effective, the MHP might model it to reduce rehospitalizations for adults.

Quality of Care

- The MHP's QM has resources and capacity to support different programs and their initiatives; however, QM did not have a regular mechanism for interfacing with the programs, which delays efforts. QM support was provided only after the programs themselves sought assistance.
- The current QM function appears to be primarily compliance oriented; however, there was evidence of the MHP moving toward a QM structure that is the driver of important and systemic changes within the organization.
- As the Department of Behavioral Health has received approval for their plan for Drug Medical-Organized Delivery System, this positions the MHP to provide more options for consumers with co-occurring substance use disorders.

Consumer Outcomes

- The MHP's survey showed that individuals with lived experience are present in all levels of staffing.
- Peers endorsed that their work and role as helpers provides them much satisfaction.
- Reaching Recovery integrates client's own experience and affords clients the ability to reflect on their progress.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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 groups with 8 to 10 participants each, the details of which can be found in each section below.

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

Consumer/Family Member Focus Group 1

CalEQRO requested a culturally diverse group of adult beneficiaries, including African-Americans, who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group consisted of two African-American men and one African-American woman. Two identified as consumers and one identified as both a consumer and family member. The focus group was held at the West Fresno Regional Center.

Number of participants: 3

There were no participants who entered services within the past year.

General comments regarding service delivery included the following:

- The three consumers expressed that they were satisfied with the services that they received.
- One consumer had an interest in receiving more services, specifically case management, but the consumer was at a loss of how to obtain it.

Recommendations for improving care included the following:

- Return the Wellness Center to a more welcoming and supportive place (as it was in previous years).
- Assist consumers with their transportation needs.
- Provide a group to assist with managing frustration.

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

Consumer/Family Member Focus Group 2

CalEQRO requested a culturally diverse group of transitional age youth beneficiaries who are mostly new clients who have initiated/utilized services within the past 12 months. The group consisted mostly of young (between 18-24 years of age) male consumers. The youth identified as mostly Hispanic/Latino, but also included African-American/Black and Caucasian/White. The focus group was held onsite at the MHP's Sierra location.

Number of participants: 15

Participants described their experience as the following:

The six participants who entered services within the past year described their experiences as the following:

- Services were easy to access.
- There were no issues with psychiatry and case management and they were generally very satisfied.

General comments regarding service delivery included the following:

- The participants reported that they felt respected for who they are, and that their cultural needs were addressed. They felt that the therapists and case managers were effective in relating to young adults.
- Participants stated that they were at times reluctant to receive services because of their perceptions of mental illness.
- Participants reported having clear goals in treatment and volunteer opportunities.
- Participants used bus vouchers, but also received direct transportation assistance to get to treatment programs.

Recommendations for improving care included the following:

- Increase work on stigma reduction, as it is still hard to seek out services due to the stigma around mental health illness.

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

Consumer/Family Member Focus Group 3

CalEQRO requested a culturally diverse group of Latino beneficiaries, including adults and parents/caregivers of child/youth beneficiaries, who are mostly new clients who have initiated/utilized services within the past 12 months. Following the notification, the MHP requested

a focus group of older adult beneficiaries as this population of their consumers had not been surveyed in some time. CalEQRO accommodated this request and had a focus group of older adult consumers. The focus group included mostly English speaking, White adults who identified as consumers. A few more women attended than men. The focus group was held on-site at the MHP's Sierra location.

Number of participants: 14

The three participants who entered services within the past year described their experiences as the following:

- Services were mostly accessed through crisis, but immediately transitioned to appropriate levels of care including housing.
- Although there was some ambivalence for new consumers, all seemed engaged in services and satisfied with the services received.

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

- Participants endorsed receiving a variety of services including transportation, assistance with living situations, in addition to mental health services.
- Most participants reported they would call an older adult staff person if they needed help. Those in crisis in the last year felt that they had received the assistance that they needed.
- Participants reported that they participated in their treatment plans.
- Participants acknowledged availability of public transportation, but that there were still challenges given mobility with wheelchairs. There were also more transportation challenges in the remote areas of the county.

Recommendations for improving care included the following:

- Make the Blue Sky Wellness Center more welcoming and supportive.

Interpreter used for focus group 3: No Language(s): N/A

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Participants described mental health services as easy to find and access.

- Participants received a wide range of mental health services to meet their individual needs.
- Changes at the Blue Sky Wellness Center have been perceived by consumers as creating a less welcoming environment, which has led some consumers to reduce their use of the centers.

Timeliness of Services

- Timely services were generally provided to participants entering services in the last year.
- Despite the MHP's increase in time to respond to urgent conditions as reported on the Self-Assessment of Timely Access, consumers felt that when they entered the system of care through crisis services that they were transitioned quickly to the appropriate level of care.

Quality of Care

- Participants were generally very satisfied with the services they were receiving, particularly TAY.
- Although transportation assistance is available for many of the participants, there are still significant challenges for persons with mobility needs.
- Stigma is a concern and prevents or delays consumer's access to services.

Consumer Outcomes

- Most participants said they were engaged in their treatment planning and TAY reported having clear goals and volunteer opportunities.

INFORMATION SYSTEMS REVIEW

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

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

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

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

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	57%
Contract providers	39%
Network providers	4%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): 1.6 percent

The budget determination process for information system operations is:

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

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 2

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

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

- Telepsychiatry services are available with English and Spanish-speaking practitioners (not including the use of interpreters or language line): Not identified
- Approximately 3,106 telepsychiatry sessions were conducted in Spanish.

Summary of Technology and Data Analytical Staffing

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

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
11	2	1	1

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

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
1	0	0	0

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

- Technology support is currently allocated 11 FTE positions, two of which are new this FY, and one of which is vacant.
- The MHP Division Manager for IT continues to act as Manager for QI and Medical Records.
- Having an epidemiologist on staff is helpful for generating the kinds of reports necessary for identifying performance improvement activities.

Current Operations

- The MHP continues to use the Avatar application from Netsmart Technologies for their EHR system, which is remotely hosted by the vendor under an Application Service Provider contract.
- Avatar user trainings are available for hands-on experience in a test database. All courses are available for County and Turning Point employees. There are monthly Avatar training classes and a library of training videos. Some Avatar users stated that they did not feel adequately trained, especially when they started with the MHP.
- Contract provider and MHP Avatar users reported that the Avatar system freezes often, is slow to start, and sometimes "goes down" in the middle of an assessment or other documentation. Because the MHP does not log trouble calls and record resolutions, the MHP had no data to either confirm or contradict these user statements.
- There is no formal Avatar help desk and the MHP does not track Avatar trouble calls or the outcome of the calls. Avatar-related calls are handled by the IT group just as any other IT call.

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

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Avatar PM	Practice Management	Netsmart	7	Netsmart
Avatar CWS	EHR	Netsmart	7	Netsmart
Avatar OrderConnect	e-prescribing	Netsmart	7	Netsmart

Priorities for the Coming Year

- SUD Waiver Implementation
- Manage Service Organization Implementation
- EHR Expansion to Contracted Providers
- Implement Electronic Perscriptions of Controlled Substances
- Expand eLabs to all lab providers
- Develop IT Infrastructure for Training

Major Changes Since Prior Year

- Web Page Redesign
- 5150 Certification Tracking System developed and implemented
- Netsmart Contract Renewal
- Expanded Dashboard Reports

Other Significant Issues

- The lack of a dedicated IT manager position at the executive level is unusual in an organization of the size and complexity of the MHP. IT is essential to nearly every MHP function and can, with executive-level leadership, be a driver for change.
- At 1.6 percent of the budget devoted to IT, the MHP is constrained in how effectively they can take advantage of Avatar and the data collected through Avatar. The MHP's IT staff are doing good work (e.g., the well-implemented Sisense dashboard) within the limited resources. They are very selective about the projects they take on, which means other projects lie in wait because of resource limitations.
- The MHP has set up Avatar without linking appointment scheduling and documentation. This makes for a more complicated documentation process for clinicians and may limit the value of some Avatar reports that link kept appointments to documentation status.

Plans for Information Systems Change

- The MHP has no plans to replace the current system.

Current Electronic Health Record Status

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

Table 13: EHR Functionality					
		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	Avatar/Netsmart	X			
Assessments	Avatar/Netsmart	X			
Care Coordination				X	
Document imaging/storage	Netsmart	X			
Electronic signature—consumer	Netsmart	X			
Laboratory results (eLab)	OrderConnect	X			
Level of Care/Level of Service	Avatar/Netsmart	X			
Outcomes	Avatar	X			
Prescriptions (eRx)	OrderConnect	X			
Progress notes	Avatar/Netsmart	X			
Referral Management				X	
Treatment plans	Avatar/Netsmart	X			
Summary Totals for EHR Functionality:		10		2	

Progress and issues associated with implementing EHR over the past year are discussed below:

- The MHP continues to move contract providers onto Avatar or onto a data sharing capability. Progress has been slower than anticipated, primarily because of resource constraints and competing priorities for both the MHP and the contract providers.
- There are some basic functions that could be migrated over to Avatar that would streamline workflow. For example, the schedule is not linked to documentation, which means that line staff keep track of their schedules in a different place and the MHP does not have visibility into all services scheduled.
- The implementation of the Netsmart MSO as part of the MHP Avatar system will facilitate the exchange and loading of electronic claims files from the contract providers. This is a necessary next step towards greater electronic data exchange.

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

☐ Paper ☒ Electronic ☐ Combination

Personal Health Record

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

☐ Yes ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SD/MC claims.

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

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
290,736	$61,823,982	**6,530**	$1,437,751	2.33%	$60,386,231	$1,204,075	$59,182,156

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017.
The statewide average denial rate for CY2016 was 4.48 percent.
Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.

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

Table 15: Fresno MHP Summary of CY16 Top Three Reasons for Claim Denial

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Other coverage must be billed prior to submission of this claim	2,778	$595,216	41%
Service Facility Location provider NPI not eligible	1,204	$291,215	20%
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	1,045	$245,377	17%
Total Denied Claims	6,530	$1,437,751	100%

- Denied claim transactions with reason "Other coverage must be billed prior to submission of this claim" and "Service Facility Location provider NPI not eligible" are generally re-billable within the state timely claim resubmission guidelines.

Information Systems Review Findings—Implications

Access to Care

- Data analysis on penetration rates provided by IT/QM helped the MHP to obtain approval from the Board of Supervisors for Turning Point of Central California, Inc. to expand services in rural areas.

Timeliness of Services

- IT and QM worked jointly to explore access and timeliness for adults and children in outpatient services. Based on these findings, the MHP identified timeliness to initial services as a PIP for FY17-18 for CMH. The MHP has planned a redesign of the intake process.

- Staff reported using a mix of Avatar scheduling, Outlook calendar, and hardcopy calendars for their scheduling needs. To the extent that clinical events are not being calendared in Avatar, it prevents the MHP from getting a comprehensive picture of timeliness of service delivery from Avatar data.

Quality of Care

- Staff felt that that the Avatar training was not adequate. More frequent, robust trainings will help to ensure that documentation is of high quality.

- While not directly related to IT, the absence of a QM Coordinator limits the capacity of IT and QM to identify priorities for data analysis and identification of performance improvement activities. The MHP hired a consultant to assist with this role and the recommendation was to explore HCBs for a future PIP.

- The MHP's IT unit, while limited in size, is making progress on significant issues facing the MHP. One of the keys to their success is being selective about the projects they take on and maintaining focus on those projects until they are delivered successfully, and then moving on to the next priority. The Sisense dashboard is an example of a project of a scale they could address with their existing resources, which will have system-wide importance and impact for years to come.

Consumer Outcomes

- Reaching Recovery includes an outcome tool administered at intake and every six months thereafter, that measures an individual's own attitude about their recovery. It is being used in establishing level of care, and as a measure of progress and outcomes. The MHP is

encouraging contract providers to begin using Reaching Recovery. There is not, as of this review, sufficient outcomes data for it to be informative about MHP-level outcomes, but this is expected by the next review.

- Three outcome measures and screening tools, the Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder 7-Item (GAD-7) and Primary Care-Post-Traumatic Stress Disorder, have console widgets in Avatar (client view), and DBT and Cognitive Behavioral Therapy (CBT) for Psychosis have widgets to view client enrollment. Trauma-focused DBT is tracked manually and submitted elsewhere for analysis.

SITE REVIEW PROCESS BARRIERS

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

- No barriers were encountered during this review.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- The MHP has the ability to increase contracting with Turning Point and other contract providers to expand services in the rural areas of Fresno County.
- The MAP program is part of an integrated and focused effort to provide services to rural areas and underserved communities with chronically low penetration rates.
- The MHP has been creative and resourceful in its effort to address the shortage of psychiatric providers (e.g., the residency program collaboration with UCSF-Fresno).

Opportunities:

- It remains to be seen if penetration rates can be substantially improved, and timeliness standards met, consistently over time pursuant to the expansion of the Turning Point contract and the MAP initiative.
- Standard 9a.m.-5p.m. service delivery hours can be a barrier to access and engagement in treatment. The MHP is not able to use, or only in a limited capacity, strategies like extended hours, which would improve access and timeliness to services in CMH.
- The lack of a permanent medical director and full staffing for psychiatry, especially child psychiatrists, undermines access to care, timeliness of services, quality of care, and outcomes of care.
- Transportation, because of the considerable distance involved for some individuals, continues to be a constraint on access to care.

Timeliness of Services

Strengths:

- The MHP has used the PIPs as a mechanism to improve timeliness for CMH.
- The QM department has the ability to produce reports and to drill down and investigate various components of timeliness.

Opportunities:

- The MHP's evaluation and investigation into timeless did not occur contemporaneously, which limits the ability to implement concurrent corrective action to resolve the delay or potential reporting error.
- Field-based clinicians reported that they must check out a vehicle each morning and check it back in at the end of the day even if they will need a vehicle for the entire week. This shortens the portion of the day available for service delivery.
- Despite the improvements in post-hospitalization follow-up rates, the rates remain below the State average and rehospitalization rates have increased.

Quality of Care

Strengths:

- This is an organization that knows what its challenges are; has (at least in general terms) a plan to address them; and, makes thoughtful decisions about the order in which they will apply their limited resources; all of which bode well for delivering care that is continuously focused on quality. There were very few issues that came up during this review, of which the MHP was not already aware.
- The MHP has an epidemiologist on staff who can provide trend reports and data analysis.

Opportunities:

- The Quality Management Coordinator position, an essential leadership position, has been occupied for only 10 months over the past four years. Certification appears to be an unduly prerequisite that has reduced the MHP's ability to fill the vacancy.
- The productivity rate for MHP clinicians, as measured by claimable services delivered, averaged 34 percent. This was a strikingly low number for an organization that otherwise presented as self-aware and capable.
- The reported co-occurring disorders rate of 12 percent is not considered reliable by the MHP, and they are addressing the documentation issues at the root of this perceived under-

reporting. As the MHP moves towards implementation of the Drug Medi-Cal Waiver during FY 18-19, it is essential that co-occurring disorders documentation be accurate.

- The MHP missed opportunities to receive input and feedback from those who experience delays in services or fragmented services by not including consumers and family members in the PIP committees.

Consumer Outcomes

Strengths:

- The comprehensive use of Reaching Recovery, including contract providers, should provide the means to look broadly at the effectiveness of MHP programs.

Opportunities:

- With only two levels, the MHP has limited career options for peers and the MHP does not appear to formally promote the transition of peers to other available positions in the MHP.

Recommendations

- Show regular, either monthly or quarterly, monitoring and evaluation of timeliness in the Access or Outcomes Committees and be able to identify/distinguish outliers from the average time to services. As necessary, review cases open for longer than 90 days (or some other fixed timeframe) with no activity to determine if the cases should be closed.
- Calculate penetration rates and monitor timeliness of service delivery in the rural areas, relative to the efforts (e.g., Multi-Agency Access Program) to increase access. (This recommendation is carried over from last year).
- Initiate a log that records both trouble/problem calls with the Avatar system and the resolution to the call, and monitor the log monthly to identify trends and potential threats to system.
- Hire an individual with the skills necessary to manage a quality improvement program and, if certification is still deemed necessary, make it a condition of employment within a fixed period.
- Pilot the use of flexible staff hours for those employees delivering services to children.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

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

Attachment A—On-site Review Agenda

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

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

Attachment B—Review Participants

CalEQRO Reviewers

Ewurama Shaw–Taylor, PhD, Lead Quality Reviewer
Maureen Bauman, 2nd Quality Reviewer, Drug Medi-Cal
Robert Greenless, IS Reviewer
Melissa Martin-Mollard, PhD, IS Reviewer, Drug Medi-Cal
Tilda de Wolfe, Consumer/Family Member Consultant
Michael Hutchinson, Quality Reviewer, Drug Medi-Cal Reviewer

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

Sites of MHP Review

MHP Sites

Fresno Department of Behavioral Health
1925 E. Dakota Avenue
Fresno, CA 93726

Contract Provider Sites

West Fresno Regional Center
142 E. California Street
Fresno, CA 93706

Poverello House
412 F. Street
Fresno, CA 93706

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Ammonds	Keisha	Staff Analyst	Department of Behavioral Health (DBH), Personnel
Anderson	Kathy	Principle Analyst	DBH, Contract-Substance Use Disorder (SUD)
Arevalo	Milagro	Senior Licensed Mental Health Clinician	DBH, Quality Improvement (QI)
Arkelian	Brian	Clinical Supervisor	DBH, Clinical Team
Armistead	Natalie	Clinical Supervisor	DBH, Intensive Outpatient Treatment
Avila	Magdalena	Social Worker Supervisor	DSS, SB 163 Wraparound
Balto	Adam	Senior Substance Abuse Specialist	DBH, SUD
Bamford	Marilyn	Executive Director	Uplift Family Services
Banks	Ryan	Deputy Regional Director	Turning Point of Central California (TPOCC)
Boyd	Karla	Clinical Supervisor	DBH, School Based Team
Bravo	Minerva	Supervising Office Assistant	DBH, Children's Outpatient
Brown	Betty	Division Manager	DBH, Managed Care
Canosa	Pablo	Clinical Director	Central Star, Psychiatric Health Facility
Castro	Gleyra	Clinical Supervisor	DBH, Children's Outpatient
Cochran	Alice	Unlicensed Mental Health Clinician	DBH, RISE Program
Dewey	Robert	Sergeant	Fresno Police Department
Dresser	Karyn	Director Research & Program Practices	Central Star

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Elliott	Jeffrey	Epidemiologist	DBH, QI/Information System Decision Support (ISDS)
Emmerson	Tracie	Supervising Accountant	DBH, Business Office
Enlow	Alyssa	Unlicensed Mental Health Clinician	DBH, Urgent Care Wellness Center (UCWC)-Mobile Access
Erwin	Sharon	Senior Staff Analyst	DBH, Contract-SUD
Escobar	Oscar	Program Technician	DBH, B.O.
Escobedo	Francisco	Senior Staff Analyst	DBH, QI
Evans	Carolyn	Chair	Behavioral Health Board
Fitak	Carla	Peer Support Specialist	DBH, Older Adult Services
Flores	Lesby	Division Manager	DBH, Children Mental Health
Flores Becker	Amina	Division Manager	DBH, Administration
Gibney	Trin	Peer Support Specialist	DBH, UCWC
Gomez	Cecilia	Licensed Mental Health Clinician	DBH, Child Welfare Mental Health
Gomez	Gabe	Senior Licensed Mental Health Clinician	DBH, QI
Gordon Browar	Jolie	Clinical Supervisor	DBH
Hernandez	Juan	Unlicensed Mental Health Clinician	DBH, Child Welfare Mental Health
Hollander	Scott	Chief Operating Officer	TPOCC
Holt	Susan	Deputy Director, Clinical Operations	DBH, Administration
Houngviengkham	Bai	Senior Staff Analyst	DBH, Administration
Ikner	Farisa	Law Enforcement Field Clinician	DBH, Adult System of Care (ASOC)
James	Noelle	Clinical Director	Uplift Family Services

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Jimenez	Dalila	Unlicensed Mental Health Clinician	DBH, Children's Outpatient
Kemble	Norton	Dual Recovery Peer	Mental Health Systems
Kent	Brenda	Regional Behavioral Health Director	Kings View
Krioghlian	Tamar	Unlicensed Mental Health Clinician	DBH, Adult Clinical
Kuoch-Seng	Jefferson	Systems and Procedures Analyst	DBH, ISDS
Le	Maryann	Deputy Director, Business Operations	DBH, Administration
Lemon	Cindy	Medical Records Coordinator	DBH, Medical Records
León	Sarah	Staff Analyst	DBH, QI
Lewis	Okie	Staff Analyst	DBH, Contract-SUD
Lucas	Les	Clinical Supervisor/UR-Rural Triage	Kings View
Madrid	Felicia	Family Partner	Uplift Family Services
Maguire	Cathy	Unlicensed Mental Health Clinician	DBH
Mann	Heather	Peer Support Specialist	DBH, RISE Program
McIllwain	Joshua	Staff Analyst	DBH, Contract- Mental Health
Miller	Michael	Senior Systems and Procedures Analyst	DBH, ISDS
Monreal	Ana	Program Director Fresno CSC	Exodus Recovery Inc.
Moreno	Karla	Peer Support Specialist	DBH, Perinatal Wellness Center
Munde	Michelle	Director of Quality and Compliance	Central Star
Muro	Mike	Senior Staff Analyst	DBH, Contract-Mental Health
Nelson	Sandra	Utilization Review Specialist	DBH, Compliance

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Nguyen	Sue Ann	Program Technician	DBH, QI
Ochoa	Ricardo	Supervising Account Clerk	DBH, Business Office
Ornelas	April	Community Mental Health Specialist	DBH, Youth Wellness
Patterson	Sean	Business Manager	DBH, Business Office
Pettengill	Natasha	Technical EMR Systems Analyst	TPOCC
Piritu	Dathan	Director of Nursing	Central Star
Puente	Tanimara	Senior Staff Analyst	DBH, Business Office
Quach	Tan	Systems and Procedures Analyst	DBH, ISDS
Ramirez	Leonard	Peer Support Specialist	DBH, Housing-Trinity
Rangel	Joseph	Division Manager	DBH, Contract Services
Reece	Melissa	Senior Admitting Interviewer	DBH, Children's Outpatient
Rexroat	Kathy	Clinical Supervisor	DBH, Managed Care
Reyes	Analinda	Office Assistance	DBH, QI
Reyes	Diana	Community Mental Health Specialist	DBH, Children's Outpatient
Reyna	Vanessa	Admitting Interviewer	DBH, Children's Outpatient
Ritchie	James	Workforce Education & Training Coordinator	DBH, Personnel
Rivas	Gilberto	Program Manager-Rural Triage	Kings View
Rodriguez Perez	Cesar	Staff Analyst	DBH, Contract-SUD
Rojas	Aimie	Clinical Supervisor	DBH, Youth Wellness
Romero	Jorge	Clinical Supervisor	PATH Program
Ross	Sharon	Regional Director	TPOCC
Ruelas	Stephanie	Accountant	DBH, Business Office

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Sahai-Bains	Sonia	Clinical Supervisor	DBH, UCWC-Mobile Access
Sanghera	Preet	Principle Analyst	DBH, Contract-Mental Health
Schmidt	Debbie	Licensed Mental Health Clinician	DBH, School Based Team
Schneider	Beth	Chief Supervising Office Assistant	DBH, Clinical Program Support
Schreiber	Chris	Utilization Review Specialist	DBH, Contract-SUD
Seidel	Jennifer	Program Director	Central Star
Stroup	Mark	Unlicensed Mental Health Clinician	DBH, Children's Outpatient
Tamayo	Domenica	Senior Staff Analyst	DBH, Clinical Program Support
Tan	David	Assistant Program Director	TPOCC
Tobias Gatewood	Deborah	Senior Administrator	Central Star
Toonnachat	Kannika	Division Manager	DBH, QI/Information Technology (IT)/Medical Records
Toscano	Marco	Senior Admitting Interviewer	DBH, Operations
Utecht	Dawan	Director of Fresno County DBH	DBH, Administration
Vanbruggen	Stacy	Division Manager	DBH, ASOC
Vang	Blia	Senior Accountant	DBH, Business Office-Finance
Vang	Sue	Staff Analyst	DBH, Contract-Mental Health
Vargas	Emily	Personal Service Coordinator Supervisor	TPOCC
Vasquez	Elizabeth	Compliance Officer	DBH, Compliance
Vasquez	Joyce	Clinical Supervisor	DBH, School Based Team

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Vasquez	Valerie	Program Technician	DBH, Child Welfare Mental Health
Vaughn	Michelle	Licensed Mental Health Clinician	DBH, Child Welfare Mental Health
Velasquez	Victoria	Peer Support Specialist	DBH, Housing- Santa Clara
Weaver	Lisa	Staff Analyst	DBH, Contract-SUD
Wells	Michelle	Licensed Mental Health Clinician	DBH, Child Welfare Mental Health
Wilbur	Katie	Vice President	Mental Health Systems
Winslow	Mark	Systems and Procedures Analyst	DBH, ISDS
Xiong	Ghia	Program Director, Living Well Program	Fresno Center for New Americans
Xiong	Mee	Staff Analyst	DBH, Contract-Mental Health
Xiong	Pa Ge	Staff Analyst	DBH, QI
Xiong	Zia V.	PHF Clinical Director	Exodus Recovery Inc.
Yee	Diana	Managed Care Coordinator	DBH, Managed Care
Zavala	Michelle	Administrative Director	California Psychological Institute

Attachment C—Approved Claims Source Data

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

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

Table C1: Fresno MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	$611,752,899	$4,310
Large	169,682	6,893	4.06%	$24,129,185	$3,501
Fresno	116,979	4,667	3.99%	$21,234,983	$4,550

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

Table C2: Fresno MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	18,289	96.04%	94.05%	$53,060,611	$2,901	$3,612	64.68%	59.13%
>$20K - $30K	363	1.91%	2.83%	$8,812,566	$24,277	$24,282	10.74%	11.98%
>$30K	392	2.06%	3.12%	$20,156,834	$51,420	$53,215	24.57%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Fresno	
PIP Title: Improving Care Coordination and Timeliness of Post-Hospital Follow-up	
Start Date (MM/DD/YY): 10/31/16 **Completion Date** (MM/DD/YY): Ongoing **Projected Study Period** (#of Months): 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 3/20-22/18 **Name of Reviewer**: Shaw-Taylor & Bauman	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP was to improve care coordination and communication between the PHF and post-discharge providers and provide more timely follow-up to youth not otherwise linked to ongoing mental health services prior to the inpatient admission.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team included staff of CMH, Central Star, IT, and QI. The team reported only indirect input from consumers or their parent/caregivers or peers, from a survey or from clinician notes (e.g., that documented reasons why a youth no-showed).
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The team provided data on readmission rates for unlinked youth in2016, at 19.5 percent. However, the PIP team did not provide a context for the rate or a comparison to some other standard. With rates as high as 40 percent in one month and 25 percent in several months, a rate of 19.5 percent would appear to be reasonable.
Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☒ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The team stated that readmission rate is a standard measure of care. The project is meant to connect unlinked youth to ongoing care, thereby facilitating continuity and consistent access to services. Ultimately, the project may improve youth's engagement in services.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The project includes all enrolled populations to whom the issue is applicable.
	Totals	**2** Met **2** Partially Met **0** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the 30-day readmission rate decrease with improved care coordination, communication, and more timely post CSYPHF follow-up on the youth not linked to treatment prior to the CSYPHF admission by Fresno FMHP's outpatient program managed by Fresno County DBH.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is clear and has measurable impact, although the specifics (goals/targets) were not provided.
Totals		**1** Met **0** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☒ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP identified to whom the study question is relevant—youth who are discharged from Central Star and were unlinked to Medi-Cal mental health services at time of admission.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data collection is through the EHR, which would be able to capture all applicable enrollees. The PIP team identified that unlinked youth made up 39 percent of admissions to Central Star.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. The percentage of unlinked clients who were readmitted within 30 days 2. The percentage of unlinked clients who received follow-up within 14 days of discharge 3. The percentage of unlinked clients who received follow-up within 7 days of discharge 4. Post Discharge FCDBH CMH Assessment no-show and cancellation	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study included four measurable indicators; however, many more indictors are necessary. These indicators were also suggested to the MHP last year (e.g., the number of youth or their caregivers that responded to and confirmed their follow-up appointments; the number of youth who were assisted with addressing barriers after the missed follow-up appointment). There were no indicators to correspond to the new intervention—providing short-term (four week) therapy until youth was transitioned to a treatment team. Process indicators (e.g., the number of home visits following a missed appointment) were lacking.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators measured change in health and functional status.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
	Totals	**0** Met **0** Partially Met **0** Not Met **3** NA **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	Of the indicators and outcomes stated, the MHP had the relevant data.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Avatar and PHF data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The sources of data were indicated.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Data collection depended on reporting from Avatar and Central Star's systems. While Avatar data was available within 5 days of service, Central Star's system took 4-6 weeks to generate. Given the time sensitive nature of the project, and the need to intervene before 30 days, waiting 4-6 weeks after service entry put the team at a disadvantage. The PIP team ought to have used another method of capturing data, perhaps by a dedicated person/PIP team member at Central Star. At some point in the study, the team realized that they had confounded some of the linked youth with unlinked youth. This mix-up however was not discovered until several months after the fact, despite purported monthly review.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Given the issues mentioned above, there was room for error or variation with the data collection instruments or strategy.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The PIP team provided a basic plan for data review, but not data analysis. Monthly reviews were indicated, but the timeframe for comparison (e.g., from month to month, quarter to quarter, etc.) were not indicated. The team did not include contingencies for untoward results.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: <Text> Title: <Text> Role: <Text> *Other team members:* Names: <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	The staff for data collection were not indicated, but presumably are the QM analysts.
	Totals	**2** Met **2** Partially Met **1** Not Met **1** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Daily conference call 2. Schedule a follow-up assessment appointment within 14 days 3. Visits a client's home if a client missed the first follow-up assessment appointment 4. Gather client demographic information and pertinent with a follow up with email throughout the day 5. Schedule a follow-up assessment appointment within 7 days and follows by a short-term 4 weeks therapy until transition to a clinical team at week 5	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	MHP indicated two interventions with sub-interventions. These have been divided into five interventions by this CalEQRO reviewer. As written, Intervention 4 is not clear.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	See 6.5. The time frame reverts to the beginning of the PIP when it should be the point of the new intervention, to be consistent with a PDSA cycle.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team provided findings by month, showing changes in admission of unlinked youth and their readmission rates after the start of the interventions.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: __monthly_____ Indicate the statistical analysis used: _____None_____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	No analysis plan was indicated, but repeated measures were used. The PIP team calculated percent change from month to month and an overall rate since the intervention.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The team interpreted the results they have so far. The team is only now beginning to see a decrease in the rate of readmission.

	Totals	**2** Met **1** Partially Met **1** Not Met **0** NA **0**UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The project is not yet complete.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The project is not yet complete.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The project is not yet complete.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The project is not yet complete.

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The project is not yet complete.
Totals		**0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

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

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

Conclusions:

The MHP reported a small improvement in the readmission rate (improved by 2.7%) and attribute this to the warm hand-off, by case managers, and brief therapy. The current follow-up also provides unlinked youth with resources and information to access services in the future. The MHP will continue to the study to further assess rehospitaliztion and linkage to ongoing services.

Recommendations:

Include a measure on new/open youth cases

Include a measure on routine access to outpatient care

Determine a benchmark for readmission rate for unlinked youth

Check one:

☐ High confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☐ Confidence in PIP results cannot be determined at this time

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Fresno	
PIP Title: Children Mental Health Outpatient Intake process Re-design	
Start Date (MM/DD/YY): 03/01/18 **Completion Date** (MM/DD/YY): 02/28/19 **Projected Study Period** (#of Months): 12 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 03/20-22/18 **Name of Reviewer**: Shaw - Taylor	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP's current children's mental health (CMH) outpatient intake process requires families to wait over 30 days before receiving services, causing some families to drop out and other families to receiving mismatched services. The MHP's goal with this PIP is to reduce the time from initial request to the first service through a re-design of their intake process.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team included MHP staff, particularly those from CMH and many of whom are directly involved in intake at CMH outpatient. The team also included QM analysts to support the project. The PIP team did not include family/consumer representatives, which would have been helpful as one of the purported drivers of the problem was family resources and supports.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	MHP provided data on intake: the average time to intake over a three-year period and the average time to intake over the last 1.5 years. The MHP averaged 40 days to assessment, well beyond the standard of 14 calendar days. The MHP also included a flow chart of the intake process. The MHP identified a number of drivers of the delay to intake, but did not provide corresponding data on how (much) they contribute to delays. Knowing the contribution of these drivers should influence where the MHP direct their interventions.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☒ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Through this PIP, the MHP has the potential to increase retention and ongoing engagement in services. Improved timeliness might also contribute to increased consumer satisfaction with CMH.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The project targets youth (and their caregivers) who seek new services at the MHP. The project is limited to the county-run CMH outpatient clinic.
Totals		**1** Met **3** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the intake process re-design and associated interventions increase initial mental health service request to first service within 14 calendar days by January 2019 [by 80% of new youth and family clients]*?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question has a measurable target, but the interventions—the re-design—are not specifically stated. The part in brackets was stated elsewhere in the PIP document, but was not put in the study question.
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP indicated that CMH outpatient is the main entry point of service for youth seeking mental health services. By being the "main", it suggests that there are other entry points for youth. The MHP did not address these other entry points and the impact of their processes, however minimal, on timeliness.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP will use the EHR, Avatar, to capture data on all youth enrollees.
Totals		**1** Met **1** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Initial service to first scheduled service average days 2. Initial service request to first kept service days rate 3. No-Show and cancellation rate 4. [Percent of] children (non-urgent) mental health request resulted in scheduled service within 14 days	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators 1, 3, and 4 are clear and measurable. It is not clear what the MHP intends to measure with indicator number 2. While it is important to track that services are scheduled timely, it is also important for the MHP to know more immediately when services are not scheduled as they should be. Rather than indictor 4, which is the same as the outcome, the MHP would need to know that services are not scheduled within 14 days and the frequency this occurs. This indicator would provide the MHP with an opportunity to make a change in their process.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators measure change in process, which affects the consumer's functional status—awaiting services or actively receiving services and, ultimately, engaged in services.
Totals		**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	No sampling.
	Totals	**0** Met **0** Partially Met **0** Not Met **0** UTD **3** NA
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is tracking the times from requests for services to scheduled services, to kept services, and for no-shows and cancellations.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: EHR, Avatar	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data source is the EHR.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The EHR ought to provide valid and reliable data. Presumably the data collection (EHR reports) will be performed monthly consistent with the frequency of review and analysis by the PIP team.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: EHR, Avatar	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The EHR ought to generate consistent data.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP reported monthly review and analysis of indicators, but did not indicate what the analyses were. The MHP is using a Plan-Do-Study-Act process, which would enable them to address untoward results; however, the MHP did not speculate on untoward results or how they would address them. The MHP does not have a prospective data analysis plan.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Francisco Escobedo Title: Senior Staff Analyst Role: PIP Facilitator *Other team members:* Names: Jeff Elliott Jefferson Kuoch-Seng SueAnn Nguyen	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP identified four staff as responsible for the data collection and analysis. Their roles are in analysis, collection, and data development.
	Totals	**5** Met **0** Partially Met **1** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Simplify intake paperwork to lessen the days needed to start the assessment 2. Timing and ability to match service family's need, including hours of operation, language, and therapeutic support 3. Staffing to meet the initial request volume 4. Conduct same day triage process	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has provided four interventions. Of this list, intervention 1 and 4 are actionable. Interventions 2 and 3 are factors that contribute to delayed intake (e.g., not having enough/adequate staff to meet the need) and do articulate improvements. While intervention 1 is actionable, it is not specific. The term "simplify" is vague and does not indicate what the MHP will actually do to decrease the intake process.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the project.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the project.

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

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the project.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the project.
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	The MHP is not at this stage of the project.
	Totals	**0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD

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

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

Conclusions:

<Text>

Recommendations:

As the MHP has not produced results from the study, there are no recommendations related to the overall validity and reliability of the study results. Recommendations for the project were included in the validation and in the PIP section of this report.t

Check one:

☐ High confidence in reported Plan PIP results

☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time