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# FY 2018–19
# MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

## MENDOCINO MHP FINAL REPORT

Prepared for:

**California Department of Health Care Services (DHCS)**

Review Dates:

**August 7-8, 2018**

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# 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 Organizations (MCOs) 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 Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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 fiscal year (FY) 2018-19 findings of an EQR of the Mendocino MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

## MHP Information

MHP Size — Small

MHP Region — Superior

MHP Location — Ukiah

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 2,224

MHP Threshold Language(s) — Spanish

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

## 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 and other additional PMs defined by CalEQRO.

## Performance Improvement Projects[2]

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 reviewed in detail later in this report.

## MHP Health Information System Capabilities[3]

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

## Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary 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:

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

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders 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.calegro.com.

# PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

## Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings 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 FY 2017-18

**Recommendation 1:** Track, monitor, and implement activities to improve timeliness between request for psychiatric services and initial appointment to meet the new established standards.
(This recommendation is a carry-over from FY 2016-17.)

Status: Met

- The MHP set and strived to meet a new timeliness standard of 15 business days (from 30 days) for first psychiatric appointment from first request for services. With this more conservative standard, overall, the MHP averaged 11 business days to psychiatric appointment and achieved an overall compliance of 71 percent, compared to an average of 23 days and 77 percent compliance reported in the previous year.
- The MHP credited a number of changes to the improvement in time to psychiatry.
    - The first change was the transition of medication services from the MHP to Redwood Quality Management Company (RQMC), their administrative service organization (ASO). RQMC has a full complement of psychiatric

providers and nursing staff, which enables regular provision of psychiatric services.

  - Second, RQMC uses a scheduling process that maximizes beneficiaries' opportunity for appointments. Additional appointment slots are given on the same day, recognizing that no-shows might occur.

  - Third, RQMC uses or reserves some crisis slots for psychiatric services when needed.

- The MHP acknowledged that the time to psychiatry for children lags that of adults (an average of 14 days versus eight days). The challenge has been the hiring of psychiatric providers for children. The MHP continues to recruit as well as use the other means, as above, to provide psychiatric services for children.

**Recommendation 2:** Continue building linkages for coordination of care with primary care providers for bi-directional transitions.

Status: Met

- The MHP and RQMC hold several regular meetings with community agencies, including primary care providers. The MHP reported weekly conference calls with clinics to discuss and follow-up on referrals to and from these clinics to SMHS.

- The MHP, through Mendocino County's Health and Human Services Agency (HHSA), is one of the entities in the Whole Person Care Pilot that will facilitate linkages to primary care providers.

In addition to primary care providers, the MHP reported strengthened relationships with other community agencies, in particular, law enforcement and jails.

**Recommendation 3:** Investigate the feasibility and use of dashboard software and incorporate products to automate data for clinical quality improvement projects across the system of care.

Status: Met

- The MHP reported that their EHR, Exym, is capable of producing automated standard and customizable reports and dashboards.

- In July 2018, RQMC created customized dashboards for contract providers' clinicians, supervisors, and managers to monitor clinical operations through Exym. Dashboards will be directly accessible to Exym users. Users will be able to filter by date range, patient and program status, as well as by specific beneficiary and/or provider. The MHP, RQMC, and contract provider can use the dashboards to monitor, manage, and report on delivered services.

- Exym dashboards are being set up for MHP quality improvement/assurance (QI/QA) staff for monitoring and compliance purposes.

- The MHP is in the test phase of using Periscope, a feature/application that enables drop-downs to capture more detail on beneficiary data.

To monitor and report on billing and fiscal operations, the Avatar system uses data dashboard (i.e., widgets) to display graphs, lists, or speedometers for MHP staff.

**Recommendation 4:** Identify a service partner and explore a health information exchange (HIE) pilot project using statewide HIE standards that can be readily expanded across the system of care.

Status: Met

- RQMC manages Exym and provides training and support to/for the six contract providers. RQMC is configuring Exym to facilitate HIE for contract providers. This allows for the sharing of beneficiary records among providers that serve the same beneficiaries.

- There are plans to extend Exym to other local healthcare organizations. A Memorandum of Outstanding (MOU) is being developed that includes the MHP, RQMC, and Alliance of Rural Community Health—a consortium of six behavioral health and medical clinics located in Boonville, Fort Bragg, Gualala, Laytonville, and (two in) Willits. All three parties will be Covered Entities as defined by Health Information Portability and Accountability Act (HIPAA) and agree to use and disclose protected health information (PHI) only as required or permitted by law, for treatment, payment, and health care operations.

- Having one EHR system permits a single beneficiary treatment plan that includes services provided by multiple providers. Providers will have access to all clinical data and be able to coordinate care more effectively.

**Recommendation 5:** Continue to expand current efforts to operationalize the level of service/level of care protocols for clinical and executive levels to provide appropriate consumer treatment across a continuum of care.

Status: Met

- The MHP uses the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) as their outcome measures for children and adults, respectively. The MHP has a scoring guide that determines the level of services appropriate for the beneficiary. The guide includes a risk assessment, identifies placement options, and types of service activities and hours per month needed to support the beneficiary relative to their symptoms and impairments.

- Clinicians and clinical supervisors endorsed the use of the CANS and ANSA as required; however, they cited variability in the results. Given this variability, CANS and ANSA were not relied on solely to determine beneficiary level of care and outcomes.

The MHP and RQMC will need to move from the CANS to the CANS-50 to meet DHCS-MHSUDS Information Notices 17-052 and 18-007.

# PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (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.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

## Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). 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 details on beneficiaries served by race/ethnicity.

| Table 1: Mendocino MHP Medi-Cal Enrollees and Beneficiaries Served in CY 2017, by Race/Ethnicity | | | | |
|---|---|---|---|---|
| **Race/Ethnicity** | **Average Monthly Unduplicated Medi-Cal Enrollees** | **% Enrollees** | **Unduplicated Annual Count of Beneficiaries Served** | **% Served** |
| White | 22,333 | 52.5% | 1,309 | 58.9% |
| Latino/Hispanic | 12,880 | 30.3% | 376 | 16.9% |
| African-American | 421 | 1.0% | 34 | 1.5% |
| Asian/Pacific Islander | 711 | 1.7% | 13 | 0.6% |
| Native American | 2,329 | 5.5% | 105 | 4.7% |
| Other | 3,858 | 9.1% | 386 | 17.4% |
| **Total** | **42,529** | **100%** | **2,223** | **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. | | | | |

## Penetration Rates and Approved Claims per Beneficiary

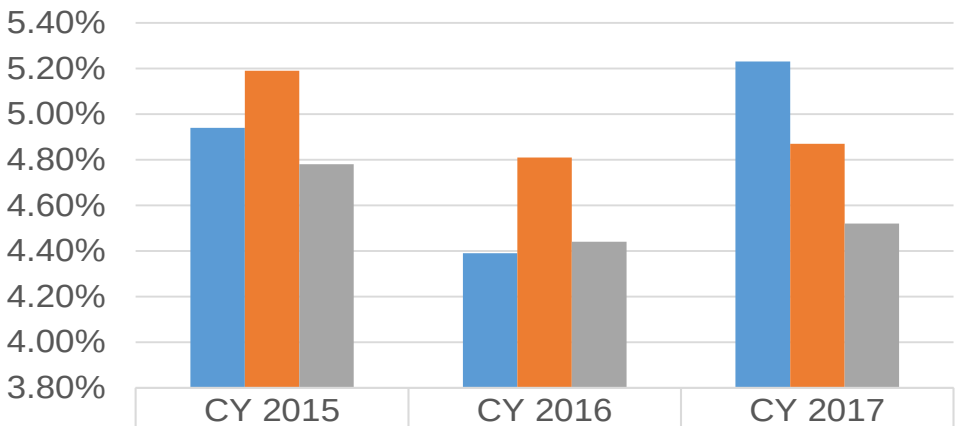
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

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

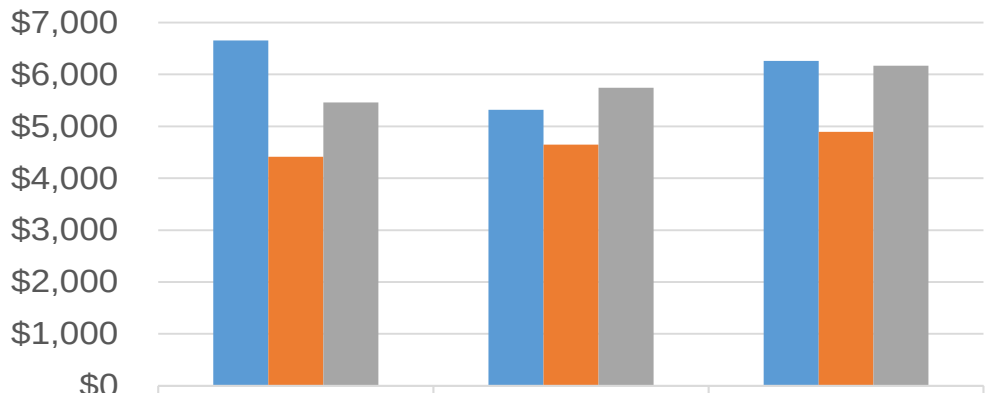
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

**Figure 1A. Overall Penetration Rates**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | 4.94% | 4.39% | 5.23% |
| Small | 5.19% | 4.81% | 4.87% |
| State | 4.78% | 4.44% | 4.52% |

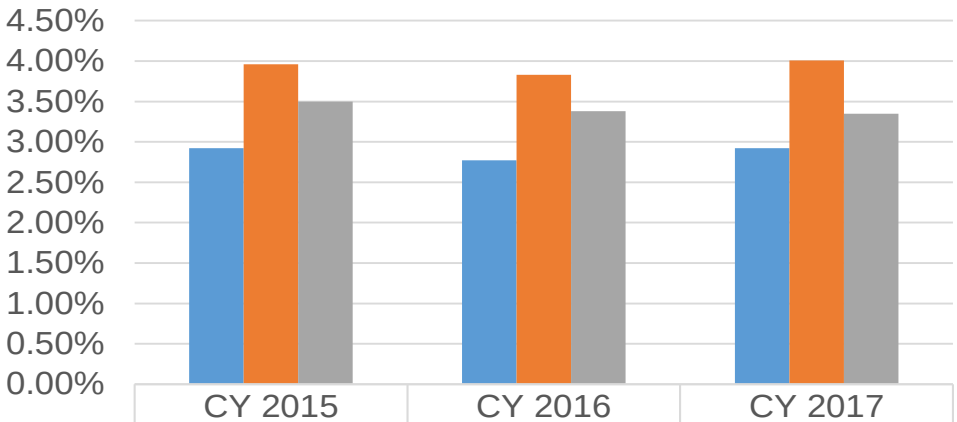
**Figure 1B. Overall ACB**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | $6,655 | $5,319 | $6,262 |
| Small | $4,417 | $4,648 | $4,895 |
| State | $5,458 | $5,746 | $6,170 |

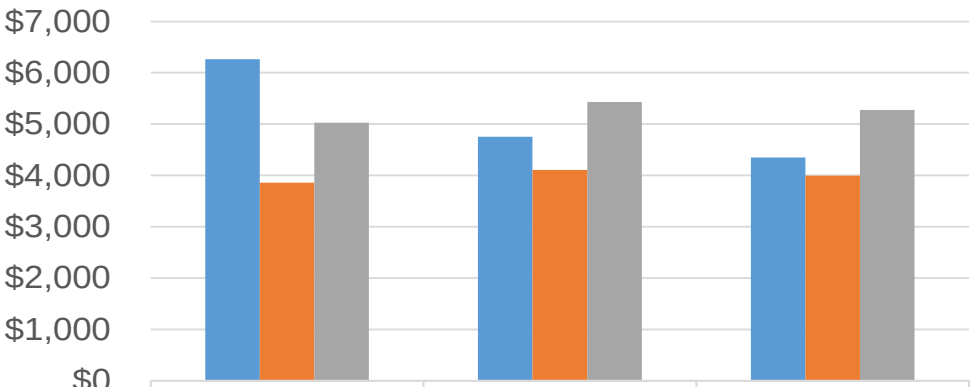
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

**Figure 2A. Latino/Hispanic Penetration Rates**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | 2.92% | 2.77% | 2.92% |
| Small | 3.96% | 3.83% | 4.01% |
| State | 3.50% | 3.38% | 3.35% |

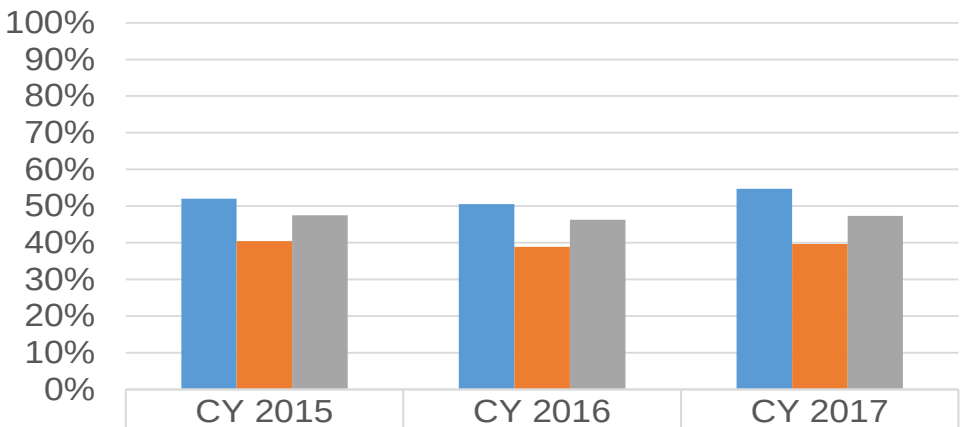
**Figure 2B. Latino/Hispanic ACB**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | $6,265 | $4,754 | $4,347 |
| Small | $3,857 | $4,105 | $3,993 |
| State | $5,029 | $5,430 | $5,278 |

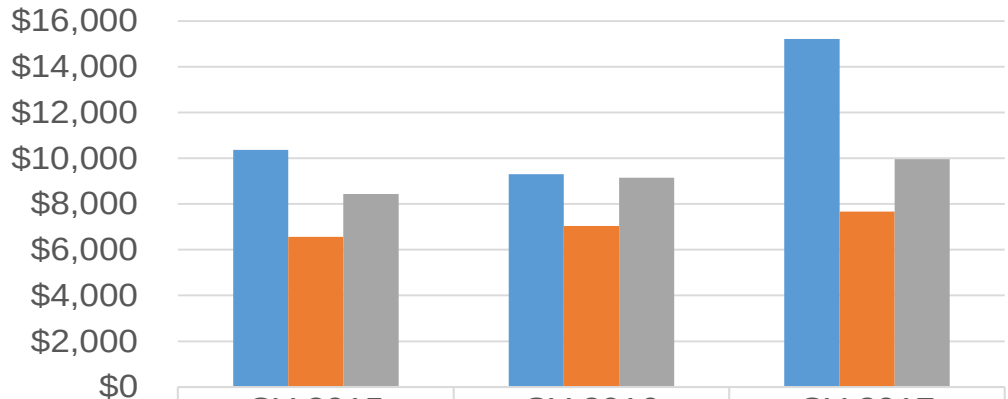
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

**Figure 3A. FC Penetration Rates**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | 52.01% | 50.56% | 54.75% |
| Small | 40.42% | 38.84% | 39.64% |
| State | 47.52% | 46.26% | 47.28% |

**Figure 3B. FC ACB**




| | CY 2015 | CY 2016 | CY 2017 |
|---|---|---|---|
| Mendocino | $10,367 | $9,296 | $15,216 |
| Small | $6,569 | $7,037 | $7,671 |
| State | $8,432 | $9,147 | $9,962 |

## High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, 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: Mendocino MHP High-Cost Beneficiaries**

| MHP | Year | HCB Count | Total Beneficiary Count | HCB % by Count | Average Approved Claims per HCB | HCB Total Claims | HCB % by Total Claims |
|---|---|---|---|---|---|---|---|
| Statewide | CY 2017 | 21,522 | 611,795 | 3.52% | $54,563 | $1,174,305,701 | 31.11% |
| MHP | CY 2017 | 83 | 2,223 | 3.73% | $54,272 | $4,504,553 | 32.36% |
| | CY 2016 | 43 | 1,850 | 2.32% | $46,587 | $2,003,225 | 20.36% |
| | CY 2015 | 92 | 2,008 | 4.58% | $47,547 | $4,374,334 | 32.74% |

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

## Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

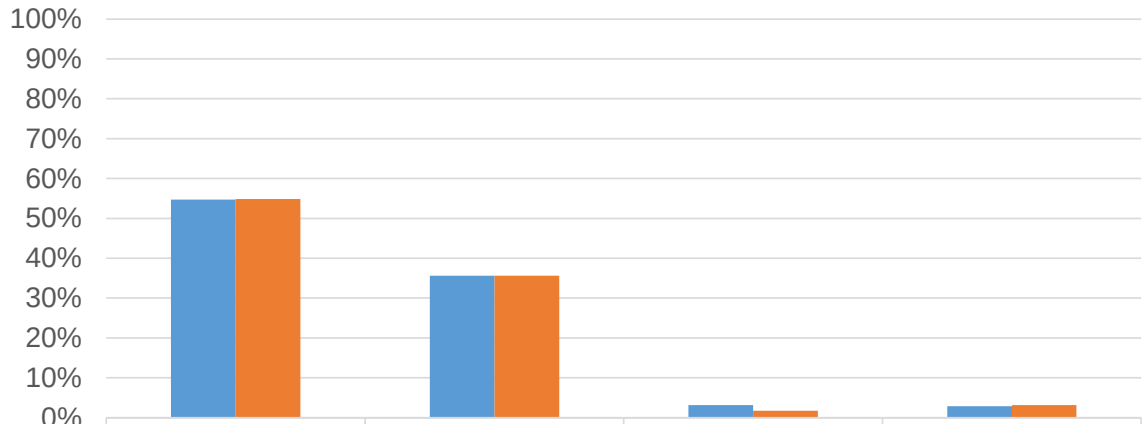
**Table 3: Mendocino MHP Psychiatric Inpatient Utilization**

| Year | Unique Beneficiary Count | Total Inpatient Admissions | Average LOS | ACB | Total Approved Claims |
|---|---|---|---|---|---|
| CY 2017 | 248 | 548 | 7.92 | $11,734 | $2,910,108 |
| CY 2016 | 214 | 370 | 8.06 | $8,078 | $1,728,697 |
| CY 2015 | 224 | 403 | 9.28 | $7,442 | $1,667,003 |

# Post-Psychiatric Inpatient Follow-Up and Rehospitalization

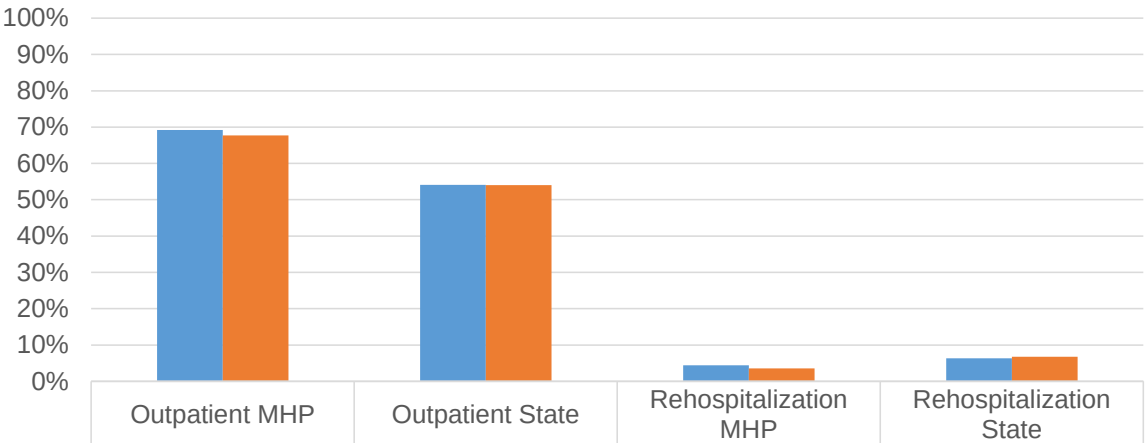
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

**Figure 4A. Mendocino MHP 7-Day Post-Psychiatric Inpatient Follow-up**




| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2016 | 55% | 36% | 3% | 3% |
| CY 2017 | 55% | 36% | 2% | 3% |

**Figure 4B. Mendocino MHP 30-Day Post-Psychiatric Inpatient Follow-up**



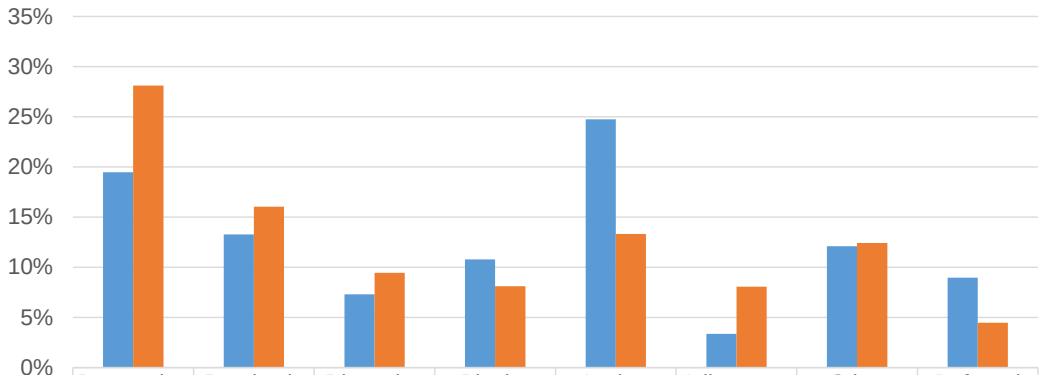

| | Outpatient MHP | Outpatient State | Rehospitalization MHP | Rehospitalization State |
|---|---|---|---|---|
| CY 2016 | 69% | 54% | 4% | 6% |
| CY 2017 | 68% | 54% | 4% | 7% |

# Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

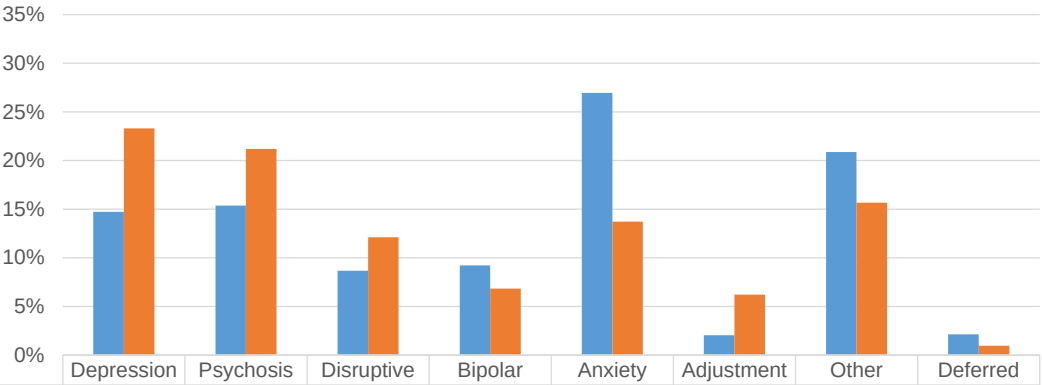
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 24.4 percent.

**Figure 5A. Diagnostic Categories, Beneficiaries Served**




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| Mendocino CY 2017 | 19% | 13% | 7% | 11% | 25% | 3% | 12% | 9% |
| State CY 2017 | 28% | 16% | 9% | 8% | 13% | 8% | 12% | 4% |

**Figure 5B. Diagnostic Categories, Total Approved Claims**




| | Depression | Psychosis | Disruptive | Bipolar | Anxiety | Adjustment | Other | Deferred |
|---|---|---|---|---|---|---|---|---|
| Mendocino CY 2017 | 15% | 15% | 9% | 9% | 27% | 2% | 21% | 2% |
| State CY 2017 | 23% | 21% | 12% | 7% | 14% | 6% | 16% | 1% |

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

## Mendocino MHP PIPs Identified for Validation

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

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

**Table 4: PIPs Submitted by Mendocino MHP**

| PIPs for Validation | # of PIPs | PIP Titles |
|---|---|---|
| **Clinical PIP** | 1 | Diagnosis of and Coordination of Co-occurring Disorders Services |
| **Non-clinical PIP** | 1 | Consumer/Family Member Participation in QIC Meetings |

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: 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 5: PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| | | | | Item Rating | |
| **Step** | **PIP Section** | **Validation Item** | | **Clinical** | **Non-Clinical** |
| 1 | Selected Study Topics | 1.1 | Stakeholder input/multi-functional team | M | NR |
| | | 1.2 | Analysis of comprehensive aspects of enrollee needs, care, and services | M | NR |
| | | 1.3 | Broad spectrum of key aspects of enrollee care and services | M | NR |
| | | 1.4 | All enrolled populations | M | NR |
| 2 | Study Question | 2.1 | Clearly stated | PM | NR |
| 3 | Study Population | 3.1 | Clear definition of study population | M | NR |
| | | 3.2 | Inclusion of the entire study population | PM | NR |
| 4 | Study Indicators | 4.1 | Objective, clearly defined, measurable indicators | PM | NR |
| | | 4.2 | Changes in health states, functional status, enrollee satisfaction, or processes of care | M | NR |
| 5 | Sampling Methods | 5.1 | Sampling technique specified true frequency, confidence interval and margin of error | NA | NR |
| | | 5.2 | Valid sampling techniques that protected against bias were employed | NA | NR |
| | | 5.3 | Sample contained sufficient number of enrollees | NA | NR |
| 6 | Data Collection Procedures | 6.1 | Clear specification of data | PM | NR |
| | | 6.2 | Clear specification of sources of data | M | NR |
| | | 6.3 | Systematic collection of reliable and valid data for the study population | PM | NR |

| Table 5: PIP Validation Review | | | | | |
|---|---|---|---|---|---|
| | | | | Item Rating | |
| **Step** | **PIP Section** | **Validation Item** | | **Clinical** | **Non-Clinical** |
| | | 6.4 | Plan for consistent and accurate data collection | PM | NR |
| | | 6.5 | Prospective data analysis plan including contingencies | PM | NR |
| | | 6.6 | Qualified data collection personnel | M | NR |
| 7 | Assess Improvement Strategies | 7.1 | Reasonable interventions were undertaken to address causes/barriers | PM | NR |
| 8 | Review Data Analysis and Interpretation of Study Results | 8.1 | Analysis of findings performed according to data analysis plan | PM | NR |
| | | 8.2 | PIP results and findings presented clearly and accurately | PM | NR |
| | | 8.3 | Threats to comparability, internal and external validity | PM | NR |
| | | 8.4 | Interpretation of results indicating the success of the PIP and follow-up | M | NR |
| 9 | Validity of Improvement | 9.1 | Consistent methodology throughout the study | NA | NR |
| | | 9.2 | Documented, quantitative improvement in processes or outcomes of care | NA | NR |
| | | 9.3 | Improvement in performance linked to the PIP | NA | NR |
| | | 9.4 | Statistical evidence of true improvement | NA | NR |
| | | 9.5 | Sustained improvement demonstrated through repeated measures | NA | NR |

Table 6 provides a summary of the PIP validation review.

| Table 6: PIP Validation Review Summary | | |
|---|---|---|
| **Summary Totals for PIP Validation** | **Clinical PIP** | **Non-clinical PIP** |
| Number Met | 9 | NR |
| Number Partially Met | 11 | NR |
| Number Not Met | 0 | NR |
| Unable to Determine | 0 | NR |
| Number Applicable (AP)<br>(Maximum = 28 with Sampling; 25 without Sampling) | 20 | NR |
| **Overall PIP Ratings** ((#M*2)+(#PM))/(AP*2) | **72.5%** | **0%** |

## Clinical PIP—Diagnosis of and Coordination of Co-Occurring Disorders Services

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

"Will diagnosis rates for co-occurring disorders approach epidemiological standards (at least 40% is the goal) and will treatment outcomes and quality of life indicators for these clients improve, as evidenced by improved: a) ANSA scores and b) EXYM participation record"?

**Date PIP began:** November 2017

**Projected End date:** November 2019

**Status of PIP:** Active and ongoing

This is the second year that the MHP has presented this project as a PIP; however, last year, the project was rated as Concept Only. The purpose of this PIP was to improve the MHP's ability to accurately diagnose, document, and treat co-occurring disorders of beneficiaries in care.

In the MHP's most recent reporting of the co-occurring (i.e., mental health and substance use) disorders rate, the MHP had a rate of 16 percent. The rates in three previous fiscal years ranged from 5 to16 percent. When compared to national rates (e.g., National Alliance on Mental Illness), which are between 37 to 53 percent, the MHP may be under-reporting or under-diagnosing co-occurring disorders or both. Whatever

the case, the MHP concluded that they were not providing the most appropriate or optimal treatment for beneficiaries who presented with a co-occurring disorder.

The MHP presented the interventions as the following: (1) Training clinical staff to diagnose substance use disorders (SUD); and (2) Provision of SUD-focused clinical treatment. Participation in the SUD-focused treatment was voluntary and was offered to adults receiving services in FY 2017-18. The MHP identified 257 beneficiaries with co-occurring disorders, recruited 77 of them for the SUD-focused treatment sessions, and obtained regular attendance (i.e., three or more SUD sessions) by 42 beneficiaries. The MHP compared the beneficiary's initial ANSA score, at the start of mental health treatment, to the ANSA scores following the SUD-focused sessions. ANSA scores did not improve for all beneficiaries and for some the rates of improvement were lower than expected. The MHP suspected variability among clinics in staffing, training, and managing the ANSA cycles as factors in the lower than expected outcomes.

As the MHP was only six months into the project at the time of the onsite review, the project will be continued in the upcoming year, ideally with more participants.

**Suggestions to improve the PIP:** It was suggested that the MHP use the ANSA score just prior to the start of the project as the most recent ANSA score, not the beneficiary's initial ANSA score, which introduces another variable of the time in treatment into the study.

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

The technical assistance (TA) provided to the MHP by CalEQRO was for the MHP to clearly identify and control the variables that influence the outcome of the intervention, including the clinics where the SUD sessions were held and the number of SUD sessions that a participant achieved. The MHP was also encouraged to evaluate and reconsider the use of the initial ANSA as the baseline for the change score. Lastly, the MHP makes a connection between improved diagnosis of co-occurring disorders and treatment for SUD, but the PIP does not actually address SUD treatment. The MHP was encouraged to include some measure that relates to SUD treatment (e.g., referrals to or kept appointment with an SUD provider).

## Non-clinical PIP—Consumer/Family Member Participation in QIC Meetings

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

"Will focused adjustments to the location, format, and outreach strategies for quality improvement committee (QIC) meetings improve attendance and participation in these meetings by consumers and family members?"

**Status of PIP:** Submission determined not to be a PIP (not rated)

The TA provided to the MHP by CalEQRO consisted of suggestions of ways for the MHP to modify the project to achieve desired outcomes of increasing beneficiary attendance at QIC meetings; however, the MHP was cautioned that without a direct benefit to the beneficiary that the project would not be a PIP. One suggestion was for the MHP to consider a designated role for a beneficiary on the QIC. At present, the MHP's QIC membership does not specify a function (e.g., chair, secretary, community liaison) for beneficiary members. Having a function (i.e., purpose) increases engagement and gives beneficiaries a reason to return to meetings, as it would for any individual who is performing a specific role. Another discussion was on the frequency of meetings. When the MHP averaged more QIC meetings in a fiscal year (e.g., 11 in FY 2013-14 compared to four in FY 2014-15), then beneficiary attendance was also more consistent. The MHP was encouraged to establish a regular QIC meeting calendar. Overall, the MHP was advised that this was not a PIP and that a viable PIP should have a direct beneficiary benefit.

Additional TA is for the MHP to identify a concrete deficiency in care or services; to focus the deficiency on the beneficiary; and to consistently apply the interventions (technical difficulties precluded the use of one of the interventions).

# INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system 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.

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 2.2 percent.

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

**Table** 7 shows the percentage of services provided by type of service provider.

**Table 7: Distribution of Services, by Type of Provider**

| Type of Provider | Distribution |
|---|---|
| County-operated/staffed clinics | 3.48% |
| Contract providers | 96.49% |
| Network providers | 0.03% |
| **Total** | **100%*** |

*Percentages may not add up to 100 percent due to rounding.

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

| Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System | |
|---|---|
| **Type of Input Method** | **Frequency** |
| Direct data entry into MHP EHR system by contract provider staff | Not used |
| Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system | Weekly |
| Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system | Weekly |
| Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system | Daily |
| Paper documents submitted to MHP for data entry input by MHP staff into EHR system | Not used |
| Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR | Not used |

- MHP does not utilize contract providers that serve beneficiaries within county service area to provide outpatient services locally in a clinic/program setting.

## Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of remote sites currently operational: 2

Identify primary reason(s) for using telehealth 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 beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e. children/youth or older adult)
☒ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries

- Telehealth services are available with English and Spanish speaking practitioners (not including the use of interpreters or language line).
- Approximately 13 telehealth sessions were conducted in Spanish.

## Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

**Table 9: Technology Staff**

| IT FTEs (Include Employees and Contractors) | # of New FTEs | # Employees / Contractors Retired, Transferred, Terminated | Current # Unfilled Positions |
|---|---|---|---|
| 7 | 2 | 1 | 0 |

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

**Table 10: Data Analytical Staff**

| IT FTEs (Include Employees and Contractors) | # of New FTEs | # Employees / Contractors Retired, Transferred, Terminated | Current # Unfilled Positions |
|---|---|---|---|
| 17 | 2 | 1 | 0 |

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

- The MHP provides technology staff that operates and supports Netsmart Avatar EHR system, which is self-hosted locally.
- MHP staff provide Avatar support and training to new MHP staff as needed.
- RQMC administers and provides oversight of SMHS for contract providers. RQMC data analytical support figures are included in Table 10, along with MHP data support.

## Current Operations

- The MHP developed the FY 2018-19 IS Strategic Business Plan, which includes identifying goals, assumptions, and deliverables. Highlights from the plan include:
    - Six goals and action steps to support each goal.
    - Eleven deliverables.
    - Assignment of staff (inclusive of HHSA, the MHP, RQMC, EPIO (contractor), and County IT) to support implementation.
- RQMC's operational duties and responsibilities as the ASO include providing management and oversight to other agencies who deliver SMHS to children, adults, and older adult populations.
- County staff directly enter beneficiary data into Avatar EHR.
- Contract provider staff enter beneficiary data directly into Exym.
- Contract provider's beneficiary data is electronically exchanged from Exym to Avatar via electronic data interchange transactions or batch file transfer on a daily to weekly cycle.
- Medi-Cal claims and state data-reporting are produced from Avatar system.
- The MHP uses two EHR systems to deliver services and complex clinical operations and, beneficiary data does flow regularly from Exym to Avatar. This two-system operational model requires a level of subject matter expertise not generally noted in small MHPs.

Table 11 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 (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

| Table 11: Primary EHR Systems/Applications | | | | |
|---|---|---|---|---|
| **System/Application** | **Function** | **Vendor/Supplier** | **Years Used** | **Operated By** |
| Avatar PM | Practice Management | Netsmart | 15 | HHSA IT/Vendor |
| Avatar CWS | Clinical Workstation | Netsmart | 4 | HHSA IT/Vendor |
| Exym | EHR | Exym | 9 | ASO/Vendor |

## The MHP's Priorities for the Coming Year

- Complete implementation of Netsmart Perceptive 2017 (document imaging) module.
- Transfer Medicare Part B billing processing from the MHP to RQMC operations.
- Implement HHSA IS Strategic Business Plan Goal C—enforce HIPAA requirements for security—and Goal F—implement state data reporting requirements. Both goals directly support key operational elements.
- Attend Client & Service Information (CSI) and Data Collection Reporting (DCR) Data Quality Improvement webinars provided by DHCS.
- Implement CANS-50 and Pediatric Symptom Checklist-35 (PSC-35) outcome instruments locally and prepare for beneficiary data submissions to DHCS.
- Develop plans to implement Netsmart - OrderConnect, CareConnect, and MyHealthPoint modules.
- Convert SUD Treatment system from FEi Systems' Web Infrastructure for Treatment Services to Netsmart – Avatar system.

## Major Changes since Prior Year

- Submitted electronic 837P transactions and received 835 transactions for Medicare Part B claims.
    - Processed claims for beneficiaries with dual Medicare/Medi-Cal eligibility for FY 2017- 18.
    - Balance-billed Medi-Cal for reimbursement.
- Revised audit tool for quality assurance to support Chart Review process.

- Installed Avatar Data Trial module to support internal auditing.
- Implemented pilot project at one program for Netsmart Perceptive 2017 (document imaging).
- Migrated DCR transactions to the MHP's website for transmission to a DHCS system.
- Completed and submitted new DHCS data reporting requirements for Network Adequacy standards.
- Completed medication consent training for staff.

## Other Areas for Improvement

- Mendocino County covers a large geographic area with a number of remote communities, where travel times can range up to two hours one-way, depending on weather conditions. It would benefit the Mobile Outreach & Prevention Services (MOPS) team to have access to beneficiary data (e.g., recent services, medications, and clinical notes) in the field. The numbers of beneficiaries that MOPS serves may be small, compared to the populated areas, but MOPS is a first responder for at-risk communities.
- Network connectivity issues would also need to be resolved to enable MOPS to have stable access in the field.

## Plans for Information Systems Change

- MHP has no plans to replace current Avatar EHR system, which has been in place for more than five years.

## Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

**Table 12: EHR Functionality**

| | | Rating | | | |
|---|---|---|---|---|---|
| **Function** | **System/Application** | **Present** | **Partially Present** | **Not Present** | **Not Rated** |
| Alerts | Avatar/Exym | X | | | |
| Assessments | Avatar/Exym | X | | | |
| Care Coordination | Exym | X | | | |

| Table 12: EHR Functionality | | | | | |
|---|---|---|---|---|---|
| | | Rating | | | |
| Function | System/Application | Present | Partially Present | Not Present | Not Rated |
| Document Imaging/ Storage | Avatar/Exym | | X | | |
| Electronic Signature—MHP Beneficiary | Avatar/Exym | X | | | |
| Laboratory results (eLab) | Exym | X | | | |
| Level of Care/Level of Service | Avatar/Exym | X | | | |
| Outcomes | Avatar/Exym | X | | | |
| Prescriptions (eRx) | Exym (RXnT) | X | | | |
| Progress Notes | Avatar/EXYM | X | | | |
| Referral Management | Exym | X | | | |
| Treatment Plans | Avatar/Exym | X | | | |
| Summary Totals for EHR Functionality: | | 11 | 1 | 0 | 0 |
| FY 2018-19 Summary Totals for EHR Functionality: | | 11 | 1 | 0 | 0 |
| FY 2017-18 Summary Totals for EHR Functionality*: | | 11 | 0 | 1 | 0 |
| FY 2016-17 Summary Totals for EHR Functionality: | | 3 | 4 | 3 | 0 |

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

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

- RQMC did implement Care Coordination and Referral Management functionality in Exym during the past year. Both functions are not currently available in Avatar; the IS vendor will need to modify core EHR systems to support these components
- BHRS did implement Netsmart Perceptive 2017 (document imaging) at a single site during the past year. The plan is to rollout Perceptive to remaining county-operated sites during FY 2018-19. Exym users currently have functional document imaging module.
- Prescription e-RX functionality is available via Exym.

## Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☐ Yes ☐ In Test Phase ☒ 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

If yes, product or application:

Dimension Reports

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

**Table 13: Mendocino MHP Summary of CY 2017 Short Doyle/Medi-Cal Claims**

| Number Submitted | Gross Dollars Billed | Number Denied | Dollars Denied | Percent Denied | Gross Dollars Adjudicated | Claim Adjustments | Gross Dollars Approved |
|---|---|---|---|---|---|---|---|
| **59,085** | $11,799,279 | **77** | $20,432 | 0.17% | $11,778,847 | $133,950 | $11,644,897 |

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent**.

- With low percent denied rate of 0.17% - it would appear the MHP puts extra effort into 'scrubbing claims' prior to submission of claim files.

Table 14 summarizes the top three reasons for claim denial.

| Table 14: Mendocino MHP Summary of CY 2017 Top Three Reasons for Claim Denial | | | |
|---|---|---|---|
| **Denial Reason Description** | **Number Denied** | **Dollars Denied** | **Percent of Total Denied** |
| Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code. | 26 | $12,389 | 61% |
| Medicare or Other Health Coverage must be billed prior to submission of claim. | 36 | $4,269 | 21% |
| Service not payable with other service(s) rendered on same day. | 6 | $2,339 | 11% |
| **Total** | 77 | $20,432 | NA |
| The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials. | | | |

# CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

## CFM Focus Group One

CalEQRO requested a culturally diverse group of beneficiaries, including adults, caregivers/parents, and transitional age youth, who are mostly new clients who have initiated/utilized services within the past 12 months. The session was attended by adults and transitional age youth (TAY), most of whom identified as beneficiaries. The majority of the participants were White, others identified as Latino, Black, and “Mixed”. All but one of participants was a man. The session was held at the Arbor Youth Resource Center.

Number of participants: Nine

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

- Easy to access, with two to three weeks to an initial assessment.
- Varying times to psychiatry, from a few weeks to three to four months.

Participants’ general comments regarding service delivery included the following:

- Frequency of contact with their clinicians was sufficient, with the ability to increase contact as needed.
- Support groups at the wellness centers are helpful and complement their clinical services.
- Communication and access to information about services, programs, and activities was by word-of-mouth and required “being in the know.”
- Sometimes, they had to advocate strongly for themselves before their psychiatric providers would try different treatment approaches besides medications.

Participants' recommendations for improving care included the following:

- Establish an in-county, inpatient psychiatric hospital.
- Listen more and incorporate the beneficiaries' wishes.

Interpreter used for focus group one: Yes Language(s): Spanish

## CFM Focus Group Two

CalEQRO requested a culturally diverse group of Hispanic beneficiaries, including adults and TAY, who are mostly new clients who have initiated/utilized services within the past 12 months. The session was attended by adults and TAY, most of whom identified as beneficiaries. There were comparable numbers of men and women. The session was held at the Arbor Youth Resource Center.

Number of participants: Six

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

- Taking a few days to weeks, which was perceived as timely.

Participants' general comments regarding service delivery included the following:

- There were no issues with language services or transportation.
- Psychiatric providers were less responsive than participants would like and were less reluctant to change medications.
- The wellness centers offer a variety of classes and programs that participants found useful and helpful.

Participants' recommendations for improving care included the following:

- Increase the announcements and publications, specifically posters, in Spanish.
- Facilitate access to prevention and early intervention programs.

Interpreter used for focus group two: Yes Language(s): Spanish

# 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 described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

## Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 15: Access to Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| 1A | Service accessibility and availability reflective of cultural competence principles and practices | M |
| The MHP has a three-year Cultural Competency Plan, effective July 2017-2020, with a CY 2018-19 update. The plan included 2017 census information for the county, from which the MHP has extrapolated to eligibles and beneficiaries in their population. The MHP has identified disparities in access (e.g., for Native Americans, Latinos, and beneficiaries with co-occurring disorders) and, in the past year, has implemented activities to increase access (e.g., use of *fotonovelas*—picture books in English and Spanish that describe the benefits of talking about their feelings and discussing stigma around mental illness). The MHP has evaluated the implementation and outcomes of their strategies, some of which were documented in the minutes of the Cultural Competence Committee and QIC. | | |
| 1B | Manages and adapts its capacity to meet consumer service needs | M |
| The MHP reported serving a total of 935 beneficiaries during the past year, of which 314 were adult and older adult beneficiaries. The MHP monitors service utilization and access at a number of stakeholder meetings (e.g., QIC, multi-agency) and through different reports (e.g., the client population report). The MHP has collaborated with their ASO and their contract providers to adapt services to meet the needs of their beneficiaries (e.g., hiring/hired more Spanish-speaking staff). The MHP also collaborated with culturally specific providers (e.g., Consolidated Tribal Health) to | | |

| Table 15: Access to Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| facilitate access for underserved populations. The MOPS increased their staffing and can now cover areas of the county that were underserved. A Homelessness Needs Assessment was commissioned (by the HHSA), which requires collaboration among county departments and community stakeholders. The MHP's role will be to improve outreach services and increase behavioral health and substance abuse rehab treatment slots for persons experiencing homelessness. While contract providers have extended the reach of the MHP, staffing is still a challenge. Staff burnout and turnover were presented as problems among contract provider agencies. Staff recruitment and retention were exacerbated by salaries that were non-competitive. The MHP uses telehealth, particularly in the outlying areas. The MHP and ASO continue to address broadband and technical issues that disrupt the use of telehealth. | | |
| 1C | Integration and/or collaboration with community-based services to improve access | M |
| The very nature of the ASO model requires integration and collaboration. RQMC is well connected to the community and has facilitated effectively collaborations with stakeholders, including those public and private. These stakeholders include primary care, substance use disorders programs, schools, law enforcement, housing agencies, and Indian and rural health clinics. Some of these partnerships will be strengthened and expanded because of Whole Person Care Pilot, which the MHP received and has begun. This past year, the MHP and RQMC signed an MOU with law enforcement, which outlines the chain of command and how to maintain a collaborative relationship. This partnership is notable given a few years of law enforcement's reticence to sign an MOU. The MHP and the County's child welfare services work collaboratively, share training, and practice the same philosophy in coordinating services for youth in foster care. The MHP recognizes the opportunity for more collaboration with faith-based organizations and improved collaboration with their local hospitals and Partnership Heath Plan.<br><br>Mendocino County Measure B, which passed in November 2017, will provide local funding to improve services, treatment, and facilities for persons with mental health conditions. This is an atypical funding stream for a county of this size. | | |

## Timeliness of Services

As shown in Table 16, 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 beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

| Table 16: Timeliness of Services Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| 2A | Tracks and trends access data from initial contact to first offered appointment | M |
| The MHP tracked the time from initial request to first offered appointment for FY 2017-18, using the new standard of 10 business days; 90 percent of the appointments met this standard. Overall, the MHP averaged six days to first appointment. The MHP reported a range of zero to 27 days to first offered, with the greatest time to appointments for adults and the least amount of time for youth in foster care. | | |
| 2B | Tracks and trends access data from initial contact to first offered psychiatric appointment | M |
| The MHP tracked the time from initial request to first psychiatry, using the new standard of 15 business days. The MHP met this standard 71 percent of the time. Overall, the MHP averaged 11 days to first psychiatry appointment, with a range of six to 66 days. The greatest delay (66 days) to psychiatry was for children, with an average of 14 days. For adults, the MHP averaged eight days. The MHP has improved time to psychiatry over the past year. The MHP credited this to the transition of medication services from the MHP to RQMC and greater access to psychiatric providers. | | |
| 2C | Tracks and trends access data for timely appointments for urgent conditions | M |
| The MHP tracked and trended the response time to urgent conditions. The MHP's tracking included stratification by business hours and after-hours, in addition to an aggregate time and by system of care. The MHP used a standard of 60 minutes and 120 minutes for business and after-hours, respectively. On average, the MHP responded to urgent conditions within seven minutes. The MHP's ability to provide timely response to urgent conditions is due to three crisis teams that provide 24-hour crisis services. | | |
| 2D | Tracks and trends timely access to follow-up appointments after hospitalization | PM |
| The MHP tracked the time for follow-up appointments after hospitalization, using the standard of seven days. The MHP reported an overall compliance of 99 percent. This compliance rate, however, is only applicable to beneficiaries who voluntarily accepted follow-up services. The MHP did not provide data on beneficiaries that needed follow-up appointments but did not accept or receive them. Time to follow-up after hospitalization is an important indicator of access and a factor in outcomes. Those who are not getting this service need to be monitored as well. Also, the MHP has confounded the data by including all individuals hospitalized (e.g., including those with Medicare, VA benefits, and private insurance) in the admission numbers, but then | | |

| Table 16: Timeliness of Services Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| only including Medi-Cal beneficiaries in the discharge numbers and subsequent follow-up. | | |
| 2E | Tracks and trends data on rehospitalizations | M |
| The MHP tracked and trended rehospitalization rates. The MHP reported an overall 30-day rehospitalization rate of 11 percent, inclusive of all individuals that they serve, not just Medi-Cal beneficiaries. | | |
| 2F | Tracks and trends no-shows | M |
| The MHP tracked no-show rates for FY 2017-18, using a benchmark of 10 percent. The MHP reported an overall no-show rate of 16 percent for psychiatry and nine percent for clinicians other than psychiatrists. | | |

## Quality of Care

In Table 17, 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 CFM staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

| Table 17: Quality of Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| 3A | Quality management and performance improvement are organizational priorities | M |
| The MHP completed an evaluation of the previous year's quality improvement activities and had just finalized the QI plan for the current fiscal year at the time of the onsite review. The MHP's QI evaluation indicated clearly if goals were achieved and the new work plan carried forward the goals that were not met. The FY 2018-19 work plan also includes strategic initiatives, which grounds the plan in being quality focused not just compliance-focused. The MHP has a designated QI manager role and has QIC membership by stakeholders in the MHP and the ASO. The MHP has worked on increasing and standardizing beneficiary attendance at the meetings, with varying success. Executive management attendance was not the norm at QIC meetings and may be an area of improvement. QIC and other committees (e.g., cultural diversity, utilization management, and multi-agency committee) were opportunities for data review and analysis. These committees also provided opportunities for the MHP to interface with other divisions, departments, and contract providers. | | |
| 3B | Data used to inform management and guide decisions | M |
| The MHP uses a variety of data to inform management and guide decisions. There are data produced by the MHP and the ASO, including dashboards that include demographics, locations, and numbers served. In addition to utilization and program management data, the MHP determines level of service for beneficiaries, based on the beneficiary's CANS and ANSA score. The MHP and RQMC have a number of management meetings (e.g., Behavioral Health Leadership, Mental Health Administrative Leadership, and MAC meetings) where data are reviewed and used to support decision-making. | | |
| 3C | Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation | PM |
| The MHP has continued their efforts to gain beneficiary input through roving QIC meetings and QIC meetings combined with MHSA meetings. The MHP has also obtained beneficiary feedback from surveys, including the annual Consumer Perception Survey (CPS) and clinical satisfaction surveys. While the MHP has an established process for obtaining beneficiary input, stakeholders voiced concerns about the MHP's mechanism for disseminating information to them. Information needed to be more accessible, shared at venues where beneficiaries were likely to be or likely to frequent, and provided in Spanish. Staff endorsed regular and transparent communication with their supervisors and managers within their agencies, through meetings or on email notices. Some staff described the communication as 'top-down'. | | |

| | | |
|---|---|---|
| Clinical demands and productivity requirements precluded line staff attendance at meetings and direct participation in decision-making forums. | | |
| 3D | Evidence of a systematic clinical continuum of care | M |
| The MHP and ASO provide a comprehensive range of services and treatment options for beneficiaries, from medication-only outpatient services, to crisis services, and to residential programs. A new residential program, a 38-room apartment complex (slated to open in May 2019), will provide permanent, supportive, and rehabilitative housing for beneficiaries at-risk of homelessness. The MHP is part of a collaborative providing grief and crisis counseling to families who were affected by the wild fires in October 2017. In the past year, the MHP has expanded transition support through a jail discharge planner position for beneficiaries with co-occurring disorders. County Measure B provides a new opportunity to improve the continuum of care. Stakeholders expressed a need for an inpatient psychiatric hospital in the county. | | |
| 3E | Evidence of peer and family member employment in key roles throughout the system | M |
| Beneficiaries and family members in paid positions were represented in the MHP. The director of the Manzanita Wellness Center was a beneficiary. The MHP and ASO have invested in advancement and further career opportunities for beneficiaries through a partnership with Mendocino College. Beneficiaries/individuals who complete and obtain a Human Service Worker Certificate can qualify for entry-level positions (e.g., client services associate and client services specialist) within the MHP. | | |
| 3F | Peer run and/or peer driven programs exist to enhance wellness and recovery | M |
| The MHP and ASO partner with agencies that support and utilize consumer-driven and consumer-run programs. Manzanita Services operates two wellness centers, the Wellness Center and Willits Resource Center (neither of which were visited during this onsite review). Manzanita was described as having an open-door policy to all individuals. The wellness centers operated Monday to Friday and Tuesday to Friday with abbreviated business hours (10am-3pm). There is a youth center, the Arbor Youth Resource Center that offer a number of consumer-run programs. There is one other consumer-run wellness center on the coast, Hospitality House. Beneficiaries and their family members are made aware of consumer-run programs at intake; they are given information about the services, activities, and contact information.<br>The Manzanita Wellness Center maintains a website, monthly calendar of activities, a newsletter, and has flyers available in English and Spanish. The center staff also does outreach to the Latino/Hispanic community through local churches and markets frequented by Spanish speakers. | | |
| 3G | Measures clinical and/or functional outcomes of consumers served | PM |
| The MHP uses the CANS and the ANSA for beneficiary outcome tools. The MHP produces some standing reports that give clinicians and their manager's information | | |

| | | |
|---|---|---|
| on progress and course of treatment. The outcome information enables clinicians to adapt services on an individual-beneficiary level. The MHP does not use the outcome information to adapt services on a program-wide, systemic level; however, the MHP and RQMC are moving toward aggregation to provide a system-wide overview of beneficiary outcomes. The MHP and RQMC were testing and revising the aggregate reports at the time of the onsite review. | | |
| 3H | Utilizes information from Consumer Satisfaction Surveys | M |
| The MHP administers the CPS twice annually. The results of the survey are shared with the contract providers and their staff. At some contract providers, analysts summarized the survey and the highlighted the outcomes and implications. The MHP received fewer surveys (403) in November 2017 than in May 2017 (478). In addition to the CPS, agencies conduct their own surveys or program-specific surveys (e.g., foster youth survey at Tapestry). | | |

# SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Mendocino MHP related to access, timeliness, and quality of care.

## MHP Environment – Changes, Strengths, Opportunities and Recommendations

### PIP Status

**Clinical PIP Status:** Active and ongoing

**Non-clinical PIP Status:** Submission determined not to be a PIP (not rated)

**Recommendations:**

- As per Title 42, CFR, §438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.
- As a first step, the MHP is encouraged to identify a deficiency in care or services that has a beneficiary impact.
- The MHP is encouraged to contact BHC for technical assistance, prior to the start of a new non-clinical PIP.

### Access to Care

**Changes within the Past Year:**

- The MHP's Innovation Project with Round Valley Indian Health Center, Yuki Trails, was approved in October 2017 and begun in March 2018. The project facilitates services, particularly crisis services, and targets Native Americans in/around in Covalo.
- The MHP transferred medication services to RQMC. This change has expanded access and enabled more timely access to psychiatric providers and medications.
- The passing of County Measure B, a Mental Health Treatment Act that funds improvements to services, treatment, and facilities for persons with mental health conditions, provides opportunities to expand access to care.
- One contract provider added an onsite clinician to conduct assessments for TAY. This change has provided consistent access to initial services for TAY.
- Another team was added to the MOPS, now making three teams. This has expanded the geographic area that the MHP serves and has purportedly increased the numbers of beneficiaries served.

**Strengths:**

- Through the ASO, the MHP has an extensive network of community-based providers that facilitate stable access for beneficiaries.
- The MHP uses telehealth to provide services to beneficiaries.

**Opportunities for Improvement:**

- Large caseloads of many high-needs beneficiaries is reported as typical, which may be a contributing factor in staff burnout, low retention, and difficulty in recruitment.
- According to the homelessness needs assessment, there is a dearth of mental health (and SUD) treatment slots and beds for individuals experiencing homelessness in Mendocino County.

**Recommendations:**

- Review or conduct some analysis of caseload distribution among the contract provider agencies and their staff.
- As necessary, assign cases to promote a more equitable distribution of different levels of care and need.
- Engage the contract provider in identifying the beneficiaries who were adversely affected by decreased transportation assistance and in implementing some improvements or alternatives.

## Timeliness of Services

**Changes within the Past Year:**

- The addition of the onsite clinician to conduct assessments has decreased clinician no-shows at/for one contract provider.

**Strengths:**

- The post-hospitalization plan for beneficiaries includes transportation from the hospital to a clinic appointment, which ensures timely follow-up after discharge from an inpatient stay.

**Opportunities for Improvement:**

- The MHP's reporting of follow-up after psychiatric hospitalization is incomplete, as it does not capture all those who have been discharged and are eligible for follow-up. The MHP only reported those who voluntarily accepted appointments in seven days.

- The MHP has protracted time to psychiatry, especially for children's services. Beneficiaries and staff alike reported wait times of three to four months for a psychiatric appointment.
- The no-show rate for psychiatry was greater than the MHP's benchmark.

**Recommendations:**

- Include all Medi-Cal beneficiaries who are discharged from the hospital and are eligible for post-psychiatric hospitalization in Mendocino County (i.e., do not exclude those who refuse appointments or who are seen beyond seven days).
- Target some improvement activities to those beneficiaries who are discharged from the hospital and remain in-county, but decline follow-up services.
- Decrease the time to children's psychiatry, through the use of telehealth, locums, or other means.

## Quality of Care

**Changes within the Past Year:**

- Modifications were made to the EHR to prompt clinicians to enter SUD diagnoses as well as mental health diagnoses.
- Construction has begun for a 38-bed apartment complex, Willow Terrace, which will provide much needed housing for beneficiaries in recovery. The expected completion is May 2019.

**Strengths:**

- The MHP has three adult wellness centers and one youth wellness center that support beneficiary and peer recovery, located in the three primary communities of the county.
- Cultural responsiveness, continual outreach, and education are part of the MHP's strategy to reduce stigma and gain trust of underserved populations.

**Opportunities for Improvement:**

- At times, beneficiaries felt that their voices were not heard in treatment decisions.
- Coordination and plan of care for the same beneficiaries that accessed multiple services and programs within the HHSA, in particular child welfare, were sometimes perceived as inconsistent and conflicting.

**Recommendations:**

- Conduct training or in-service for psychiatric providers that reinforces beneficiary input and collaboration in treatment planning.

- In the training or in-service, engage psychiatric providers in discussion about challenges and ways to incorporate beneficiary preferences.

## Beneficiary Outcomes

**Changes within the Past Year:** None noted

**Strengths:**

- Through a partnership with Mendocino College, beneficiaries can obtain a Human Service Worker certification which may be used as credentials for entry-level position within the MHP.

**Opportunities for Improvement:**

- The outcome measures were not perceived as reliable by clinical staff who administered them. The same outcome measure produced different results upon re-administration.

**Recommendations:**

- Provide refresher training on the use and scoring of CANS and ANSA, to ensure that clinicians have a satisfactory level of proficiency and are confident in the use and reliability of the measure.

## Foster Care

**Changes within the Past Year:**

- The MHP has developed a CANS scoring guide, along with diagnostic assessments, which support both risk and service placement levels for FC beneficiaries.

**Strengths:** None noted

**Opportunities for Improvement:**

- The scoring guide and diagnostic assessments are not adapted to CANS-50.

**Recommendations:**

- Modify the scoring guide and diagnostic assessments to support implementation of the CANS-50, as per Information Notices 17-052 and 18-007.

## Information Systems

**Changes within the Past Year:**

- The MHP installed Avatar Data Trial module to support internal auditing.

- The MHP migrated DCR transactions to the MHP's website for transmission to a DHCS system.

**Strengths:**

- The MHP developed the FY 2018-19 IS Strategic Business Plan, which includes identifying goals, assumptions, and deliverables.

**Opportunities for Improvement:**

- While the MOPS team is a first responder for remote communities, the team does not have ready-access to beneficiary information while in the field.
- While the MHP's current process to assign user access works adequately, this process and the validation of it are labor-intensive.

**Recommendations:**

- Provide the MOPS teams with mobile devices (e.g., secure laptops and/or tablet) with Internet connectivity to enable clinicians' access to beneficiary's EHR information while in the field.
- Implement Goal C of the FY 2018-19 IS Strategic Business Plan, part of which is to assign role-based levels of security on a 'need to know' basis and is a less involved process.

## Structure and Operations

**Changes within the Past Year:**

- The MHP implemented electronic 837P and 835 transactions for Medicare Part B claims.
- The MHP revised the audit tool for quality assurance to support Chart Review process.

**Strengths:** None noted

**Opportunities for Improvement:** None noted

**Recommendations:** None noted

# Summary of Recommendations

**FY 2018-19 Recommendations:**

- Include all Medi-Cal beneficiaries who are eligible for post-hospitalization follow-up in Mendocino County in the tracking and reporting of the timeliness metric on follow-up encounters post-psychiatric inpatient discharge. The metric should include the number that were discharged and eligible for follow-up, the number that received any follow-up, and the number that received the follow-up within seven days.
- Compare the same populations for the entirety of the metric on follow-up encounters post-psychiatric inpatient discharge.
- Provide the Mobile Outreach and Prevention Services (MOPS) teams with mobile devices (e.g., secure laptops and/or tablet) with Internet connectivity to enable clinicians' access to beneficiary's electronic health record (EHR) information while in the field.
- Conduct quarterly monitoring FY 2018-19 Information Systems (IS) Strategic Business Plan Goal C, which is to enforce Health Information Portability and Accountability Act (HIPAA) security requirements by assigning levels of security to each User Role Definition on a 'need to know' basis.
- Provide refresher training on the use and scoring of Adult Needs and Strengths Assessment (ANSA), to ensure that clinicians have a satisfactory level of proficiency and are confident in the use and reliability of the measure.
- Conduct training or in-service that reinforces beneficiary input and collaboration in treatment planning for all psychiatric providers.

**FY 2018-19 Foster Care Recommendations:**

- Use the CANS-50 and, as required, results from historical CANS to evaluate effectiveness of clinical service levels compared to current symptoms, impairment, and risk levels.

**Carry-over and Follow-up Recommendations from FY 2017-18:** None noted

# ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: 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 - Mendocino MHP |
|---|
| Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations |
| Use of Data to Support Program Operations |
| Cultural Competence, Disparities and Performance Measures |
| Timeliness Performance Measures/Timeliness Self-Assessment |
| Quality Management, Quality Improvement and System-wide Outcomes |
| Consumer Satisfaction and Other Surveys |
| Performance Improvement Projects |
| Primary and Specialty Care Collaboration and Integration |
| Health Plan and Mental Health Plan Collaboration Initiatives |
| Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Consumer Family Member Focus Group(s) |
| Contract Provider Group Interview – Operations and Quality Management |
| Contract Provider Group Interview – Clinical Management and Supervision |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) |
| Information Systems Billing and Fiscal Interview |
| Information Systems Capabilities Assessment (ISCA) |
| Telehealth |
| Contract Provider Site Visit |
| Final Questions and Answers - Exit Interview |

# Attachment B—Review Participants

## CalEQRO Reviewers

Ewurama Shaw-Taylor, PhD, Lead Quality Reviewer
Bill Ullom, Chief Information Systems Reviewer
Deb Strong, Consumer/Family Member Consultant

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

## Sites of MHP Review

MHP Sites

Mendocino County Behavioral Health & Recovery Services
1120 South Dora Street
Ukiah, CA 95482

Contract Provider Sites

The Arbor Youth Resource Center
810 N. State Street
Ukiah, CA 95482

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Abbott | Scott | Compliance Manager | Behavioral Health & Recovery Services (BHRS) |
| Anderson | Bonnie | Clinical Director | Redwood Community Services |
| Anderson | Dan | Chief Operations Officer | Redwood Quality Management Company (RQMC) |
| Ashurst | MaryAlice | clerical supervisor | Manzanita Services |
| Bainbridge | Alisha | Clinical Staff | Mendocino County Youth Project |
| Barlow | Michaela | Program Specialist II | Health & Human Services (HHSA)-Family and Children's Services |
| Bernsdorf | Kathyrn | Staff Therapist | Mendocino County Youth Project |
| Bhandari | Navin | Program Administrator | BHRS |
| Bogner | Kristine | Operations Manager | Tapestry Family Services |
| Cosman | Meghan | Clinical Staff | Manzanita Services |
| Criss | Heather | Program Administrator | HHSA |
| Crossman | Zack | Clinical Staff | Redwood Community Services |
| Davis | Paul | Operations Manager | Mendocino Coast Hospitality Center |
| Deniz | Marcella | Clinical Staff | Mendocino Coast Hospitality Center |
| Dodge | Michael | Program Specialist II | BHRS |
| Dreiling | Juanita | Administrative Services Manager | BHRS |
| Epstien | Andre | Whole Person Care | Redwood Community Services |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Fine | Heather | Executive Director | Tapestry Family Services |
| Gillespie | Cecelia | Staff Therapist | Mendocino County Youth Project |
| Guthrie | Libby | Executive Director | Mendocino County Aids/Viral Hepatitis Network (MCAVHN) |
| Hoaglen | Venus | Staff Services Administrator | BHRS |
| Jamison | Tawna | Clinical Staff | Manzanita Services |
| Johns | Nicole | Clinical Director | Tapestry Family Services |
| Kaye | Martin | Account Specialist III | BHRS |
| Kazan | Zoy | Clinical Supervisor | MCAVHN |
| Kelly | Victoria | Program Director | Redwood Community Services |
| La Delle-Daly | Lois | Compliance and QA/QI Coordinator | RQMC |
| Landis | Cliff | Mental Health Clinician II | BHRS |
| Livingston | Sarah | Crisis Director | Redwood Community Services |
| Logan | Alisha | Business and HR Administrator | RQMC |
| Lovato | Karen | Acting Deputy Director | BHRS |
| Lower | Danielle | Electronic Health Record Manager | RQMC |
| Malone | Tim | Clinical Staff | Tapestry Family Services |
| Metts | Kinsey | MHRS Supervisor | Redwood Community Services |
| Miller | Jenine | Director | BHRS |
| Novotny | Wynd | Executive Director | Manzanita Services |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Ornelas | Janette | Clinical Staff | Mendocino Coast Hospitality Center |
| Pantelon | Amanda | Clinical Supervisor | Tapestry Family Services |
| Petersen | Kylee | Clinical Staff | MCAVHN |
| Rathbun | Terri | Clinical Director | Mendocino County Youth Project |
| Riley | William | Senior Program Specialist | BHRS |
| Saraceno | Jenna | Clinical Staff | Redwood Community Services |
| Schraeder | Camille | Chief Financial Officer | RQMC |
| Schraeder | Tim | Chief Executive Officer | RQMC |
| Sullivan | Laura | Clinical Supervisor | Redwood Community Services |
| Thompson | Dustin | Acting Program Specialist | BHRS |
| Timberlake-Smith | Rendy | Acting SUDT Supervisor | BHRS |
| Turchin | Andrea | Sr. Department Analyst | BHRS |
| Vokoun | CJ | Department Analyst II | BHRS |
| White | Katherine | Clinical Consultant | Mendocino Coast Hospitality Center |
| Winter | Ian | Mental Health Rehab Specialist | BHRS |
| Wyant | Billie | Clinical Staff | Redwood Community Services |
| Zapanta | Darryl | Clinical Staff | MCAVHN |

# 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 11 (*). 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 ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

**Table C1: Mendocino MHP CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB**

| Entity | Average Monthly ACA Enrollees | Beneficiaries Served | Penetration Rate | Total Approved Claims | ACB |
|---|---|---|---|---|---|
| Statewide | 3,816,091 | 147,196 | 3.86% | $703,932,487 | $4,782 |
| Small | 175,611 | 7,175 | 4.09% | $27,856,376 | $3,882 |
| MHP | 13,038 | 495 | 3.80% | $2,407,037 | $4,863 |

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

**Table C2: Mendocino MHP CY 2017 Distribution of Beneficiaries by ACB Range**

| Range of ACB | Beneficiaries Served | Percentage of Beneficiaries | Statewide Percentage of Beneficiaries | Total Approved Claims | ACB | Statewide ACB | Percentage of Total Approved Claims | Statewide Percentage of Total Approved Claims |
|---|---|---|---|---|---|---|---|---|
| < $20K | 2,077 | 93.43% | 93.38% | $7,874,195 | $3,791 | $3,746 | 56.56% | 56.69% |
| >$20K - $30K | 63 | 2.83% | 3.10% | $1,542,402 | $24,483 | $24,287 | 11.08% | 12.19% |
| >$30K | 83 | 3.73% | 3.52% | $4,504,553 | $54,272 | $54,563 | 32.36% | 31.11% |

# Attachment D—List of Commonly Used Acronyms

| Table D1—List of Commonly Used Acronyms | |
|---|---|
| **ACA** | Affordable Care Act |
| **ACL** | All County Letter |
| **ACT** | Assertive Community Treatment |
| **ART** | Aggression Replacement Therapy |
| **CAHPS** | Consumer Assessment of Healthcare Providers and Systems |
| **CalEQRO** | California External Quality Review Organization |
| **CARE** | California Access to Recovery Effort |
| **CBT** | Cognitive Behavioral Therapy |
| **CDSS** | California Department of Social Services |
| **CFM** | Consumer and Family Member |
| **CFR** | Code of Federal Regulations |
| **CFT** | Child Family Team |
| **CMS** | Centers for Medicare and Medicaid Services |
| **CPM** | Core Practice Model |
| **CPS** | Child Protective Service |
| **CPS (alt)** | Consumer Perception Survey (alt) |
| **CSU** | Crisis Stabilization Unit |
| **CWS** | Child Welfare Services |
| **CY** | Calendar Year |
| **DBT** | Dialectical Behavioral Therapy |
| **DHCS** | Department of Health Care Services |
| **DPI** | Department of Program Integrity |
| **DSRIP** | Delivery System Reform Incentive Payment |
| **EBP** | Evidence-based Program or Practice |
| **EHR** | Electronic Health Record |
| **EMR** | Electronic Medical Record |
| **EPSDT** | Early and Periodic Screening, Diagnosis, and Treatment |
| **EQR** | External Quality Review |
| **EQRO** | External Quality Review Organization |
| **FY** | Fiscal Year |
| **HCB** | High-Cost Beneficiary |
| **HIE** | Health Information Exchange |
| **HIPAA** | Health Insurance Portability and Accountability Act |
| **HIS** | Health Information System |
| **HITECH** | Health Information Technology for Economic and Clinical Health Act |
| **HPSA** | Health Professional Shortage Area |
| **HRSA** | Health Resources and Services Administration |
| **IA** | Inter-Agency Agreement |
| **ICC** | Intensive Care Coordination |
| **ISCA** | Information Systems Capabilities Assessment |

| Table D1—List of Commonly Used Acronyms | |
|---|---|
| **IHBS** | Intensive Home Based Services |
| **IT** | Information Technology |
| **LEA** | Local Education Agency |
| **LGBTQ** | Lesbian, Gay, Bisexual, Transgender or Questioning |
| **LOS** | Length of Stay |
| **LSU** | Litigation Support Unit |
| **M2M** | Mild-to-Moderate |
| **MDT** | Multi-Disciplinary Team |
| **MHBG** | Mental Health Block Grant |
| **MHFA** | Mental Health First Aid |
| **MHP** | Mental Health Plan |
| **MHSA** | Mental Health Services Act |
| **MHSD** | Mental Health Services Division (of DHCS) |
| **MHSIP** | Mental Health Statistics Improvement Project |
| **MHST** | Mental Health Screening Tool |
| **MHWA** | Mental Health Wellness Act (SB 82) |
| **MOU** | Memorandum of Understanding |
| **MRT** | Moral Reconation Therapy |
| **NP** | Nurse Practitioner |
| **PA** | Physician Assistant |
| **PATH** | Projects for Assistance in Transition from Homelessness |
| **PHI** | Protected Health Information |
| **PIHP** | Prepaid Inpatient Health Plan |
| **PIP** | Performance Improvement Project |
| **PM** | Performance Measure |
| **QI** | Quality Improvement |
| **QIC** | Quality Improvement Committee |
| **RN** | Registered Nurse |
| **ROI** | Release of Information |
| **SAR** | Service Authorization Request |
| **SB** | Senate Bill |
| **SBIRT** | Screening, Brief Intervention, and Referral to Treatment |
| **SDMC** | Short-Doyle Medi-Cal |
| **SELPA** | Special Education Local Planning Area |
| **SED** | Seriously Emotionally Disturbed |
| **SMHS** | Specialty Mental Health Services |
| **SMI** | Seriously Mentally Ill |
| **SOP** | Safety Organized Practice |
| **SUD** | Substance Use Disorders |
| **TAY** | Transition Age Youth |
| **TBS** | Therapeutic Behavioral Services |
| **TFC** | Therapeutic Foster Care |
| **TSA** | Timeliness Self-Assessment |

| Table D1—List of Commonly Used Acronyms | |
|---|---|
| **WET** | Workforce Education and Training |
| **WRAP** | Wellness Recovery Action Plan |
| **YSS** | Youth Satisfaction Survey |
| **YSS-F** | Youth Satisfaction Survey-Family Version |

## Attachment E—PIP Validation Tools {If the MHP did not submit a Clinical PIP, keep the first page of the Validation Worksheet but delete the remaining worksheet pages. For all other ratings, retain entire completed worksheet.} {these worksheets should follow the DHCS style guide for punctuation and grammar}

| PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP | |
|---|---|
| **GENERAL INFORMATION** | |
| **MHP**: Mendocino County | |
| **PIP Title**: Diagnosis of and Coordination of Co-occurring Disorders Services | |
| **Start Date**: 11/29/17<br><br>**Completion Date**: Ongoing<br><br>**Projected Study Period**: 24 Months<br><br>**Completed**: Yes ☐ No ☐<br><br>**Date(s) of On-Site Review**: 08/07-08/18<br><br>**Name of Reviewer**: Shaw-Taylor | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br><br>**Rated**<br>☒ Active and ongoing (baseline established and interventions started)<br>☐ Completed since the prior External Quality Review (EQR)<br><br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br>☐ Concept only, not yet active (interventions not started)<br>☐ Inactive, developed in a prior year<br>☐ Submission determined not to be a PIP<br>☐ No Clinical PIP was submitted |

**Brief Description of PIP** (including goal and what PIP is attempting to accomplish):

The MHP has averaged a mental health and substance use disorders co-occurring rate of 12 percent over four fiscal years (from FY 2013-17). Because this overall percentage rate is lower than national standards, the MHP has concluded that they are under-diagnosing substance use disorders in their beneficiary population. The MHP has developed a two-year project to evaluate current diagnosing standards, co-occurring rates, and clinical training to improve diagnostic accuracy and provide coordinated treatment services.

**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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP was developed based on input from clinicians, supervisors, and managers on how to best serve beneficiaries with co-occurring disorders, which prompted a review of the co-occurring rates. In addition to mental health and substance use clinicians and manager, the PIP team included QI staff and program managers. One clinician was identified as having lived experience with SUD and MH treatment. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The MHP collected retrospective data on their co-occurring rates over four years. |

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| ***Select the category for each PIP:***<br>*Clinical:*<br>☐ Prevention of an acute or chronic condition ☐ High volume services<br>☒ Care for an acute or chronic condition ☐ High risk conditions | | *Non-clinical:*<br>☐ 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?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The project addresses diagnosis of co-occurring disorders. Indirectly, the project addresses access to treatment. |
| 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)?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The project targets adults who were diagnosed with a co-occurring disorder between July 2016 and June 2018. |
| | **Totals** | **4** Met **0** 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?<br>*Include study question as stated in narrative:*<br>Will diagnosis rates for co-occurring disorders approach epidemiological standards (at least 40% is goal) and will treatment outcomes and quality of life indicators for these clients improve, as evidenced by improved: a) ANSA scores and b) Exym participation record? | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The study question is clear and more targeted than the previous year's submission; however, what the team intends to collect of/from the Exym participation record and how it relates to coordinated treatment was not articulated. |
| | **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?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The team stated that the population to whom the project is relevant was adult beneficiaries who are receiving ongoing mental health treatment and are diagnosed with a co-occurring disorder. (For this reason, beneficiaries whose services were limited to medication only or crisis were not included). The MHP anticipated that 360 beneficiaries would meet criteria for the project. Demographics were not provided on the population. |

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| 3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?<br>*Methods of identifying participants:*<br>☐ Utilization data ☐ Referral ☐ Self-identification<br>☐ Other: <Text if checked> | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The team has a mechanism to include beneficiaries who are new to the system and diagnosed with a co-occurring disorder and beneficiaries who were already diagnosed with a co-occurring disorders. However, the team did not articulate the mechanism to identify those beneficiaries who were already receiving services and have a co-occurring disorders, but did not have a diagnosis on record. Given the start of the project (i.e., the SUD-focused sessions) was in January 2018 and the MHP was over seven months into the project, it is likely that not all relevant beneficiaries have been identified. |
| | **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?<br>*List indicators:*<br>1. Clinician rating on adequate training to identify co-occurring disorders<br>2. Co-occurring disorders rate<br>3. Percentage of beneficiaries with $3^+$ SUD treatment sessions<br>4. Percentage attending $3^+$ sessions with improved ANSA<br>5. Average number of service hours for those attending $3^+$ sessions<br>6. Average number of months in service for those attending $3^+$ sessions | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The indicators are objective and measurable; however, most of them are process indictors that relate to how the project is being carried out (e.g., 1, 3, 5, and 6). The team has limited the outcome indicators to/for only those participants who showed an improvement in their ANSA score, rather than the raw/straight ANSA score. There is no indicator per se on the coordination of treatment (e.g., number of referrals or entry into SUD treatment). |

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| 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 beneficiary-focused.<br>☐ Health Status ☐ Functional Status<br>☐ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☐ Yes ☐ No<br><br>Are long-term outcomes implied? ☐ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Indictors 2 and 4 measure change in health and functional status respectively. Increased rates of co-occurring disorders relate to improved diagnosis and change in health status and the improved ANSA relates to change in 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:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | The project does not include sampling. All those who are eligible and consent to the SUD sessions were included. |

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| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| **Totals** | **0** Met **1** 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<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The team indicated the data that they will collect, but there appeared to be more variables in the study for which data ought to have been collected or provided (e.g., the numbers that do not have two ANSA scores, the latency between the ANSA scores, and the different clinics where the sessions took place). |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:* | ☒ Met<br>☐ Partially Met<br>☐ Not Met | The sources of data are indicated. The EHR, Exym, was used to extract co-occurring disorder diagnoses, the number of SUD-focused sessions, the service |

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| ☐ Member ☐ Claims ☐ Provider<br>☒ Other: Survey | ☐ Unable to Determine | hours, and ANSA scores. For the staff training, a survey was used. |
| 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<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | While the data on co-occurring rates and utilization of SUD treatment session come from Exym (the latter through a check-box), the team did not indicate how they were able to determine that 257 (of 684 receiving services) had a co-occurring disorder. If the identification is based on an annual review, it is possible that many beneficiaries (those whose annual review is due to occur between July 2018 and December 2018) would not have been included. |
| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☒ Survey ☒ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Data in the EHR (e.g., the use of UCLA intervention and diagnosis of co-occurring) was dependent on clinician input. While supervisors and QA staff reviewed clinicians' notes and verified that clinicians were operating within their scope of practice, this notes/documentation review did not address the accuracy of the information that clinicians entered. It was possible to click that the SUD intervention was used, without it actually being used. It was possible to indicate that a beneficiary has a co-occurring disorder, without the beneficiary having a co-occurring disorder. There were also differences in the number of SUD sessions that any one beneficiary might have. |

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| 6.5 Did the study design prospectively specify a data analysis plan?<br>Did the plan include contingencies for untoward results? | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | There were differences in the study plan that the team outlined compared to what was actually done. The plan indicated participation by beneficiaries who accessed services from 2016-2018, but the analysis was only based on those receiving services from 2017-2018. The analysis did not indicate that the results would be stratified, based on the number of SUD sessions attended or based on the clinic. |
| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Name: Cliff Landis<br>Title: Mental Health Clinician II<br>Role: QA/QI Clinician<br>*Other team members:*<br>Names: Dan Anderson (to collect Exym data)<br>Venus Hoaglen (to collect co-occurring rates)<br>Barbie Svendsen (to collect clinician survey data) | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The staff collecting the data are familiar with Exym and know how to extract relevant data. |
| | **Totals** | **2** Met **4** Partially Met **0** 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?<br><br>*Describe Interventions:*<br>1. UCLA ISAP training on diagnosis and treating co-occurring disorders.<br>2. Provision of SUD-focused treatment sessions for co-occurring clients. | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The intervention addresses the diagnosing of a co-occurring disorder, but it does not address sufficiently the identification of individuals who have a co-occurring disorder or the coordinated treatment for the co-occurring disorder. |
| **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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | In the documentation of the project, the team indicated quarterly review of statistics, but data appear to be presented at varying frequencies, including 9 months, 4 months, and 3 months. |

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| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled?<br>☐ Yes ☐ No<br>Are they labeled clearly and accurately?<br>☐ Yes ☐ No | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The team presented their data to date. The data on the numbers of beneficiaries in the study were not clear. Per the team, the number that completed at least three sessions was 42, which ought to be the denominator upon which the indicators are based. But for indicator 4 (i.e., the number with improved ANSA score), the denominator is 75. |
| 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?<br>Indicate the time periods of measurements:<br>_____<br>Indicate the statistical analysis used:<br>_____<br>Indicate the statistical significance level or confidence level if available/known: ____percent<br>_____Unable to determine | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The team has completed one round of repeated measures. More time is needed for subsequent measures. Mentioned previously, the plan indicated quarterly review of statistics. There are also factors that influence comparability that were not adequately addressed: clinic differences and differences in the number of SUD sessions that any one beneficiary can have. |

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| 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?<br>*Limitations described:*<br>Clinic differences<br>*Conclusions regarding the success of the interpretation:*<br>Improved ANSA scores were lower for those receiving SUD sessions than clients with a co-occurring disorders who did not receive SUD sessions<br>*Recommendations for follow-up:* | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The team presented an interpretation of the preliminary findings. Some indicators improved in the desired direction, others did not. The team has speculated that clinic differences/variability may account for less than anticipated outcomes. |
| **Totals** | **1** Met **3** Partially Met **0** 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?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | The study has not been completed. |

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| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |

| | | |
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| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| **Totals** | **0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD | |

## ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

| Component/Standard | Score | Comments |
|---|---|---|
| Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement? | ☐ Yes<br>☐ No | |

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

*Conclusions:*

The study has not been completed.

| ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS | |
|---|---|
| *Recommendations:*<br>The recommendations to the team was to use the most recent ANSA, just before the beneficiary's participation in the study/SUD-focused treatment and for the team to include some measure that relates to improved access to SUD treatment. | |
| Check one: | ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results<br>☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible<br>☐ Confidence in PIP results cannot be determined at this time |

{If the MHP did not submit a Non-clinical PIP, keep **the** first page of **the** Validation Worksheet but delete the remaining worksheet pages. For all other ratings, retain entire completed worksheet.} {these worksheets should follow the DHCS style guide for punctuation and grammar}

| PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19<br>NON-CLINICAL PIP | |
|---|---|
| **GENERAL INFORMATION** | |
| **MHP**: Mendocino | |
| **PIP Title**: Consumer/Family Member Participation in QIC Meetings | |
| **Start Date**: 07/01/17<br><br>**Completion Date**: 06/30/18<br><br>**Projected Study Period**: 12 Months<br><br>**Completed**: Yes ☒ No ☐<br><br>**Date(s) of On-Site Review**: 08/07-08/18<br><br>**Name of Reviewer**: Shaw-Taylor | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br><br>**Rated**<br>☐ Active and ongoing (baseline established and interventions started)<br>☐ Completed since the prior External Quality Review (EQR)<br><br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br>☐ Concept only, not yet active (interventions not started)<br>☐ Inactive, developed in a prior year<br>☒ Submission determined not to be a PIP<br>☐ No Non-clinical PIP was submitted |

**Brief Description of PIP** (including goal and what PIP is attempting to accomplish):

The MHP has noted that attendance by beneficiaries and family members at the bi-monthly QIC meetings has historically been very low. The MHP recognizes QIC meetings as an opportunity for beneficiary and family input and feedback. Through increased attendance, beneficiaries have an input/influence on decision-making and the MHP has increased accountability.

**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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP topic was generated by QI department. The PIP committee includes QI staff and MHP and RQMC management. There was a beneficiary representative through the family advocate, but no beneficiaries themselves. For a project about beneficiary participation, direct beneficiary participation on the committee seems essential. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The team provided data on attendance of past QIC meetings, which also showed variability in the frequency of the meetings over the past few years, a possible contributor to why beneficiaries do not attend consistently. |

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|---|---|---|
| ***Select the category for each PIP:***<br>*Non-clinical:*<br>☐ Prevention of an acute or chronic condition<br>☐ Care for an acute or chronic condition<br>☐ Process of accessing or delivering care<br>☐ High volume services<br>☐ High risk conditions | | |
| 1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The project does not identify a deficiency in care or 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)?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language<br>☐ Other | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The project's focus is on the meetings and not the beneficiaries. |
| | **Totals** | Met Partially Met Not Met 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?<br>*Include study question as stated in narrative:*<br>Will focused adjustments to the location, format, and outreach strategies for QIC meetings improve attendance and participation in these meetings by consumers and family members? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The study question has a measurable component, but there is no established connection between increased attendance at an organizational meeting and improved beneficiary outcome. The practical impact on beneficiaries is not clear. |
| | **Totals** | Met Partially Met Not Met 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?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language<br>☐ Other | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | All (adult) beneficiaries were eligible to attend the QIC meetings. |
| 3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?<br>*Methods of identifying participants:*<br>☐ Utilization data ☐ Referral ☐ Self-identification<br>☐ Other: <Text if checked> | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The data collection was a count of beneficiary attendance at QIC meetings. |
| | **Totals** | Met Partially Met Not Met UTD |

| STEP 4: Review Selected Study Indicators | | |
|---|---|---|
| 4.1 Did the study use objective, clearly defined, measurable indicators?<br>*List indicators:*<br>1. Number of consumers/family members in attendance<br>2. Number of comments by consumers/family members<br>3. Number of follow-ups provided to comments | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The indicators were measurable; however, they did not give a sense of the content of the comment or the quality of the response. |
| 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.<br>☐ Health Status ☐ Functional Status<br>☐ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☐ Yes ☐ No<br><br>Are long-term outcomes implied? ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The indicators did not address any of these four changes or outcomes. |
| | **Totals** | Met Partially Met Not Met UTD |

| STEP 5: Review Sampling Methods | | |
|---|---|---|
| 5.1 Did the sampling technique consider and specify the:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The study did not include sampling. |
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The study did not include sampling. |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The study did not include sampling. |
| **Totals** | Met Partially Met Not Met NA UTD | |

| STEP 6: Review Data Collection Procedures | | |
|---|---|---|
| 6.1 Did the study design clearly specify the data to be collected? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Yes. The data to be collected were the indicators. One data element that was not included and should have been was the attendance at MHSA meetings. |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:*<br>☐ Member ☐ Claims ☐ Provider<br>☐ Other: | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | See above. |
| 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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | In addition to the number of comments, there was some measure of the valence of the comment, either positive or negative, but this did not appear to be included in the actual data. |
| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☐ Survey ☐ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | There were inconsistencies with the recording of participant feedback/commentary and follow-up to participant's feedback. The team also had technology difficulty with the video-conferencing, which curtailed its use. The instruments used for data collection did not provide for consistent and accurate data collection. |

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|---|---|---|
| 6.5 Did the study design prospectively specify a data analysis plan?<br>Did the plan include contingencies for untoward results? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | There was no data analysis plan, as such. The plan was to collect and report on data. |
| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Name:<br>Title:<br>Role:<br>*Other team members:*<br>Names: | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Not indicated |
| | **Totals** | Met Partially Met Not Met UTD |

| STEP 7: Assess Improvement Strategies | | |
|---|---|---|
| 7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?<br><br>*Describe Interventions:*<br>1. Combine QIC Meeting with Mental Health Service Act Stakeholder Meeting<br>2. Videoconferencing between different sites during QIC meeting<br>3. Hold QIC meetings at wellness centers and enhance meetings to be welcoming, interesting and pertinent so consumers/family members will participate. Meeting reports presented with PowerPoint. | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The team did not identified an actual problem to which beneficiary attendance at QIC meetings would mitigate. |
| **Totals** | Met | Partially Met Not Met 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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | As this was not a PIP, further detail on analysis are not needed. |

| | | |
|---|---|---|
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled?<br>☐ Yes ☐ No<br>Are they labeled clearly and accurately?<br>☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 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?<br>Indicate the time periods of measurements:<br>_____<br>Indicate the statistical analysis used:<br>_____<br>Indicate the statistical significance level or confidence level if available/known: ____percent<br>_____Unable to determine | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?<br>*Limitations described:*<br><br>*Conclusions regarding the success of the interpretation:*<br>*Recommendations for follow-up:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| **Totals** | Met | Partially Met Not Met NA UTD |
| **STEP 9: Assess Whether Improvement is "Real" Improvement** | | |
| 9.1 Was the same methodology as the baseline measurement used when measurement was repeated?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☒ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| **Totals** | Met Partially Met Not Met NA UTD | |

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

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

*Conclusions:*

This was not a PIP.

| ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS | |
|---|---|
| *Recommendations:*<br>The recommendation to the team was to identify a veritable problem to which beneficiary input is necessary and/or has a direct beneficiary impact or benefit. The attendance at QIC meetings is an organizational goal and not necessarily a benefit to beneficiaries. In the larger scheme, the MHP may wish to define a role for beneficiaries in the QIC meetings—something that would encourage regular attendance (by the same beneficiaries, for a given period of time) because their input is necessary and fulfills a certain purpose. | |
| Check one: | ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results<br>☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible<br>☐ Confidence in PIP results cannot be determined at this time |