TIME

FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Shasta

Conducted on

August 11-12, 2015

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INTRODUCTION

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

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

- MHP information:
  - Beneficiaries served in CY14—3,353
  - MHP Size—Small
  - MHP Region—Superior
  - MHP Threshold Languages—None
  - MHP Location—Redding

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

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP

[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.

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

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

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY14-15

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

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below. It should be noted that the MHP had not received the final FY14-15 report until June 30, 2015 which impacted its ability to address the FY14-15 recommendations prior to the FY15-16 review held on August 11-12, 2015.

Assignment of Ratings

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

Key Recommendations from FY14-15

- Recommendation #1: Institute a new non-clinical PIP that improves services for a broad range of beneficiaries.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has initiated a non-clinical PIP to use Milestones Of Recovery Scale to measure level of care needs and capture consumer functional status outcomes for all beneficiaries 21 and older.
  - The PIP started as a pilot project and from January 2015, the target population has been expanded to include all 21 and older beneficiaries.

- The PIP as presented to CalEQRO did not have any consumer level outcomes as indicators, a requirement for PIPs. Instead, the MHP only included a process indicator. Further details and recommendations regarding this PIP are provided in the Performance Improvement Projects section and the Non-Clinical PIP Validation Tool in the attachment.

- Recommendation #2: Implement Medicare Part B electronic claim transactions as soon as practical. About 25% of clients served are dual Medicare and Medi-Cal eligible and electronic claim submissions improves claim processing turnaround time and eliminates paper claim submissions which are more prone to errors and labor-intensive.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has been approved as a Medicare Part B provider and is currently working to come into compliance with Medicare regulations prior to billing. The fiscal intermediary for Medicare Part B claims is Noridian Healthcare Solutions who is a source of technical administrative support.
  - Currently the MHP does not produce Medicare Part B claims, therefore they do not generate Medicare or Medi-Cal revenue from Medi-Medi beneficiaries who receive direct services in clinic setting from a Medicare–authorized clinician or physician. CalEQRO was unable to determine if the MHP produces Medi-Cal claims for Medi-Cal beneficiaries who receive services outside clinic-setting or phone calls.
  - The MHP is considering seeking technical assistance from other MHPs or outside consultant knowledgeable of Medicare Part B billing requirements.

- Recommendation #3: Develop a cultural competency plan that addresses the current needs of the MHP.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has an active Cultural Competency Committee. The Committee meets every other month and recently held (in May 2015) its annual 2 hour cultural competency training on interpreter usage (30 minutes) and one on military culture (90 minutes) that were well-attended.
  - In preparation for drafting a new cultural competency plan, the committee has recently surveyed the MHP employees (in June 2015) to determine areas of interest for cultural training. The survey has solicited information from employees on cultural events in the community the MHP can participate in, resources that would be utilized to learn about cultures, and recommendations for culturally aware books, movies or websites. The MHP Cultural Competency committee will use this information in drafting a new cultural competency plan and in planning for future trainings.

- The MHP reported that it expects new and updated Cultural Competency Plan guidelines from DHCS during 2015 and that it would be more meaningful to finalize a plan once the new guidelines are received. Consequently, the 2011-14 plan remains the most current one in effect.

- Recommendation #4: Implement an Adult assessment tool system wide for consistent tracking of outcomes.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - As noted in response to Recommendation #1, the MHP has started implementing MORS as its adult assessment tool with an aim to administer monthly for each beneficiary.
  - The MORS tool is now available in their EHR system as staff continue to develop policy and procedures to support best practice use.
  - This project started as a pilot, and from January 2015 the target population has been expanded to include all 21 and older beneficiaries. MORS review has been made a part of the clinical supervision.
  - As of June 2015, the MHP has completed MORS for approximately half of its beneficiaries at least once. The target of administering monthly remained a work in progress at the time of the review.

- Recommendation #5: Examine the reasons for a decline in timely access for 18-20 year-old beneficiaries.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP found that the beneficiary number in this category was too low to draw any statistically reliable conclusions.
  - It reviewed a number of cases from the reporting period that showed the decline and found the following possible reasons:
    - Beneficiaries in this age group are often more transient with less reliable follow-up contact mechanisms
    - Phone numbers change frequently or become inactive
    - Unstable housing resulting in frequent moves, including movement out of the service area
    - Many are referred for treatment by law enforcement, social services or, the family, but because of ambivalence toward mental health treatment, many in this age group do not follow up after initial contact
  - Recognizing that with this age group, outreach and engagement need to be an ongoing process, the MHP has a designated clinic for this age group with the purposes of engaging and supporting the beneficiaries with services.

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

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

- Access to Care
  - The MHP expanded its group and rehab services for adult beneficiaries.
  - It added digital (ISDN) phone system to facilitate multiple phone lines on the 24/7 access line. The language line vendor has been changed from AT&T to Language Link for improved access experience for non-English speakers.
  - The MHP completed a major remodeling at its walk-in clinic and reception area to create a welcoming atmosphere. (See further observations on this in the Consumer/Family Member Focus Group section).
  - The MHP opened Ridgeview, a 15-bed, licensed transitional residential facility for adults. The same facility has supported apartment upstairs (12), and independent living downstairs (4).
- Timeliness of Services
  - Both emergency rooms (Shasta regional and Mercy regional Medical Centers) now have tele psychiatry.
  - A contract is in place with Mid-Valley to open a four-person group home that will be licensed as a board and care for individuals with behavioral issues to prevent IMD placement.
- Quality of Care
  - The MHP completed two intensive treatment foster care (ITFC) memoranda of understanding to allow transition of children from group homes to a lower level of care. This is the interim step in preparation for Therapeutic Foster Care (TFC) implementation once approved by CMS for Medi-Cal billing.
  - At the time of the review, the MHP reported that the FY15-16 quality improvement plan was nearly complete, as was the evaluation of the FY14-15 plan.
- Consumer Outcomes
  - Two individuals have graduated from the behavioral health court (capacity = 15). The typical engagement period is16-18 months. Graduation means that they have gone through all steps, met all expected treatment goals, completed the

curriculum, had no trouble with probation office, and went through reintegration – volunteer, employment, education. Graduates receive after care for a year, after which the court may drop certain charges, felony or misdemeanor.

- The MHP is in the final stages of contracting with a vendor to create a CANS database that will provide a web-based interface.
- It has also implemented MORS now for all adults 21 and older.

PERFORMANCE MEASUREMENT

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

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

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

TOTAL BENEFICIARIES SERVED

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

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

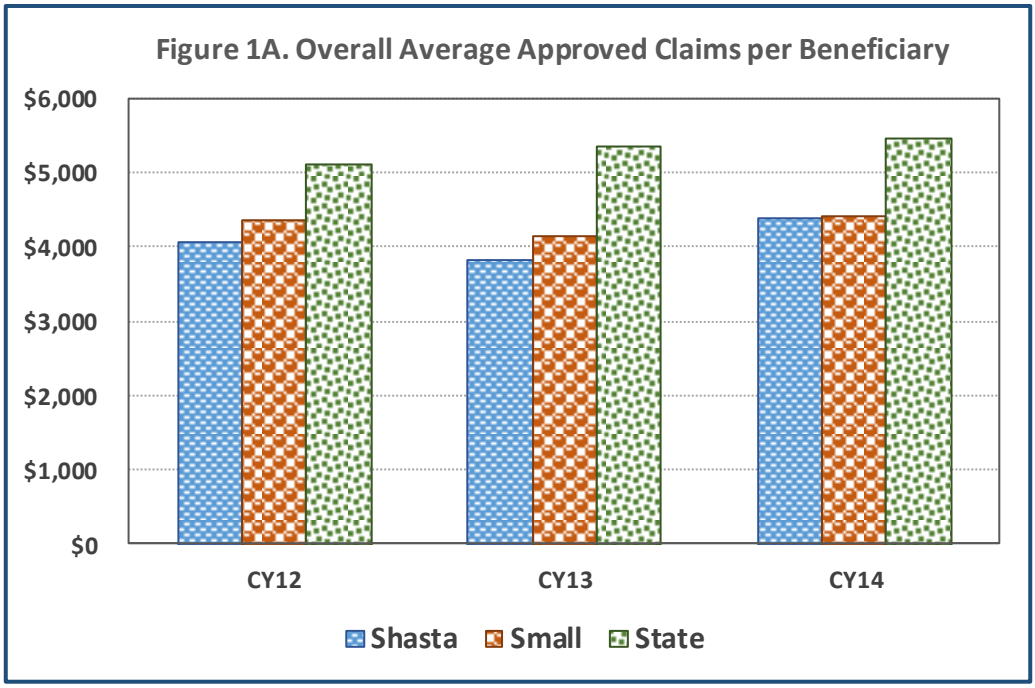
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	34,740	2,503
Hispanic	4,544	185
African-American	911	105
Asian/Pacific Islander	1,778	83
Native American	1,559	81
Other	5,170	396
Total	48,702	3,353

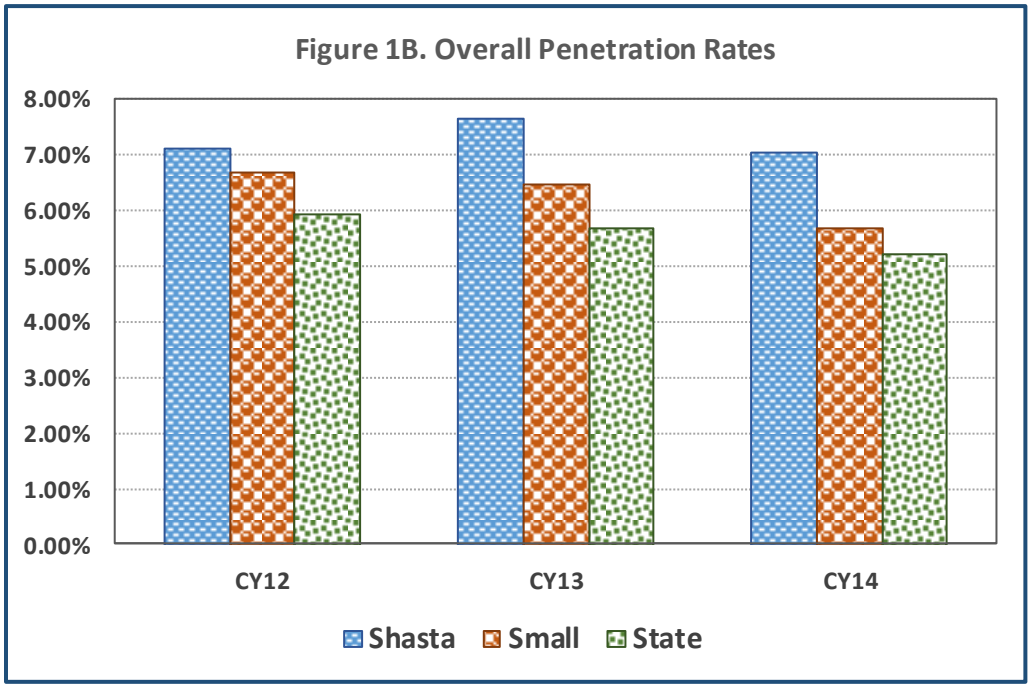
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

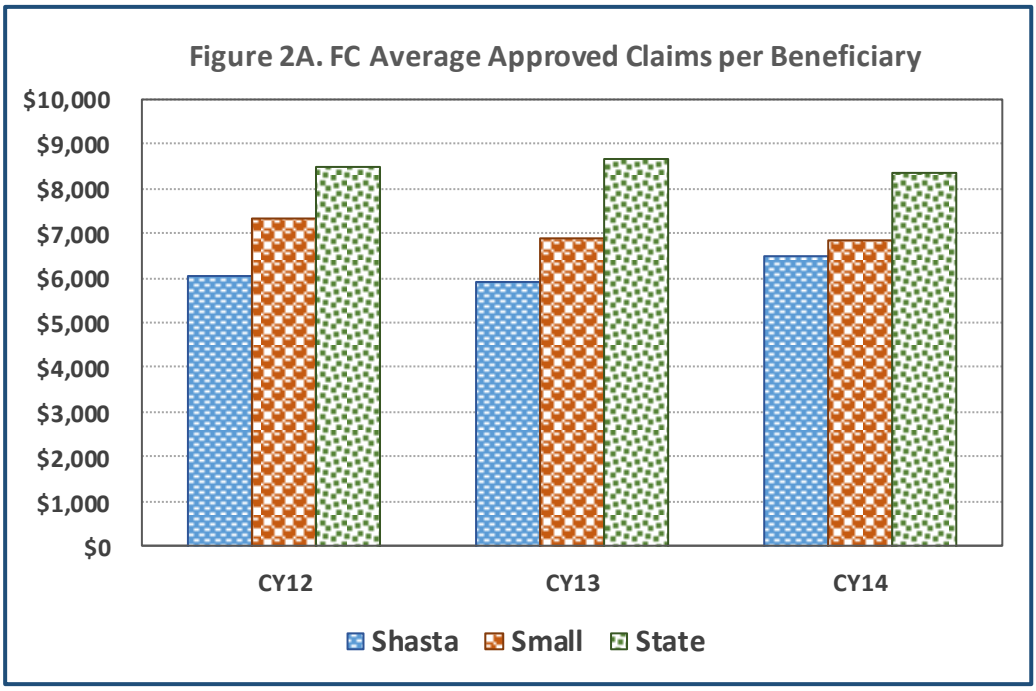
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

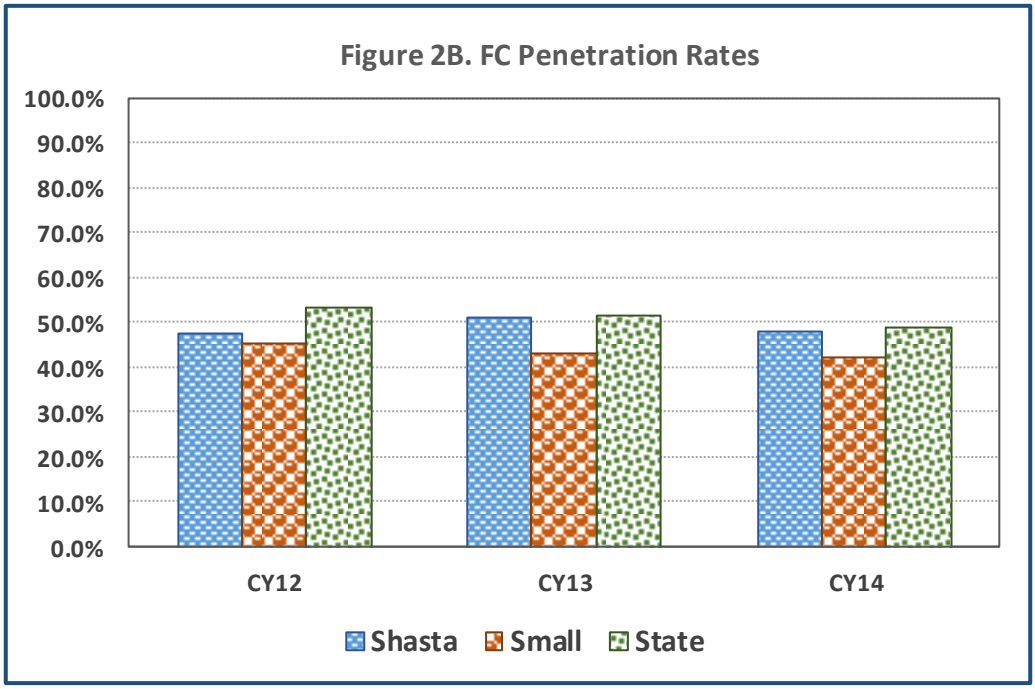
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



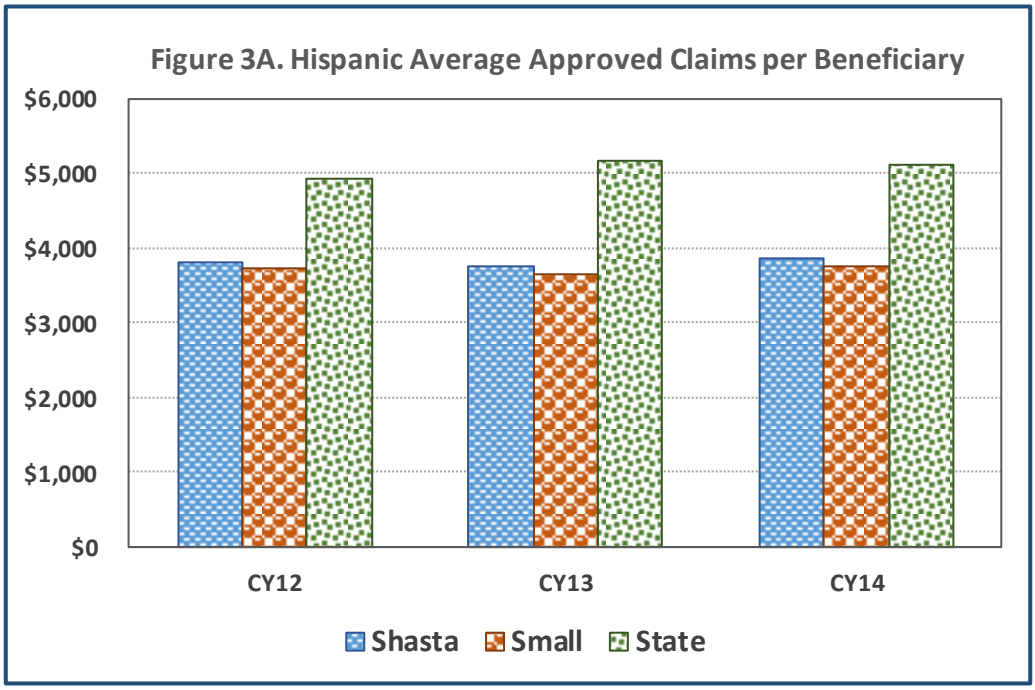


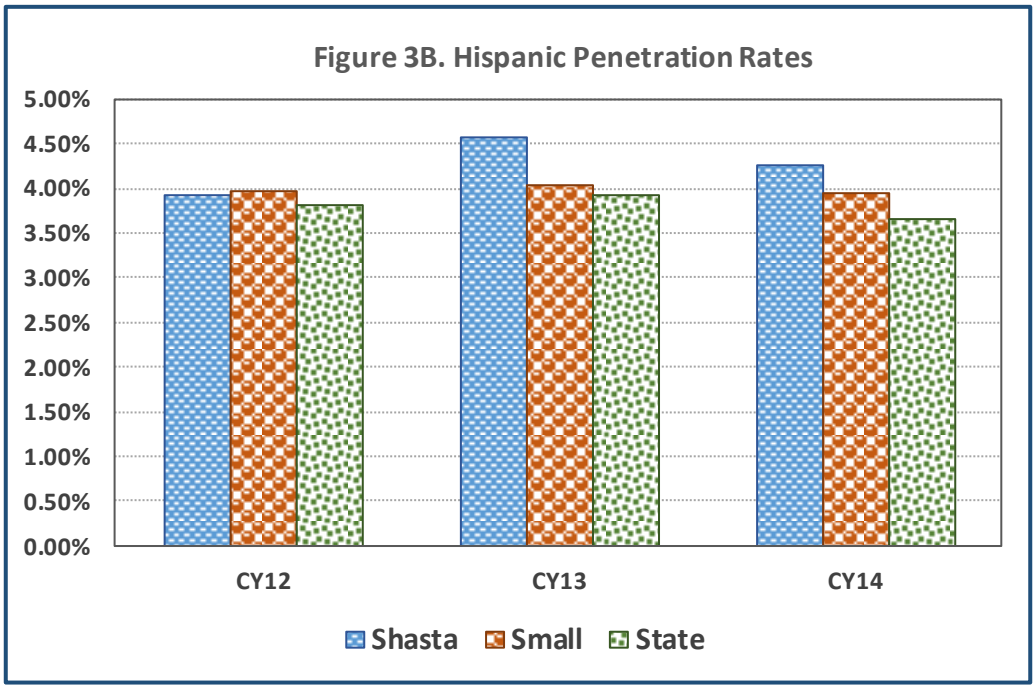
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.





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





HIGH-COST BENEFICIARIES

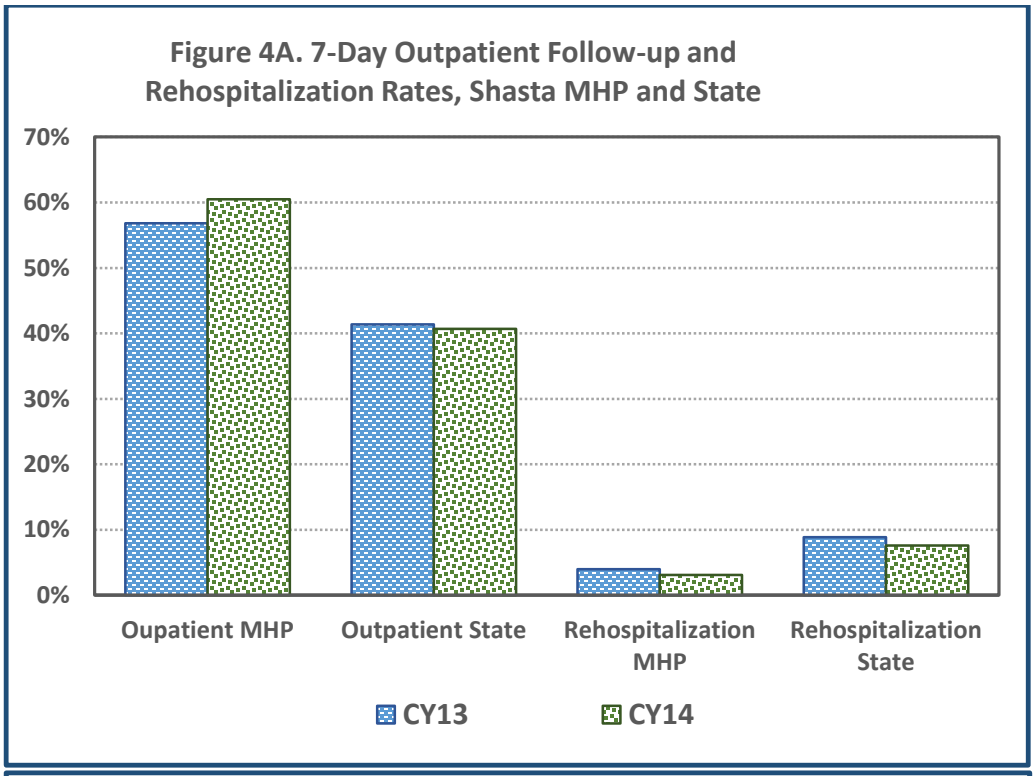
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

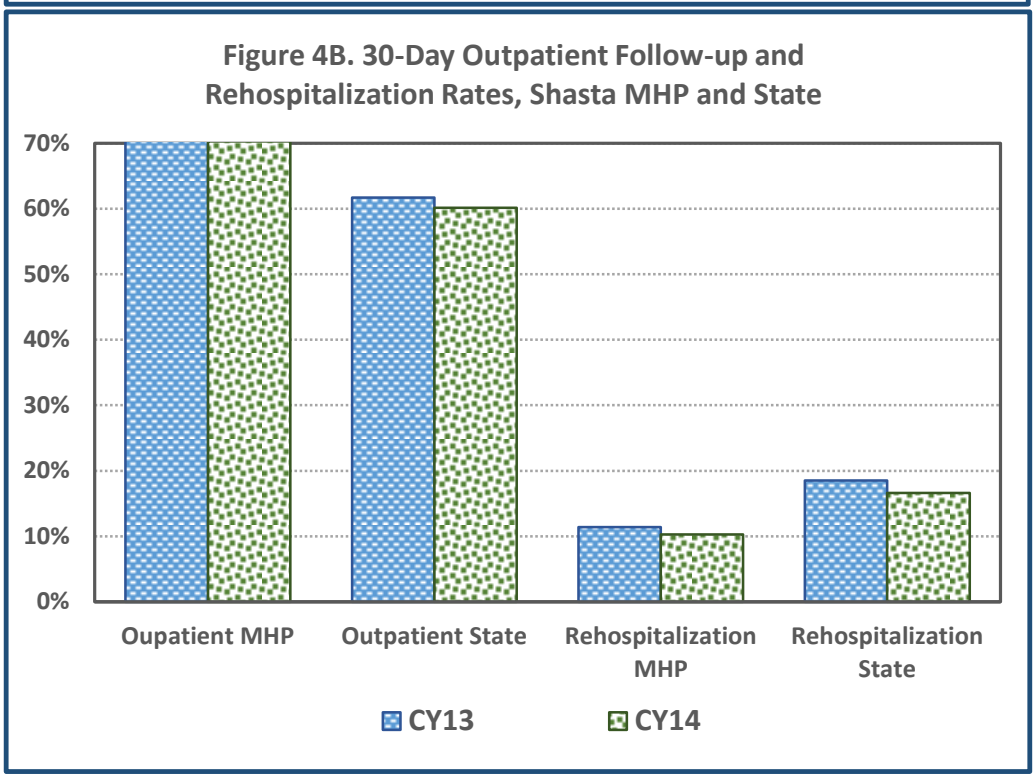
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Shasta	CY14	65	3,411	1.91%	$46,707	$3,035,978	21.18%
	CY13	52	3,311	1.57%	$46,607	$2,423,567	19.25%
	CY12	51	3,048	1.67%	$47,793	$2,437,449	19.74%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

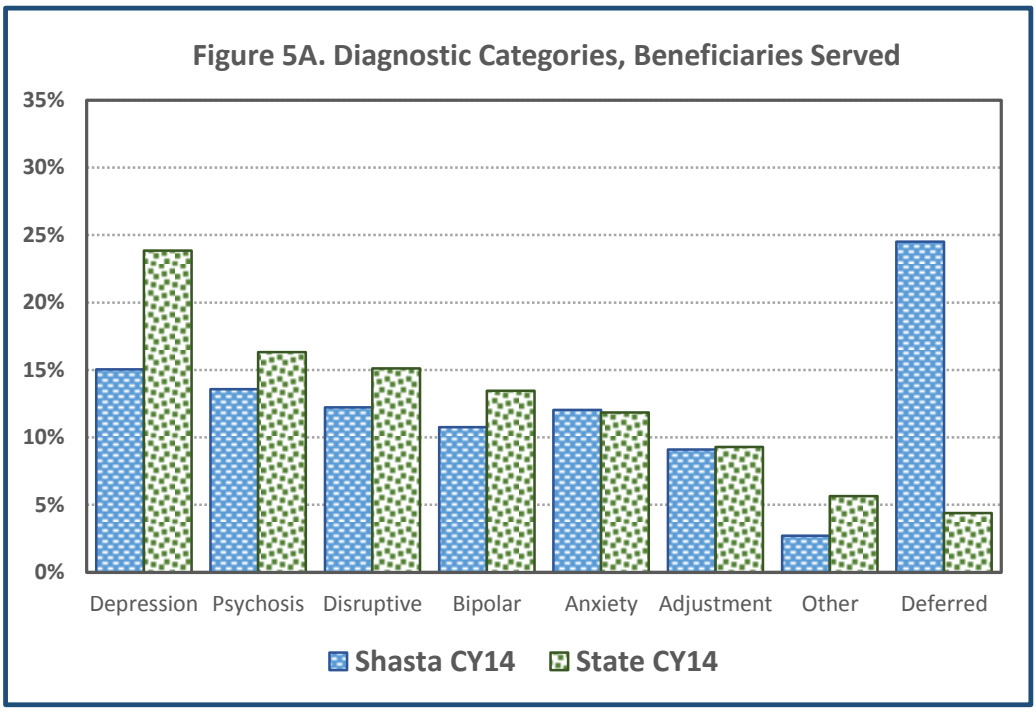
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.

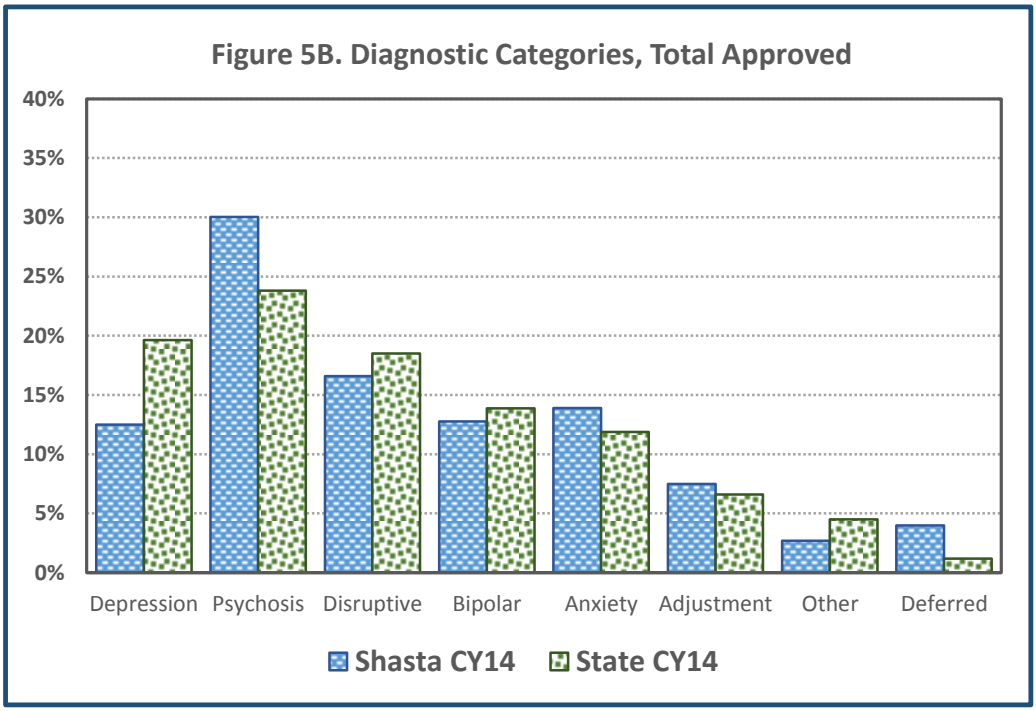




DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate declined slightly from CY13 but remains significantly higher than the Small MHP and statewide averages.
  - In CY13 and CY14, the MHP's foster care penetration rates were similar to statewide and higher than Small MHP averages.
  - The MHP's Hispanic penetration rate has been higher than both statewide and Small MHP averages in both CY13 and CY14. Both these rates were higher than CY12 when the MHP's Hispanic penetration rate was lower than the Small MHP average.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from psychiatric inpatient treatment have been significantly higher than that statewide in both CY13 and CY14.
- Quality of Care
  - The MHP's percentage of high cost beneficiaries (HCB) as well as the total approved claims for HCBs was lower than the corresponding statewide figures from in CY14. However, when compared to CY 12 and CY13, there appears to be an increase in both the HCB percentage and approved claims.
  - The MHP's average approved claims per beneficiary which was lower than both Small MHP average and statewide in CY12 and CY13, showed an increased in CY14 and was almost equal to the Small MHP average but significantly lower than the statewide average in CY14.
  - The increase in average approved claims is also seen with the foster care beneficiaries. It stayed mostly flat for the Hispanic beneficiaries.
  - The MHP continued to have a high percentage, almost a quarter of its beneficiaries with deferred diagnoses in CY14 compared to less than five percent statewide. This almost appears to account for lower than statewide average percentages for most other major diagnostic categories. Specific reasons behind high percentage of deferred diagnosis should be examined by the MHP.
  - Total approved claims for deferred diagnosis category is not as significantly higher than statewide. Instead, the total approved claims for psychotic disorders category is the only one with significantly higher than the corresponding statewide average.

- Consumer Outcomes
    - Perhaps reflective of the higher than statewide outpatient follow-up rates, the MHP's rehospitalization rate has been significantly lower than that statewide.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

SHASTA MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Youth – Triple P Implementation
Non-Clinical PIP	Adult Services Milestones Of Recovery (MORS)

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

[4] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

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

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

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

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

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	4	5
Number Partially Met	12	16
Number Not Met/Unable to Determine	14	9
Number Applicable (AP) (Maximum = 30)	30	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	33.33%	43.33%

CLINICAL PIP—YOUTH – TRIPLE P IMPLEMENTATION

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

- "Can our system increase the delivery of Triple P and improve the submission of data into the appropriate database?"
- Date PIP began: July, 2013
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☒ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

This PIP, as submitted, cannot be considered a clinical PIP. The study question focuses solely on the processes of implementation and there are no beneficiary treatment outcomes specified in this PIP that would make it a clinical PIP. The only consumer level outcome specified was satisfaction scores, but no results were available.

The project also suffers from potential threats to internal validity and rather modest improvement goals given the scope of the project and the time it has been running under different iterations.

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

The technical assistance provided to the MHP by CalEQRO consisted of:

- Adding beneficiary functional, behavioral and/or health outcomes.
- Consideration of moving on to a broader PIP of treatment appropriateness and outcomes for children and youth.

NON-CLINICAL PIP—ADULT SERVICES MILESTONES OF RECOVERY (MORS)

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

- "Currently Shasta County Adult Services does not have an evidence based method for measuring outcomes. Can the agency implement an evidence based method for measuring outcomes? Can the MORS be completed on a regular basis by staff? Will the MORS provide informative outcome data that is helpful in providing quality treatment by ensuring the clients are receiving the appropriate level of services? "
- Date PIP began: October, 2013
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

From on-site discussions, CalEQRO determined that the true purpose of this PIP is to improve clinical care and consumer outcomes through better level of care determination. For this purpose, the MHP has chosen the Milestones Of Recovery (MORS) Scale for implementation across all adult beneficiaries 21 years or older.

However, as submitted, the PIP only addressed the challenges of MORS implementation and interventions to overcome those challenges which make it a borderline PIP.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool. These details should be considered for modification to this PIP or starting a new PIP.

The technical assistance provided to the MHP by CalEQRO consisted of

- How to improve the methodology to track progress toward the stated goal.
- Inclusion of beneficiary level outcomes.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  - The clinical PIP aims at making an evidence-based treatment, Triple-P, more available to children and youth who are considered in need of Triple-P. However, the PIP has modest improvement goals and none capture beneficiary clinical outcomes needed for a clinical PIP.
- Timeliness of Services
  - None noted.
- Quality of Care
  - The clinical PIP aims at improving quality of care for children and youth by providing an evidence-based treatment.
  - The non-clinical PIP aims at improving quality of care for adults 21 years and older by better determination of their level of care needs.
- Consumer Outcomes
  - Both PIPs lack appropriate beneficiary level outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP continues to use 2011-14 Cultural Competency Plan (CCP) as its most current plan. The cultural competency committee noted in its minutes not receiving a new All Plan Letter (APL) from DHCS as the primary reason for not developing a new one yet. The MHP anticipates completing this task in May-June of 2016. The MHP has a higher than statewide average of Hispanic penetration rate. However, its count of eligible, beneficiaries served and penetration rate for the Other race/ethnicity category exceeds that of the Hispanic beneficiaries. The MHP presented a number of analyses for access and capacity, but other than access test calls in different languages; no further culture specific analyses were performed in-house. However, the MHP does include EQRO performance measures in its quality improvement reports.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP has continued its service capacity assessment primarily through two means. One is through a management dashboard that is reviewed at the agency management level. The second one consists of extensive analyses as part of the annual quality management (QM) plan. These two combined together account for quarterly or monthly analysis by provider, service modality, and service region. These are discussed at and follow-up actions taken by the agency administration or QI committee. Examples of such actions include new transitional residential program, hospital tele psychiatry as discussed in the MHP Changes and Initiatives section.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP is part of an integrated health and human services agency and the agency director is also the designated MHP Director. Consequently, the MHP has very strong partnership with social services including children's welfare services (CWS) and presented comprehensive and exemplary Katie A. implementation efforts. The MHP presented a number of examples of recent collaboration or integration efforts with the local hospitals – tele psychiatry and information exchange, Beacon - for management of mild and moderately mentally ill, schools, and contract providers. MHP also noted difficulties associated with providing appropriate services to children who are enrolled with Beacon and reported having discussions around these issues.

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

Timeliness of Services

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

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP defines this as first assessment that occurs from request of service and tracks this by children and adult services, and further by organizational providers for children. It also includes these Quality Improvement Committees activities for quarterly monitoring and improvement. The MHP's goal is to have the first assessment visit within 20 days from first request. As noted in previous year's EQRO report, the MHP's denominator includes only those assessed within 60 days. This methodology needs to be modified to include all. As such, the assumption is that all requests are met within 60 days and noted as the upper limit of the range provided.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP standard is 30 days and it is met for 62% of adult and 8% of children beneficiaries. The children's psychiatry appointment timeliness is only captured for the organizational providers, so the 8% figure does not capture any psychiatry appointment that might have been received directly by the MHP psychiatrists.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP is awaiting a statewide definition based on the DHCS and California Behavioral Health Directors' Association Joint Metrics Workgroup recommendations.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP has a standard of 7 days for adults and 14 days for children. The MHP was able to report timeliness for adults only during the FY14-15 EQRO review. During FY15-16 review, it was able to provide information on both.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2E	Tracks and trends data on rehospitalizations	FC	The MHP fully tracks it for both adults and children and uses the previous year's percentages as the goal. It was advised that this is an area where previous year's statistics are not suitable as goals. Ideally, the goal for this specific measure could be zero percent.
2F	Tracks and trends No Shows	PC	The MHP tracks and reports on this measure only for psychiatrist appointments, not for other clinicians.

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

Quality of Care

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

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The QIC meets monthly and covers a wide range of regulatory and quality improvement topics including the domains noted in item 3B and consumer perception survey results.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	FC	The MHP QIC and the Shasta County Health and Human Services Agency (HHSA) Management both review and make decisions based on quarterly data on the identified priority indicators. The MHP presented the latest available data on these indicators to CalEQRO. These reports focus on access, timeliness service capacity, quality, service appropriateness, and fiscal indicators. The Managed Care dashboard is color coded to indicate the presence and severity of any issues by indicator.
3C	Evidence of effective communication from MHP administration	PC	The MHP reports quarterly meetings with the organizational providers. The organizational providers also noted improvement in these meetings in terms of timely information sharing with new Managed Care staff in place. At the same time, they expressed the need for a designated contract monitor who can act as the sole contact instead of the contract providers having to figure out on an issue-by-issue basis who to contact. The MHP line staff in general seemed to be well-informed about the current initiatives. However, depending on the program or unit the line staff is from, the type of information flow from the supervisor level appeared to lack uniformity. The MHP noted improvements in communication and coordination with Beacon and Partnership Health in terms of the ACA expansion population.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	The organizational providers noted that the meetings with the MHP are usually for information sharing purposes or individual contract related. However, citing the children's PIP as an example, the providers expressed a greater need for input from the providers in identifying individual specific, most appropriate treatment.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP is a part of the HHSA which has a vertically integrated structure for adults and children's services separately. The success of this structure is best illustrated by the MHP and CWS joint implementation of the Katie A. mandated services. In addition, the MHP works jointly and/or collaboratively with other agencies in the county including the schools and probation services.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP has now implemented CANS for Children's and MORS for Adult services. CANS is collected at intake, annually and at discharge by the organizational providers and stored in a standalone system. The MHP is currently in the process of selecting and implementing a web-based CANS database vendor. MORS was expanded from the Advanced Recovery Collaborative participants to all adult beneficiaries from January 2015. MORS data will be integrated in the EHR.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP devotes an entire section of its QI Plan to beneficiary satisfaction comprising of the findings from the Performance, Outcomes, Quality Improvement (POQI) Survey, Service Satisfaction Survey, Crisis Residential and Recovery Survey (CRRS), Grievances, and Notices of Action (NOA-E). The results are compared to previous administration and coded to identify improvement or decrease in scores.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP has one sub-section of QI Plan devoted to employment and volunteers and uses a measure to track participation in four key MHP committees: Maintain consumer and family member participation in MHP committees, by attendance of a minimum of once per quarter, including the Mental Health Alcohol and Drug Advisory Board (MHADAB), Quality Improvement Committee (QIC), Advancing Recovery Performance Improvement Project (ARC), Triple P Performance Improvement Project, and Cultural Competency Committee (CCC).
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP has a Wellness Center in Redding. At the end of the ARC PIP, the MHP has incorporated MORS in the Adult System of Care to track and advance wellness and recovery among the adult beneficiaries 21 and older.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP has a walk-in access model whereby the initial screening is done within a day. The MHP also provides this option to those calling the access line.

  - The MHP walk-in access area renovation has been completed and looks spacious and inviting. However, the reception desk staff appeared to be in need for further training regarding consumer greeting and providing a sense of welcome. The MHP may also consider peer navigators/greeters for this area to make it more welcoming.
  - The MHP is waiting for new guidelines from DHCS before developing its new cultural competency plan.
- Timeliness of Services
  - Currently, the MHP reports the timeliness of first appointment by children and adult. No overall metric was presented to the EQRO.
  - Children's first psychiatry appointment timeliness is met for only 8% of the beneficiaries and needs further investigation.
- Quality of Care
  - The MHP needs to explore how to best utilize Triple-P while balancing the individual beneficiary needs.
  - The HHS Agency level vertical integration by Adult and Children's systems results in better coordinated care within each system of care.
- Consumer Outcomes
  - The MHP has implemented CANS and MORS. The MHP is in the process of selecting a database vendor for CANS while MORS is integrated into the EHR.
  - The MHP routinely collects and monitors consumer satisfaction surveys in addition to the DHCS mandated POQI instruments.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups, which included the following participant demographics or criteria:

- Family members/foster parents/guardians of children and youth beneficiaries who have received or initiated Medi-Cal funded EPSDT services from Shasta County MHP in the previous 12 months.
- A culturally diverse group of adult beneficiaries who have received or initiated Medi-Cal funded services from Shasta County MHP in the previous 12 months.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

Only one participant showed up for the first focus group at the MHP building in Redding, CA on August 11, 2015. Given this, it would not have been possible to maintain anonymity or draw conclusions. Therefore, this focus group had to be cancelled.

The MHP reported having invited 12 individuals and making reminder calls 48 hours in advance. There was no obvious reason why all but one of the invited individuals failed to show up. However, the lone participant who did show up reported having waited at the walk-in clinic reception area for a long time but staff did not assist this person despite having taken the appointment card the participant had presented. Eventually when the EQRO reviewer walked over to the reception area to see if any participants were waiting, it was the security guard on duty who was helpful than the front desk staff in finding this individual.

The sole participant could not recall having seen any other potential participant waiting in the reception area.

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

- Not available.

Recommendations arising from this group include:

- Not available.

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

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

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

* No data reported in order to preserve anonymity.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

Nine participants attended the second focus group at the Olberg Wellness Center in Redding, CA on August 12, 2015. The group consisted of 4 men and 5 women. Eight of the participants were

consumers and one was a family member. Participants had been in services from 1 month to many years. Two participants were homeless. Typical services received by people in the group included psychiatry, case management and individual therapy.

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

- Finding psychiatrists and getting timely medication refills were major concerns for a few participants.
- Accessing services for people who are homeless was cited as another concern.
- Two people reported starting outpatient services was quick and relatively easy.
- Most participants agreed that some staff had treated them rudely. In this context, one individual commented on the politeness of ER staff as a contrasting experience. (Also see the Focus Group 1 description)
- One participant had to wait 7 days in the emergency room because there were no empty beds at the Restpadd Psychiatric Health Facility (PHF).

Recommendations arising from this group include:

- Taking the next appointment into account when prescribing medication refills so that consumers do not run out of medication prematurely.
- Hiring more case managers and therapists.
- Reviewing the 30-day in and 30-day out policy at the local homeless shelter.

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

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		9
Number/Type of Participants	Consumer Only	8
	Consumer and Family Member	0
	Family Member	1
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	1
	Adult (25–59)	7
	Older Adult (60+)	1

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Preferred Languages	English	9
	Spanish	0
	Bilingual_____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	5
	Hispanic/Latino	1
	African American/Black	0
	Asian American/Pacific Islander	0
	Native American	2
	Other(s)___Declined to state___	1
Gender	Male	4
	Female	5
	Transgender	0
	Other	0
	Decline to state	0

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

Interpreter used for focus group 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Outpatient services appear relatively easier to access.
  - Access to psychiatrist is a concern as there appears to be a shortage of psychiatrists.
  - There can be at times shortage of PHF beds. (The new transitional residential and other boarding facilities may partially address this issue – See MHP Current Initiatives section.)
- Timeliness of Services
  - Psychiatrist appointment timeliness was cited as a concern.
- Quality of Care

  - Medication refills need to take into account the time to the following appointment.
  - Rude treatment by the staff appears to be quite prevalent according to the focus group participants. The general sentiments around this issue appeared to be not being treated in a welcoming manner or being outright belittled.
  - Shortage of PHF beds may at times result in sub-optimal treatment modality.
- Consumer Outcomes
  - None noted in the focus group.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	75.67%
Contract providers	23.89%
Network providers	0.44%
Total	100%

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

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

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

13.7%

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

6.2%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- The MHP did calculate Penetration Rates (PR) for FY13-14 and FY14-15 for comparative analysis and to assess if services and resources are appropriately allocated across years to support mental health treatment needs.
- The most granular PR analysis includes all city-zip codes of the whole county which provides detail data on remote regions to monitor resources and service capacity needs.

CURRENT OPERATIONS

- The MHP continues to use Cerner Community Behavioral Health (CCBH) system to support electronic health record functions, billing and state reporting requirements. They currently use software promotion 218; Cerner's most recent promotion available to MHPs is 220.
- Information technology support remains unchanged from prior year. Currently are allocated 5 FTE positions to Health and Human Services Agency. There are no unfilled technology support positions.
- The MHP continues use tele-psychiatry application to deliver services for children and youth clients by two contract providers.
- Managed Care Unit access phone line is staffed 8AM to 5PM, Monday – Friday. After business hours calls are handled by a live person between 5PM to 8AM, Monday – Friday, and on weekends and holidays.
- The MHP continues to improve upon Managed Care Quarterly Dashboards. Performance Indicators currently track and reported on include:
    - ▷ 28 hospitalization indicators
    - ▷ 8 Adult outpatient indicators
    - ▷ 15 Children and Youth outpatient indicators
    - ▷ 3 Quality and Appropriateness of Service indicators
    - ▷ 7 Fiscal indicators
    - ▷ 4 High Utilizers indicators.

MAJOR CHANGES SINCE LAST YEAR

- Completed implementation of CCBH system – Managed Care module
- Alcohol and Drug Program records for active clients were scanned into FileBound – Electronic Document Management System (EDMS)
- Alcohol and Drug Program records for closed clients scanned into FileBound –EDMS.

PRIORITIES FOR THE COMING YEAR

- Implement CCBH system - Perinatal and Alcohol & Drug modules
- Medicare Part B claiming
- Implement CCBH system – electronic prescribing of Controlled Substances
- Implement automated appointment reminder call and/or text messages – CallPoint
- Implement Secure Disaster Recovery solution with Cerner Corporation.

OTHER SIGNIFICANT ISSUES

- The MHP has not yet implemented Medicare Part B production billing
- Contract Providers continue to transport paper documents daily to MHP for data entry into CCBH system.
- The business relationship between MHP and Beacon Health Strategies to support and improve care coordination activities for consumers with mild to moderate diagnoses.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Client Database	PM, Clinician Homepage, Scheduler	CCBH	3	MHP
Client Database	Doctor's Homepage	CCBH	3	MHP
FileBound	Document Imaging	Upland Software	8	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace Cerner Community Behavioral Health system as it meets their EHR, billing and state reporting requirements.

ELECTRONIC HEALTH RECORD STATUS

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

Table 10—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	CCBH	X			
Clinical decision support					X
Document imaging	FileBound	X			
Electronic signature—client	CCBH	X			
Electronic signature—provider	CCBH	X			
Laboratory results (eLab)				X	
Outcomes	CANS/MORS		X		
Prescriptions (eRx)	CCBH	X			
Progress notes	CCBH	X			
Treatment plans	CCBH	X			
Summary Totals for EHR Functionality		7	1	1	1

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

- Shasta and Mendocino MHPs plan to use Redwood Toxicology to process laboratory tests. Shasta is waiting for Mendocino to complete testing and validation of HL7 transaction before they implement laboratory transactions.
- The MHP implemented a standalone CANS database for children and youth clients outcomes. They started a small pilot to implement MORS data into CCBH.
- The MHP continues to rely on hybrid (paper and electronic) medical record model for legal documentation purposes.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - MHP and Beacon Health Strategies need to develop strategies to improve case coordination for clients with mild to moderate mental health diagnoses.
- Timeliness of Services
  - None noted.
- Quality of Care
  - The MHP uses CCBH data to produce a number or QI reports and dashboard performance indicators to measure care quality.
  - A hybrid (paper and electronic) medical record model remains a barrier to measure quality of care standards for children and youth clients.
  - MHP and Beacon need to plan and develop strategies to implement interoperability for exchange of health information.
- Consumer Outcomes
  - Functional assessment tools are not yet fully integrated with the EHR.

SITE REVIEW PROCESS BARRIERS

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

- The focus group for family members of children and youth had to be cancelled due to lack of attendance.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - During the past year, the MHP has opened a transitional residential facility to reduce inpatient and Emergency Room (ER) utilization.
    - The facility also has additional residential options on other floors.
    - Other housing options are also in the pipeline, a 4-bed group home to reduce IMD use, and an MHSA funded 19-unit low income independent housing for the MHP beneficiaries.
  - Both hospital ERs in the county now have tele psychiatry in place. The MHP plans to provide ER doctors limited access to its EHR for quicker and appropriate treatment of MHP beneficiaries.
- Opportunities:
  - A psychiatry shortage as noted in the FY14-15 EQRO report continues to be a problem, especially for children. The MHP is contracting with a psychiatrist recruitment firm to address this concern.
  - The newly renovated reception area at the walk-in clinic provides a cleaner and spacious environment. However, following staff turnover at the reception desk, there appears to be a need for further ongoing training for the reception staff to make the consumer experience more welcoming and user-friendly.

Timeliness of Services

- Strengths:
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from psychiatric inpatient treatment have been significantly higher than the statewide averages in both CY13 and CY14.

  - The MHP's walk-in model ensures at least an initial screening on the first day of contact with the MHP.
- Opportunities:
  - The MHP does not currently track its timeliness to services for urgent conditions and is awaiting a statewide definition of what constitutes urgent conditions.
  - Consumers reported difficulties in getting timely psychiatrist appointment.

Quality of Care

- Strengths:
  - The MHP completed two intensive treatment foster care (ITFC) memoranda of understanding to allow transition of children from group homes to a lower level of care. This is the interim step in preparation for Therapeutic Foster Care (TFC) implementation once approved by CMS for Medi-Cal billing.
  - The MHP QIC and the HHSA Management regularly examine the MHP's access, service capacity, and satisfaction indicators for quality improvement purposes.
- Opportunities:
  - The MHP continued to have a high percentage, almost a quarter of its beneficiaries with deferred diagnoses in CY14 compared to less than five percent statewide. This almost appears to account for lower than statewide average percentages for most other major diagnostic categories.
  - The organizational providers lack a single point of contact within the MHP that can facilitate easier management of this large segment of Children's services.

Consumer Outcomes

- Strengths:
  - The MHP has now implemented two level of care tools, CANS and MORS in the Children's and Adult systems of care respectively.
  - The Behavioral Health Court is producing positive outcomes. From the initial cohort, two have successfully graduated fulfilling all the required criteria.
  - Perhaps reflective of the higher than statewide outpatient follow-up rates, the MHP's rehospitalization rate has been significantly lower than that statewide.
- Opportunities:
  - CANS results cannot yet be summarized at an overall level. The MHP is in the process of contracting with a vendor to create a standalone solution from the EHR.

RECOMMENDATIONS

- Review the comments and recommendations made in the PIP Validation Tool to ensure that these and future PIPs follow the CMS EQRO protocols for performance improvement projects and incorporate appropriate consumer outcomes.
- Establish a mechanism for ongoing training for clinical and walk-in clinic reception staff to create a welcoming environment and improve consumer experience at every step of treatment.
    - Consider adding peer navigators/greeters to the walk-in clinic setting as one way to improve the access and treatment experience.
- Examine the reasons for high rates of deferred diagnosis and how it impacts beneficiary care.
- Prioritize the current efforts to improve psychiatry hours and capacity that translate to better timeliness of access to a psychiatrist
    - In the interim, make sure that medication refills are sufficient to cover the gap between psychiatry appointments.
- Consult with the organizational providers to determine the most efficient ways of managing this large segment of children's services through a single point of contact or a contract monitor and offering the most appropriate treatment to the beneficiaries.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:

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

Shasta County MHP
FY15-16 CalEQRO Agenda

Tuesday, August 11, 2015

Time	Activity
8:30 am - 9:00 am	**Opening Session** • Introduction to BHC • MHP Team Introductions MHP Participants: MHP Leadership, Quality Management Staff, Key Stakeholders EQRO: All Location: MH Admin Conference Room
9:00 am- 10:15am	**Review of Past Year** • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • Use of Data in the Past Year MHP Participants: MHP Leadership, Quality Management Staff, Key Stakeholders EQRO: All Location: MH Admin Conference Room A
10:15 am - 10:30am	**Break**
10:30 am - 12:00pm	**Quality Management Activities** • Quality, Access, Timeliness, Outcomes • Timeliness Self-Assessment Document • MHP Timeliness Metrics and Procedures Participants: MHP Leadership, Quality Management Staff, Key Stakeholders EQRO: All Location: MH Admin Conference Room
12:00 pm - 1:00 pm	**BHC EQRO Working Lunch Meeting**

Shasta Review Agenda FY15-16 FINAL

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Executive Director, BHC-CalEQRO
Bill Ullom, Chief Information Systems Reviewer, BHC-CalEQRO
Walter Shwe, Consumer Family Member Consultant, BHC-CalEQRO

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

Sites of MHP Review

MHP SITES

MHP Administration, 2640 Breslauer Way, Redding, CA 96001

CONTRACT PROVIDER SITES

Ohlberg Wellness Center, 2757 Churn Creek Road, Suite D, Redding, CA 96002

Participants Representing the MHP

Name	Position	Agency
Adam Hilton	Mental Health Clinician	HHSA – Children's
Aileen Bal	Mental Health Social Worker	HHSA – Children's
Allison Scroggins	Clinical Division Chief	HHSA
Alyson Kohl	Clinician II – Managed Care	HHSA – BSS
Amanda Curtis	Mental Health Clinician	HHSA – Children's
Amber Condrey	Community Development Coordinator	HHSA – Children's
Angelique Gray	Mental Health Clinician	HHSA – Children's
Angie Terhorst	District Director	Remi Vista
Bernie Beffon	Clinical Program Coordinator	HHSA – Adult
Bev Sherer	Analyst	HHSA – BSS
Brian Abbott	Clinical Program Coordinator	HHSA – Children's
Cheryl Madrid	MHSA Analyst	HHSA – Adult
Chris Kufner	Mental Health Clinician	HHSA – Children's
David Salvato	Clinical Program Coordinator	HHSA – Adult
Dean True	Branch Director – Adult	HHSA

Name	Position	Agency
Deb Engs	Executive Director	Victor Community Support Services.
Dianna Wagner	Deputy Branch Director	HHSA
Donnell Ewert	HHSA Director	HHSA
Doug Shelton	Division Chief	HHSA – Children's
Elizabeth Leslie	Program Manager	HHSA
Glenda Atkins	Mental Health Clinician	HHSA –Adult
Jamie Hannigan	Program Manager – MHSA	HHSA – Adult
Jeff Van Ausdall	Senior Analyst	HHSA – OPE
Jennifer Grovet	Clinical Supervisor	VCSS
Jim Ward	Patients' Rights Advocate	SCMH
Jocelyn Barron	Mental Health Clinician II	HHSA – Children's
Josette McKrola	Staff Services Analyst	HHSA – OPE
Juanita Garcia	Business Office Support	HHSA – BSS
Justina Larson	QI Coordinator	HHSA – BSS – Managed Care
Karen Davis	Office Manager	Remi Vista
Kiley Castaneda	Mental Health Clinician	HHSA – Children's
Laura Stapp	Regional Director	NVCSS
Lisa Sol	Deputy Branch Director	HHSA – Adults
Lori Steele	Clinical Division Chief	HHSA – Children's
Lorilei Ruddell	Fiscal Program Manager	HHSA – BSS
Maxine Wayda	Branch Director – Children's	HHSA
Micki Mills	Program Manager	HHSA – BSS
Monteca Zumalt	Managed Care/Compliance	HHSA – BSS
Nathalie Kuhn	Staff Nurse II	HHSA – Manage Care/Compliance
Nathan Read	Mental Health Clinician	HHSA – Children's
Patrick O'Leary	Clinical Program Coordinator	HHSA – Adult Outpatient
Rachel Freemon	Mental Health Clinician	HHSA – Managed Care
Roxanne Burke	Interim BSS Deputy	HHSA – BSS
Sheila Townley	Supervising Accountant	HHSA – BSS
Shepard Greene	Psychiatrist	SCMH
Sophie Guta	Mental Health Clinician	HHSA – Children's
Stephanie Taylor	Supervising Epidemiologist	HHSA – OPE
Susan Brooks	Sr. Staff Analyst	HHSA – BSS
Terry McCauley	Clinical Program Coordinator	HHSA – Children's

Name	Position	Agency
Tracy Tedder	Interim Branch Director	HHSA – BSS
Wendy Dickens	Child Welfare Program Manager	HHSA – Children's

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:

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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Shasta	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Youth – Triple P Implementation		
Dates in Study Period: FY13/14-FY15/16		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP team is comprised of internal and external participants representing: MHP Children's Services, MHP Managed Care, HHSA Outcomes, Planning and Evaluation (OPE) and contracted Organizational Providers. Team members were selected to ensure representation from a cross-section of the MHP and providers that utilize Triple P.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? *Select the category for each PIP:* *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Based on the PIP as submitted, it appears that the overarching goal of this PIP is improving the process of delivering care, namely, Triple P. While the population being served is in acute or chronic conditions, and the intervention being provided is an evidence based treatment that is clinical, the aim of the PIP is non-clinical in nature, i.e., improving access to and the process of delivering Triple P. The focus group results used to identify the barriers and solutions underscore this point.

Shasta Clinical PIP Validation Tool ssg v2.0 Page 1 of 10

Non-Clinical PIP:

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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Shasta	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Adult Services Milestones of Recovery		
Dates in Study Period: October 2013 (Prep with CIBHS), FY14/15 Actual PIP Period		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP developed a PIP team comprised of different stakeholders. The reason cited for choosing this topic was the lack of clinical level of care data in the adult system of care.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? *Select the category for each PIP:* *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP reviewed several tools and measures and selected Milestones of Recovery Scale (MORS) as best suited to its improvement needs in delivering care. However, the MHP purpose for this PIP was stated as implementation of MORS which is not the purpose of a PIP. The purpose should be to deliver increased quality of care through the implementation of MORS.

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