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

SAN LUIS OBISPO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 4-5, 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 San Luis Obispo 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 — Medium

MHP Region — Southern

MHP Location — San Luis Obispo

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 3,663

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: Investigate the causes of the disparity between the penetration rate for Latino/Hispanic beneficiaries and Whites, and the declining trend in claims per beneficiary for Latino/Hispanic beneficiaries that is below average for both statewide and medium county averages. Conduct a systematic analysis of service needs, demand, access, and utilization in order to understand the conditions and factors affecting penetration rates and claims to improve access to services.

Status: Partially Met

- Although the MHP has taken steps to address disparities in the penetration rate between Latino/Hispanic beneficiaries and Whites, these differences persist and the MHP has not identified specific causes. While the MHP does calculate its penetration rates, it uses data that is obtained from different sources than the data used by CalEQRO.
- Notably, the MHP is an integral part of the regional health plan CenCalHealth®. The MHP obtains its denominator information for its calculations from the health plan rather than the monthly Medi-Cal extract file used by most MHPs. This may partially explain the higher penetration rates reported by the MHP. The Medi-Cal extract file used by CalEQRO and most MHPs shows a Latino/Hispanic

penetration rate of 3.15 percent in CY 2017, while the MHP's calculated penetration rate is 6.60percent in CY 2017.

- The MHP continues to recruit and retain bilingual and bicultural providers and increase engagement and retention of Latino beneficiaries. The MHP expanded a contract with its promotores to provide translation and interpretation service.

- The MHP expanded the membership of the Cultural Competence Committee (CCC) to include five bicultural and four bilingual members, as well as members representing the perspective of other non-ethnic cultural groups.

- The MHP has developed a new cultural competence training for all agency staff, with a goal to open conversations about culture. The first training is planned for January 2019 and they plan to measure learning objective outcomes. As part of its service provider contracts, the MHP is now including in its deliverables that contractors provide reports on cultural competence trainings provided to staff.

- The Quality Support Team's (QST) quality improvement (QI) plan includes a goal to increase capacity to serve Latino beneficiaries from a CY 2017 baseline of 6.60 percent. They plan to increase the percentage of Latino beneficiaries served by 5 percent, measuring the penetration rate annually, measuring the number and percentage of beneficiaries served who are Latino, and maintaining bilingual staff capacity at all key points of contact, including at the central access line. The MHP will continue to use CenCalHealth® data rather than the monthly Medi-Cal extract file.

Recommendation 2: Expand timeliness data collection and reporting to include actual wait-times to appointments. Establish timeliness standards for psychiatry, urgent services, and no-shows/cancellations. Evaluate wait-times against standards across sites. Expand no-shows/cancellations tracking to include both adult and children's data, reason for cancellation, and initiator (beneficiary or MHP). Identity gaps in services and allocate resources accordingly.

Status: Partially Met

- Effective 3/30/2018, the MHP established timeliness standards for assessment and follow up services that match the Managed Care Final Rule.

- The MHP expanded timeliness data collection to include wait times to follow up appointments beginning 10/1/2018. The MHP tracks time from first assessment service to second and third service. In some instances, the second service may be a follow up assessment service or a second contact with the assessing clinician. The MHP has yet to fully track and report the time from initial assessment to service with the treating provider.

- The MHP is not tracking the percent of appointments that meet timeliness standards for service request to actual urgent appointment, initial request to first psychiatry appointment, nor initial request to first kept appointment.

- There is no MHP standard for no-shows for clinicians or psychiatrists, and only the no-show rates for psychiatrists can be assumed to be reasonably accurate because all their services are scheduled in the EHR. For other clinicians, the no-show rate is too low to be an accurate representation and likely only reflects the subset of services that are scheduled in the EHR.

- This year the MHP began entering both offered and scheduled appointments in the Access Journal component of their EHR manually to allow detailed timeliness reports. A new update from Cerner may allow this process to be automated rather than having to enter it manually.

Recommendation 3: The MHP should evaluate stigma related to mental health issues within the system, provide appropriate training for county and contract staff, and provide a forum for receiving ongoing updates by consumer family member employees related to their work experiences and employment support needs.

Status: Partially Met

- The MHP continued to provide both in-person and eLearning opportunities for staff to become increasingly aware of cultural differences and stigma. Additionally, they surveyed staff regarding training needs and are implementing needed training. The adult services contractor, Transitions Mental Health Association (TMHA), continues to train staff and to expand beneficiary employment opportunities.

- The Peer Advocacy and Advisory Team (PAAT) provides a forum for incorporating beneficiary strengths in the development of programs, but attendance by MHP or contract provider staff is neither required nor incentivized (e.g. via continuing education units). There has been increasing PAAT involvement in the MHP's QST committee and it continues to be an important goal for the committee this year.

- Stakeholder feedback indicates that stigma and discrimination persists within the mental health system, including at contractor sites. County staff members and contract provider staff would benefit from sensitivity training to address ongoing problems, particularly with discrimination and difficulties with staff in supported housing.

- There continues to be a need for a career ladder for beneficiaries and more beneficiary positions, especially with bilingual capabilities.

Recommendation 4: Establish a formal process of reconciliation of claims (837/835). Research and consider implementing an investigative tool such as Dimensions for effective oversight and remediation of claims. Investigate the high percentage of denials of claims for CY 16 (6.45 percent).

Status: Met

- The MHP possesses a formal methodology for the reconciliation of claims data using Excel™ spreadsheets.

- During the review period the MHP researched and considered the use of enhanced tools. It has selected the Dimensions tool suite for enhancement of its reconciliation, cost reporting, and general data analytics requirements for both the mental health and DMC-ODS systems. It may expand this analysis to its Medicare system in the future.

- This tool choice is currently in funding and implementation and will likely be active within the first quarter of 2019.

Recommendation 5: Establish a means to formally monitor beneficiaries following release from conservatorship, periodically and routinely through their transition. Assess the beneficiaries' needs including housing, medications, and mental health status. Provide support accordingly.

Status: Partially Met

- The MHP established an Adult Placement Committee (APC) prior to this recommendation to coordinate services for high utilizers of services, including Lanterman-Petris-Short (LPS) Act conservatees, but it is not focused specifically on this group. The committee meets monthly and works with Full Service Partnership (FSP) beneficiaries in general, not just those leaving conservatorship.

- The MHP reports meeting regularly with the public guardian to coordinate services, and working closely with community partners to keep high-risk individuals engaged in treatment during transition periods.

- While housing is not a mandate, beneficiary care is impacted by the housing demand. As part of the APC's activities, they instituted a process of referrals for supportive housing (provided by their largest contract provider), mostly focused on FSP referrals. Given the demand, the APC has to prioritize those beneficiaries who are most needy, so they are using the Service Prioritization Decision Assistance Tool (VI-SPDAT) (ranked by referrer) and when there is an opening the individual is reevaluated.

- The APC handles coordination of care, evaluating who is next for FSP, transitions between levels of care and a higher level of oversight for contracts. This creates continuity across FSP teams.

- For the 75 beneficiaries under conservatorship, sometimes the FSPs are full and it is difficult to get services. Currently, there are approximately eight individuals who are ready to leave conservatorship waiting for space to open up in FSP programs.

- The MHP is very limited in the ability to track LPS conservatees after the conservatorship is terminated if the beneficiary elects to leave services. They are

also limited in tracking or understanding the needs of other beneficiaries who leave services.

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 calendar year (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.

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[4] Public Information Links to SB 1291 Specific Data Requirements:
1. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx
2. 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

- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- 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. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity San Luis Obispo MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	28,585	46.5%	1,950	53.2%
Latino/Hispanic	20,349	33.1%	642	17.5%
African-American	755	1.2%	69	1.9%
Asian/Pacific Islander	1,551	2.5%	37	1.0%
Native American	349	0.6%	22	0.6%
Other	9,870	16.1%	943	25.7%
Total	**61,458**	**100%**	**3,663**	**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.				

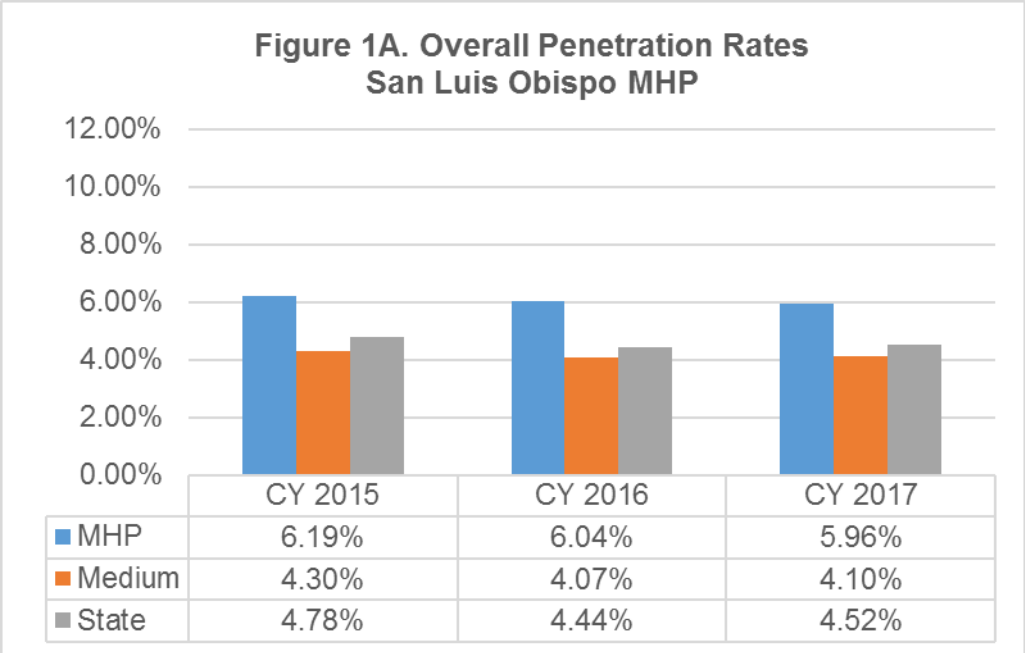
Penetration Rates and Approved Claims per Beneficiary

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.

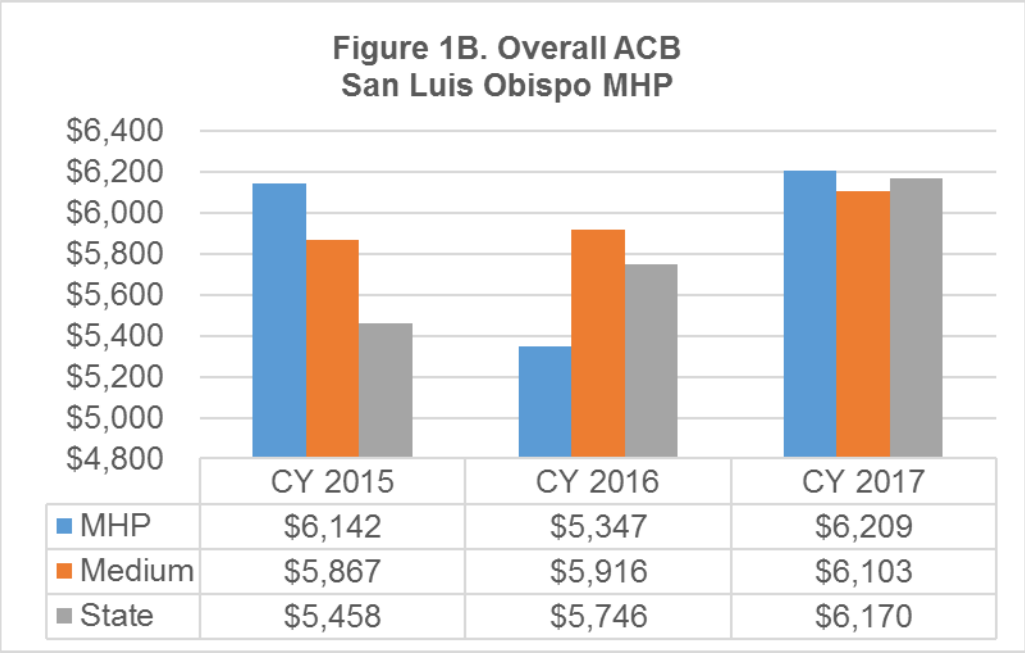
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA Penetration Rate and Approved Claims per Beneficiary.

Regarding the calculation of penetration rates, the San Luis Obispo MHP uses a different method than that 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 medium MHPs.



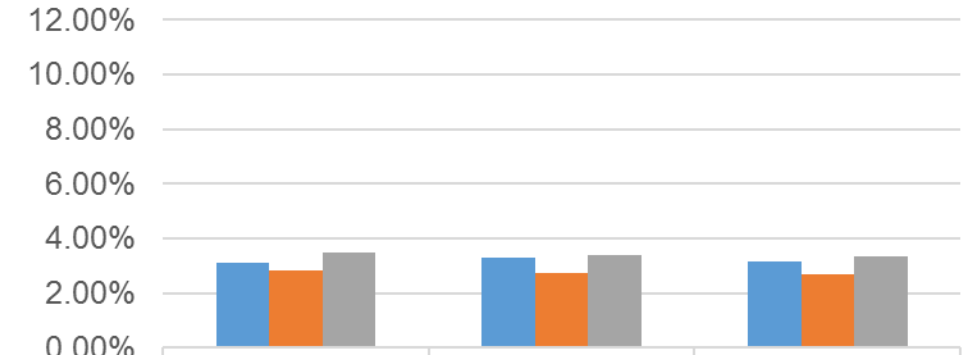
	CY 2015	CY 2016	CY 2017
MHP	6.19%	6.04%	5.96%
Medium	4.30%	4.07%	4.10%
State	4.78%	4.44%	4.52%



	CY 2015	CY 2016	CY 2017
MHP	$6,142	$5,347	$6,209
Medium	$5,867	$5,916	$6,103
State	$5,458	$5,746	$6,170

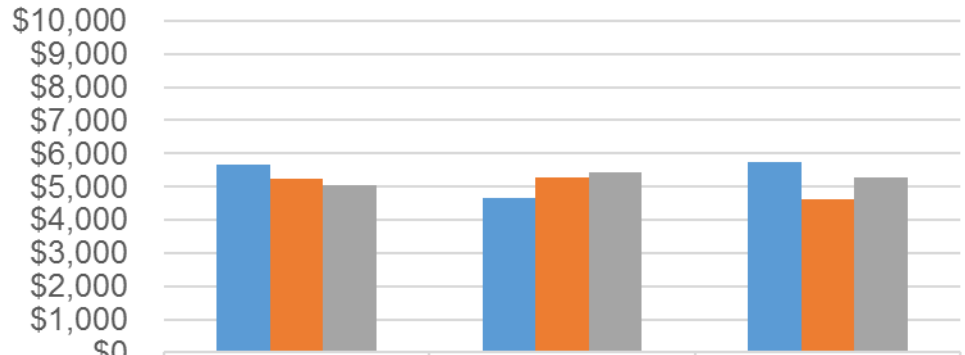
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
San Luis Obispo MHP



	CY 2015	CY 2016	CY 2017
MHP	3.13%	3.31%	3.15%
Medium	2.84%	2.74%	2.67%
State	3.50%	3.38%	3.35%

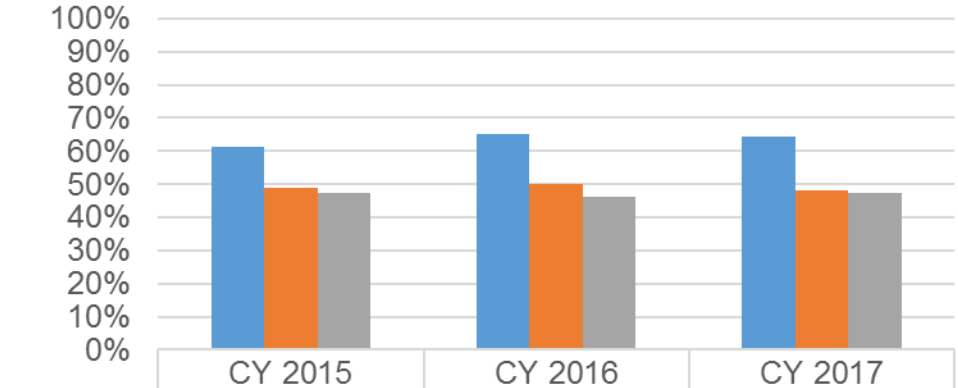
Figure 2B. Latino/Hispanic ACB
San Luis Obispo MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,660	$4,660	$5,741
Medium	$5,240	$5,279	$4,622
State	$5,029	$5,430	$5,278

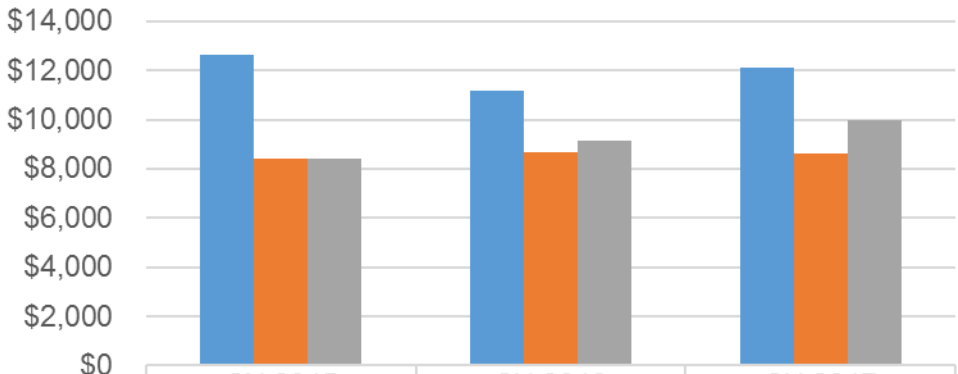
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 3A. FC Penetration Rates
San Luis Obispo MHP



	CY 2015	CY 2016	CY 2017
MHP	61.15%	65.12%	64.25%
Medium	49.03%	50.23%	48.15%
State	47.52%	46.26%	47.28%

Figure 3B. FC ACB
San Luis Obispo MHP



	CY 2015	CY 2016	CY 2017
MHP	$12,654	$11,161	$12,117
Medium	$8,435	$8,696	$8,642
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. High-Cost Beneficiaries
San Luis Obispo MHP

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	149	3,663	4.07%	$48,788	$7,269,438	31.96%
	CY 2016	102	3,811	2.68%	$47,440	$4,838,859	23.75%
	CY 2015	141	3,814	3.70%	$51,343	$7,239,356	30.90%

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 2015-2017) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

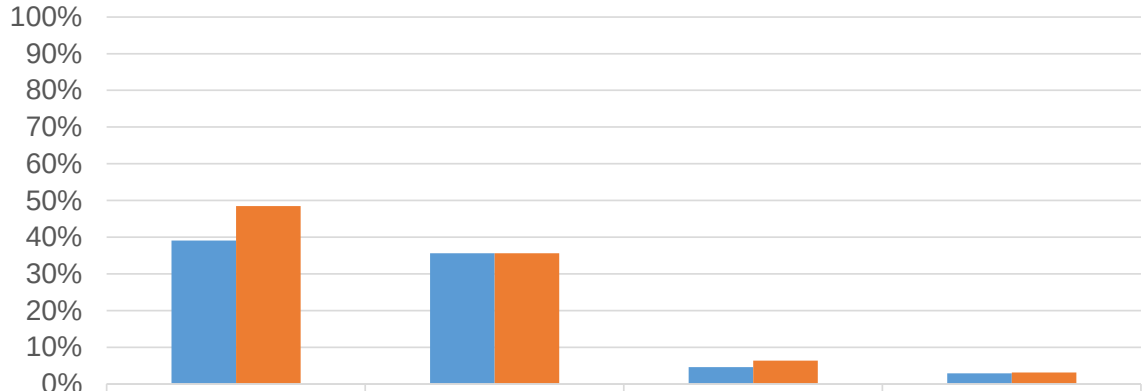
Table 3. Psychiatric Inpatient Utilization - San Luis Obispo MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	326	807	4.97	$7,490	$2,441,801
CY 2016	383	817	4.96	$6,399	$2,450,970
CY 2015	387	799	4.98	$4,553	$1,762,195

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

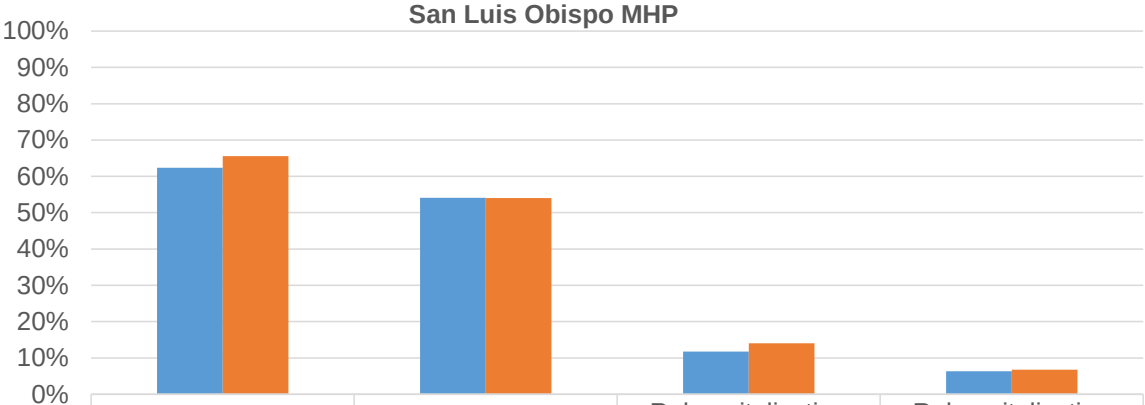
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
San Luis Obispo MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	39%	36%	5%	3%
CY 2017	48%	36%	6%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
San Luis Obispo MHP



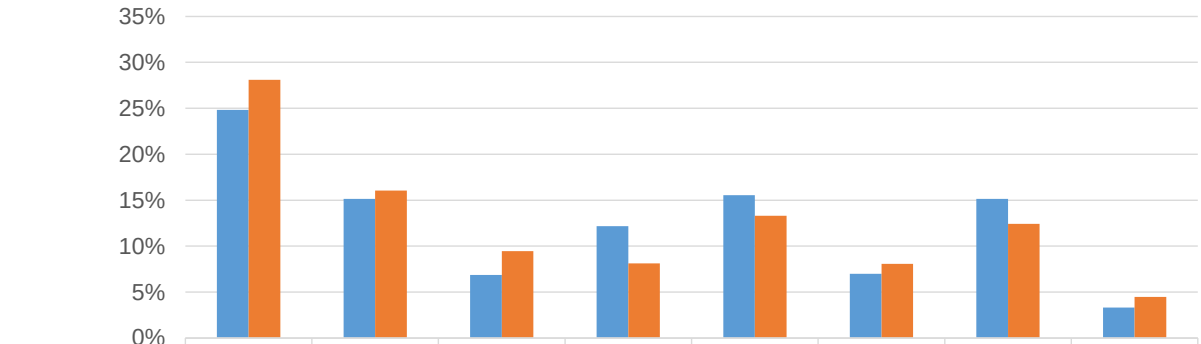
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	62%	54%	12%	6%
CY 2017	66%	54%	14%	7%

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.

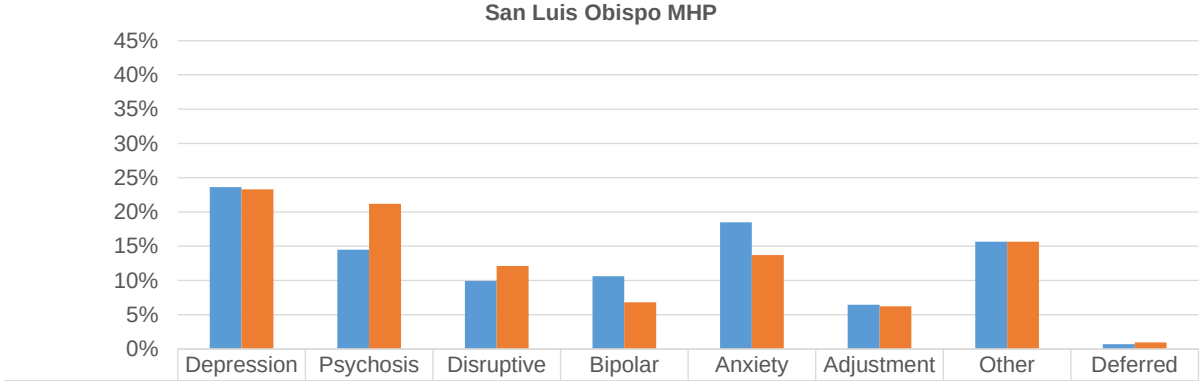
MHP self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 24.5 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
San Luis Obispo MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	25%	15%	7%	12%	16%	7%	15%	3%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

Figure 5B. Diagnostic Categories, Total Approved Claims
San Luis Obispo MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	24%	14%	10%	11%	18%	6%	16%	1%
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.

San Luis Obispo 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 two PIPs, 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 San Luis Obispo MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Beneficiary/Family Satisfaction with Treatment Plan Development
Non-clinical PIP	1	Improving Care Transitions From a Higher Level of Care to Outpatient Services

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					
Step	**PIP Section**	**Validation Item**		**Item Rating**	
				Clinical	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	PM
		1.3	Broad spectrum of key aspects of enrollee care and services	PM	M
		1.4	All enrolled populations	UTD	M
2	Study Question	2.1	Clearly stated	PM	PM
3	Study Population	3.1	Clear definition of study population	PM	M
		3.2	Inclusion of the entire study population	PM	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	PM	PM
		6.2	Clear specification of sources of data	PM	M
		6.3	Systematic collection of reliable and valid data for the study population	PM	PM
		6.4	Plan for consistent and accurate data collection	UTD	M
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	M	M

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

Table 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	3	8
Number Partially Met	11	8
Number Not Met	0	0
Unable to Determine	2	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16	16
Overall PIP Rating ((#M*2)+(#PM))/(AP*2)	**53%**	**75%**

Clinical PIP—Improving Beneficiary/Family Satisfaction with Treatment Plan Development

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

"Will ongoing youth in collaborative treatment planning using the Transformational Collaborative Outcomes Management (TCOM) treatment-planning strategy result in higher beneficiary satisfaction with their treatment plans?

Will collaborative treatment planning improve beneficiary outcomes by reducing failure to show (FTS) for services?"

Date PIP began: October 2017

Projected End date: April 2019

Status of PIP: Active and ongoing

The primary goal of the clinical PIP is to increase beneficiary and family involvement in and satisfaction with treatment plan development. The MHP postulates that increased involvement in and satisfaction with the treatment planning process will improve clinical outcomes. The intervention is the application of the TCOM strategy. The goal is to help youth and families participate more meaningfully in the development of the treatment plan using the Child Adolescent Needs and Strengths (CANS-50) assessment as a communication tool. Beneficiary outcomes are measured using the CANS-50 tool in addition to an assessment of beneficiary satisfaction with the process.

Suggestions to improve the PIP: The problem the MHP is attempting to address is a lack of engagement and participation in treatment planning, which the MHP feels leads to poorer treatment outcomes; however, data on engagement was not presented. Rather, the MHP selected the focus of this PIP based upon its yearly consumer perceptions surveys (CPS). Youth CPS respondents reported not feeling included in the treatment planning process. In establishing need, the MHP neither adequately cited literature that made the causal link to the negative outcomes they predict from lack of engagement, nor presented their own data on the causes of lack of youth engagement. Also, data which reflects the lack of engagement was not presented (e.g., no-shows, retention). The other shortcoming of using CPS data to define the problem is that there is no evidence that changes in scores are clinically significant. Given that the MHP is considering a score of four in a five-point scale to be low, there is no evidence to establish that it is a real change. Therefore, the significance of the identified problem is not apparent.

Going forward, both no- show rates and retention in services rates should be included as a baseline and used to measure a comparison before and after the application of the intervention. The use of the CPS rating tool as an indicator does not provide the ongoing data needed for a PIP. As an adjunct tool, it may provide relevant information, but as a study indicator, it does not capture information at sufficient intervals to yield reliable results. It would be better to utilize an indicator which can be evaluated monthly, bimonthly or on a quarterly basis after the interventions are implemented, to allow the MHP time during the PIP to address untoward results. The MHP should identify specific skills and/or tools that it expects its staff to use, including a tracking mechanism, so that the MHP can ensure fidelity to the TCOM treatment model; further, this would provide the MHP increased confidence in the reliability of its follow-up measurement data and any correlation to its interventions.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of reviewing PIP requirements, gathering sufficient data to define the problem, its causes and identifying related interventions. CalEQRO discussed analytic design and suggested claims data to assist in clarifying the problem (e.g., beneficiary retention in services, change in no-shows) to measure engagement in services. CalEQRO also clarified to the MHP that training is not an intervention, rather the application of specific evidence based practices are the interventions, which we confirmed onsite is their approach. Further, CalEQRO suggested a year-to-year equivalent quarter comparison of beneficiary data pre-intervention and post-intervention. Also discussed is the need to measure which staff are using the intervention.

Non-clinical PIP—Improving Care Transitions from a Higher Level of Care to Outpatient Services

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

"Will implementing an outreach telephone call intervention for beneficiaries transitioning from the psychiatric health facility (PHF) to outpatient services increase beneficiaries' participation in outpatient care, evidenced by an increase in the show rate for post-hospitalization outpatient follow-up appointments?"

Date PIP began: November 2018

Projected End date: November 2019

Status of PIP: Active and ongoing

The non-clinical PIP aims to improve the follow-up appointment attendance rate of beneficiaries who were not using services at the time of their hospitalization.

The results of the MHP's FY 2017-18 third quarter beneficiary services report shows only a 58 percent attendance rate at post-hospitalization services, with an attendance rate of 34 percent for beneficiaries not currently open to a mental health clinic for outpatient care and a 79 percent attendance rate for open beneficiaries.

The MHP reached out to beneficiaries who have failed to show for their scheduled initial outpatient services. Transportation barriers, childcare needs, forgetting their appointment, and not feeling confident that behavioral health services could meet their needs were the reasons beneficiaries gave for missing their initial appointments. The MHP selected an intervention to provide outreach/reminder calls to closed beneficiaries from hotline staff with the intention to provide support and connection.

Suggestions to improve the PIP: The MHP only reported one quarter's data so it is unclear if the low attendance rate is an anomaly; further data on readmission rates would help inform the scope of the problem. Readmission rates for 30 days, 60 days and 90 days should also be included in the PIP design. Alone, outreach/reminder calls are limited and not predictive of any beneficiary outcomes. Attendance rates, while informative, are incomplete. Other indicators which could be appropriate include readmission rates, adverse medication events, suicide attempts, and crisis visits. Additional indicators are needed to evaluate the scope of impact of the interventions. Regarding the data collection and analysis plan, more detail is needed on how often the data will be collected, what tools/training the staff have access to, descriptive information on baseline groups, how often the data will be analyzed, what tools will be used to analyze the data, what they expect the data to show and what plans are there in the event that the data does not show what is expected.

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

The TA provided to the MHP by CalEQRO consisted of discussions on collecting more in-depth data to determine if the show rate is an anomaly or a trend. Also discussed were approaches to barrier analysis to determine the causes so that a specific barrier-related intervention could be selected; further, CalEQRO suggested that the MHP evaluate its current approaches to discharge planning to identify where engagement and connection to services could be strengthened. Lastly, CalEQRO advised the MHP to provide additional detail on the study design and analysis plan.

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): 2.35 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	52%
Contract providers	45%
Network providers	3%
Total	**100%**

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	Daily
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	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Daily
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

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of remote sites currently operational: 4

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).
- While the MHP has four operational sites it is still acquiring and implementing the necessary staffing for full utilization of this resource.

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**
10.75	0	0	1.75

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**
N/A			

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

- The MHP does not have dedicated data analytic staff, but divides data reporting and analysis between staff in various classifications who have other duties. The MHP submitted a request to the Board of Supervisors to hire data analytic staff for FY 19-20.
- Stakeholder responses to both MHP and DMC-ODS inquires lead to the conclusion that the MHP does not currently possess enough clinical QI data analytics staffing to accomplish routine QI inquires or state mandates for either the MHP or DMC-ODS portions of normal agency business.

- The MHP is currently relying on health agency IT staff to complete custom reporting activities but the health agency IT management has not hired staffing sufficient to accomplish this task nor do these tasks appear to be receiving reasonable prioritization. For example, the MHP currently has implemented the CANS-50 toolset within its EHR workflow but cannot get reporting to supply even cursory utility from the data or meet state reporting requirements in 2019.

Current Operations

- The MHP continues to use the Cerner Community Behavioral Health (CCBH) product suite, maintained by health agency IT staff, for its primary EHR.
- The MHP is in the implementation queue for upgrades that will allow the MHP to exchange health information with the regional One California Partnership Regional Health Information Organization (OCPRHIO). Beginning February 4, 2019, the MHP will be able to access external patient records from outside facilities who are participants in the exchange. The MHP is also in the process of migrating to a new Electronic Health Record (EHR) platform offered by its current vendor, Cerner Corporation. Upon migration to this new platform, estimated in 2021, the MHP will also be able to upload patient records to the exchange.

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
CCBH	Practice Management	Cerner	8.5	MHP
CCBH	Clinical	Cerner	8.5	MHP

The MHP's Priorities for the Coming Year

- Prepare for transition from CCBH to Cerner's Millennium.
- Add protected health information messaging through the Ultra-Sensitive Exchange™ product.
- Finalize a partnership with OCPRHIO for regional Health Information Exchange.
- Continue to improve security with two-factor authentication (2FA) and Radio-frequency identification (RFID) technologies. Further adoption of National

Institute of Standards and Technology's (NIST) newly updated best practices for information systems security.

- Disaster Recovery Planning.
- Improve reporting capabilities around service data for all beneficiary attributes captured in assessments.

Major Changes Since Prior Year

- Finalized move from 2X™ to Enterprise Remote Access products.
- Redesigned and launched County Website.
- Implemented Secure Print.
- Implemented RFID chips in badges.

Other Areas for Improvement

- The MHP does not require all contracted organizational providers to enter clinical data into the MHP's EHR, but does require all service/claims data to be entered.
- While health agency IT stakeholders did discuss fledgling data governance (DG) standards, the MHP does not broadly engage in DG activities currently. This complicated the process of understanding and interpreting some of the MHP's submissions to the EQR. The MHP would benefit from a strong engagement with health agency IT staff to craft methodologies for the transparent memorialization of reporting goals, baselines, extraction methodologies, assumptions, and end use. Everyone should be able to look at reports with DG documentation and plainly understand what they are being told by these reports.
- Given current difficulties obtaining reports from the CANS-50 toolset, MHP management should try to obtain the resources necessary either via current methodologies or outside consulting to empower 2019 DHCS reporting mandates.
- The Medical Director would be materially aided in her due diligence and oversight activities if the QI team could provide enhanced medication management oversight reports using the data collected by the electronic prescribing tool. Such reports would allow the Medical Director to move beyond legacy sampling methods for oversight activities.
- Discussion with stakeholders indicated that they are aware of SB 1291 resources being provided by DHCS. They report that they are doing regularly scheduled metabolic monitoring on these beneficiaries but were not aware that these results did not appear to be showing up in the state's reporting. An investigation by the QI team may be in order to ensure data quality.

Plans for Information Systems Change

- The MHP has no plans to replace the current system; however, the MHP has formally decided to make the upgrade transition from the current CCBH product suite to the Cerner Millennium product. This project is expected to initiate in the last quarter of 2019 with a go live date currently anticipated for some time in 2020. This upgrade should radically improve the MHP's reporting environment and empower the creation of more robust data analyses and dashboards.

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	CCBH	x			
Assessments	CCBH	x			
Care Coordination	CCBH			x	
Document Imaging/ Storage	CCBH	x			
Electronic Signature—MHP Beneficiary	CCBH	x			
Laboratory results (eLab)	CCBH			x	
Level of Care/Level of Service	CCBH			x	
Outcomes	CCBH	x			
Prescriptions (eRx)	CCBH	x			
Progress Notes	CCBH	x			
Referral Management	CCBH			x	
Treatment Plans	CCBH	x			
Summary Totals for EHR Functionality:					
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0
FY 2017-18 Summary Totals for EHR Functionality:		9	3	0	0

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
FY 2016-17 Summary Totals for EHR Functionality:		9	0	1	0

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

- Stakeholder reported that while some outcomes tools like the CANS-50 and Pediatric Symptom Checklist (PSC-35) are in the EHR workflow it is impossible to get scoring or reports from these toolsets.

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:

The MHP is actively in the process of acquiring the Dimensions Reports product to provide reconciliation, targeted reporting dashboards, and cost report functionality.

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims San Luis Obispo MHP							
Number Submitted	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Claim Adjustments**	**Dollars Approved**
87,574	$23,730,732	**2,027**	$750,876	3.16%	$22,979,856	$975,075	$22,004,781
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.**							

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial San Luis Obispo MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	667	$439,549	59%
Beneficary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	707	$165,277	22%
Service not payable with other service(s) rendered on same day.	47	$76,635	10%
TOTAL	2,027	$750,876	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- The MHP is implementing the Dimensions suite of tools which should empower the MHP to improve its denials rate.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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/family member 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 consumer and family member involvement. CalEQRO provides gift cards to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group One

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries, including FC, who are mostly new beneficiaries who have initiated/utilized services within the past 15 months.

The onsite group consisted of Latino/Hispanic and Caucasian parents and caregivers, both male and female, all of whom spoke English and were over the age of 25. The focus group was held at Family Care Network, Inc. (FCNI) in San Luis Obispo, CA.

Number of participants: Six

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

- Most found that the services provided by FCNI were comprehensive and helpful once they had access to wraparound services.
- The service providers were described as patient and responsive to caregiver questions.
- For those without current access to the wraparound services for foster children, the process of accessing care could be complicated and involve multiple referrals, leaving them to feel “bounced around.”

Participants’ general comments regarding service delivery included the following:

- There has been frequent turnover of psychiatrists.
- Specialty telehealth services received mixed reviews, with some describing discomfort and difficulty communicating via the portal (due to appointments not being in person).

- Because of this, many caregivers felt that they needed to be extra vigilant about advocating for their children, particularly to avoid medication errors.
- Overall, the FCNI FSP was perceived as very positive and helpful.

Participants' recommendations for improving care included the following:

- Caregivers would like to receive an updated list of resources and county services, in writing (by mail) at least once per year.
- A need for inpatient psychiatric services for minors who are experiencing extreme states (e.g. self-harm or crisis) was noted, or at least a place where children could be "stabilized" without having to go to the emergency department or rely on in-home services from FCNI.

Interpreter used for focus group one: No

Consumer/Family Member Focus Group Two

CalEQRO requested a culturally diverse group of Spanish-speaking adult beneficiaries, who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. However, it should be noted that the group was comprised of English speaking beneficiaries, mostly identifying as Caucasian. The group was attended by slightly more females than males. Group participants were over the age of 25, with a few participants over the age of 60. The focus group was held at Hope House Wellness Center operated by TMHA in San Luis Obispo, CA.

Number of participants: 14

There were no participants who entered services within the past year. Participants described their experience as the following:

- The San Luis Obispo Health Integration Project (SLO-HIP) has been wonderful. Beneficiaries can access a medical provider at the MHP, and see a physician assistant at the same place as they receive mental health care.
- There were concerns about access to supportive housing via TMHA for those who have children.
- Additionally, a policy change that introduced a lottery for Section 8 housing vouchers has complicated access to safe, affordable housing, although there is a county team that help with this.
- Staffing changes at TMHA have led to dissatisfaction with services (described as disorganized and not transparent, and that staff used communication perceived by beneficiaries as intimidating and sometimes threatening). Beneficiaries who

have used the grievance process through both TMHA and the MHP do not feel there has been resolution, particularly in regards to housing services.

- There has been turnover in psychiatrists, but overall there seemed to be higher satisfaction with medication management services.
- The job club and other employment services were described as “flexible and supportive.”

Participants’ recommendations for improving care included the following:

- More housing for beneficiaries who are homeless, including expanding access to housing for people who have Section 8 vouchers or who have dependent children.
- Staff need to be trained in communication with beneficiaries, sensitivity to people with disabilities, trauma, and anti-discrimination.
- The peer-to-peer speakers’ bureau is not well-attended by staff, in part because notifications about the meetings are not sent ahead of time and there is no incentive for staff to attend.

Interpreter used for focus group two: No

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	PM
The MHP evaluates penetration and cultural/language needs as part of its ongoing quality improvement program. The MHP tracks access for Spanish language services and uses data to determine needs. Increasing access for Spanish-speaking beneficiaries is an ongoing QST Work Plan goal. Promotores are used for translation services along with the language line through TMHA. Currently, the MHP is performing an LGBTQ needs assessment across county services. Training needs are identified by the CCC through staff surveys and community research. Findings are discussed in the CCC. However, disparities persist in access for Latino/Hispanic beneficiaries, and the causes are unclear.		
1B	Manages and adapts its capacity to meet beneficiary service needs	PM
Services are tracked by type and location, including Spanish language services, penetration rates, wait-times, productivity and caseloads. Last year the MHP was able to extend its service hours at the San Luis Obispo (SLO) site to 6 p.m., two days per week. Currently, the extended hours are available every day Monday through Friday. The MHP evaluates its efforts through the QST and reports on various measures as outlined in the annual QI work plan.		

Table 15: Access to Care Components		
Component		**Quality Rating**
The MHP provides staff with monthly reports that identify beneficiaries who have not recently received services and who no longer meet medical necessity criteria; however staff are not fully aware of how to use these reports to right-size their caseload. The contract provider FCN was issued an expanded contract in September 2018 that includes Youth and Transition Aged Youth (TAY) FSP teams. FCN has more flexibility to provide comprehensive services around the clock, as well as bilingual access. It is unclear whether the MHP evaluates the implementation of strategies to address disparities in access. From data provided by the MHP it is unclear if there is enough clinical QI data analytics staffing to adequately meet the need for evaluation activities.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP collaborates with many community based organizations (CBO), including TMHA, FCN, Wilshire Health and Community Services, Inc., Sierra Wellness, Seneca, and Kinship Center. CBOs are prominent partners on the QIC Committee. Training opportunities are also extended to CBO staff. The MHP has a forensics program which provides both substance use disorder (SUD) and behavioral health (BH) services through clinic-based and jail-based programs. There are two therapists embedded at the juvenile services center and a psychiatrist who provides services there weekly. The Assisted Outpatient Treatment (AOT) court petition process was finalized in October 2018. However, the MHP is hoping not to have to use a court process but rather aims to engage beneficiaries voluntarily. The MHP established a 40-hour crisis intervention training (CIT) for law enforcement beginning May 2018. The goal is to train all law enforcement officers in crisis intervention strategies to deescalate and support community members with severe mental health needs. They have held three rounds of training and trained 70 officers who work in jails, custody, street enforcement, law enforcement, and fire management.		

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	PM
The MHP separately tracks English language access and Spanish language access to monitor parity. The MHP reports an overall average length of time from first request for service to first offered appointment of 10 days, with a standard of 14 calendar days and 83 percent of the overall appointments meeting the standard [9 days for adults, 83 percent; 8 days for children, 84 percent; no FC data provided]. The MHP changed its method of case assignment post assessment. It went from a site authorization team to a rolling assignment to stay within the network adequacy standards. The meeting occurs weekly, however, if later that same day an assessment is completed, it will be assigned via a supervisor, rather than wait an additional 7 days for the meeting to occur. The MHP does not track first kept appointment nor did it break out FC. While the MHP does routine analyses they do not currently monitor these metrics for their entire system of care. It is not entirely clear why they are not gathering data from all of their providers into the EHR for analysis. Additionally, the MHP needs to begin analysis of timeliness metrics on its FC population.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
Again this year, the MHP tracked time to next available appointment from a point in time. Data provided is FY 2017-18 data. Starting in October 2018, the MHP began to input data into an EHR module that calculated wait from first assessment to first offered psychiatric evaluation. Of the 22 beneficiaries whose assessment resulted in authorization of medication support, the mean wait-time until offered psychiatric evaluation is 21.54 calendar days, with a range of 0-96 days. The MHP reports an overall average length of time from first request for service to first psychiatry appointment of 10.4 days, with a standard of 15 business days. The percentage of overall appointments meeting the standard was not provided. For timeliness of psychiatry appointments, the MHP reported an average of 13.4 days for adults and 7.4 days for children; no FC data was provided.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
The MHP expanded telehealth capability to three additional sites: North County Atascadero and SLO adult services will go live in January, and SLO youth services are ongoing. They will expand to DMC as well. The MHP is implementing a new methodology within its EHR to track timeliness from first determination of need, but this functionality is just in the beginning phase of development. Also, the MHP did not submit documents for any of its timeliness metrics to clarify how evaluations were being conducted.		
2C	Tracks and trends access data for timely appointments for urgent conditions	M
The MHP tracked the wait-time from request to first offered urgent appointment. Urgent initial requests for services that are not post-hospital requests are also tracked as urgent requests and were tracked for (N = 91). The MHP reported an overall average of 5.22 days, with a goal of 7 days, with a range of 0-26 days. For adults, the average urgent wait-time reported was 4.07 days and for children was 6.14 days. The MHP began tracking kept appointments and follow up beginning 10/1/18. . It is unclear if the MHP possesses adequate clinical QI data analytics capability to regularly track this metric.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
The MHP historically only tracks new beneficiaries who are discharged, but began tracking all discharges from the PHF beginning FY 2018-19. The MHP began tracking follow-up from all beneficiaries from all hospitalizations beginning in October 2018. Note that the data reported on is for the county-operated PHF only, unless otherwise specified. Admissions have decreased significantly due to severely curtailing minor admissions from jail. Mobile crisis provider diverts a large number of admissions to out-of-county facilities that are not reflected below, but will be in future versions of this tool. There were 680 hospitalizations with 243 having follow-up appointments after hospital discharge (216 adults, 27 children). The average for adults was five days, and for children was seven days; however, data for FC children was not separated out. While the MHP has historically tracked only a subset of this data, it has implemented a protocol to fully be able to accumulate and analyze this data in FY 2019-20.		
2E	Tracks and trends data on rehospitalizations	M

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
Of the 680 hospitalizations, 73 beneficiaries were rehospitalized within 30 days at a rate of 10.7 percent. The MHP does not track metrics from all routinely utilized inpatient facilities, but working towards this capability. Metrics provided were only from county operated facilities.		
2F	Tracks and trends no-shows	PM
The no-show rate for psychiatrists is reasonably accurate because all their services are scheduled in the EHR. Other clinician no-show rates are too low to be an accurate representation and likely only reflect the subset of services that are scheduled in the EHR. The MHP reports a no-show rate of 14 percent for psychiatrists, 15 percent for adults, and 14 percent for children; no standard was provided. The MHP reports a no-show rate of 6 percent overall for clinicians, 7 percent for adults, and 6 percent for children. Again, no standard was provided While the MHP does examine its no-show rates, it has yet to set a baseline standard for its evaluations.		

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

Table 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	PM
The MHP has an integrated QST which meets monthly and encompasses inpatient and outpatient services, as well as DMC-ODS. The MHP evaluates its efforts through the QIC and reports on various measures as outlined in the annual QI work plan. The MHP does not have enough staffing resources dedicated to clinical QI data analytics. Most of the current analytics capability seems captive to purely fiscal, compliance, and operations' needs.		
3B	Data used to inform management and guide decisions	PM
Since December 2014, the MHP has been collecting system-wide data on several measures related to quality, however, the MHP has limited ability to extract the data. Last year the MHP reported that it was very close to being able to pull the data out within a couple of months; however, the MHP still does not have the ability to aggregate its data. Stakeholders reported that the MHP is currently experiencing challenges in the system-wide analysis of its store of outcomes tool data. While the MHP does set some baselines and time bound goals, it does not perform these activities in a ubiquitous manner across its entire system of care for all programs, providers, and practitioners. According to the ISCA and QST Work Plan Evaluation, the MHP analyzes waits, trends in access, penetration rates, regional utilization of services, differences between low, medium and high utilizers of services, ICC trends, relationship between IHBS and TBS, to name a few.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
Contractors attend at least quarterly, or for some weekly meetings with the MHP administration. Each contractor has a designated point of contact. They also meet with the director separately. Line staff indicates that the staff advisory committee has not met since 3/2018. It was an unfiltered venue for staff to direct concerns to the BH Administrator and the BH Administrator will attend regional staff meetings during 2019 to allow staff input and to improve communication. Communication with program managers was viewed as bidirectional. There are issues with retention and recruitment of enough providers to meet capacity. New hire processes are lengthy. Communication with executive and middle management was not streamlined. Some		

MHP staff plan to participate in the Countywide employee strike that will occur next week. Primary issues that resulted in a contract negotiation impasse include disagreements about compensation and benefits. MHP management provided support to staff in exercising their right to strike and took active steps to ensure that MHP essential services remain operational in all regions.

The MHP posts a newsletter online, uses email to publish meeting minutes, redesigned its internet website, and is redesigning its intranet to communicate with stakeholders ~~in an effort to save paper~~. The MHP conducts weekly management meetings, weekly Program Supervisor meetings, and, at most sites, a weekly in-person staff meeting to communicate important information. Peer advocates share resources in the communities. The three wellness centers are open to the public. Information is shared at the wellness centers in meetings, flyers, and brochures.

Parents/Caregivers have similar access to information but some would like information and updates through the mail. FCNI has an open-house once per year.

3D	Evidence of a systematic clinical continuum of care	PM

The MHP uses the CANS-50 and PSC-35 but does not aggregate data. The MHP uses annual assessment updates to determine whether beneficiaries continue to meet medical necessity, and to allow for appropriate level of care assignment.

The PHF has a transfer coordinator and a social worker for discharge planning. The MHP is evaluating its strategies for care transition through its performance improvement projects.

The new Crisis Stabilization Unit (CSU) began operations in April 2018, with a four bed capacity. Stakeholders report that it seems to be operating smoothly. The MHP reports that it seems to have reduced inpatient admissions. In the first 90 days, it is reported that there were approximately 90 admissions to the CSU.

The MHP reports that it is not possible to get practical scoring data from the outcomes tools to assist in timely level of care activities in a quantitative framework.

The MHP should identify how often and why beneficiaries are unsuccessful in transitioning to the MHP's providers and to a lower level of care provided by the MCP.

3E	Evidence of consumer and family member employment in key roles throughout the system	PM

The MHP meets this criteria mainly via a significant ($5.7 million) contract with TMHA. Consumers are employed in various roles including Health Navigators (assisting beneficiaries in navigating the many peer recovery resources in the community), Consumer and Family Advocates (deliver early intervention system navigation services, some serve as "case managers"), and Personal Services Specialists (typically involved in such activities as day-to-day beneficiary skills-building and resource support).

Beneficiary positions include – peer program managers, peer advocates, behavioral health navigators, youth family partners, and family advocate for adults. There is also PAAT, SLO-HIP collaboration with mental health and physical health, and Transition and Relapse Program (TARP) with two part-time peer positions traveling throughout the county to meet beneficiary needs as they arise.

The lack of full-time, benefited, and career advancement opportunities for peer staff make it difficult to grow in their positions. Most positions are part-time (20 hours) or volunteer positions without pay or benefits. More peer positions are needed, especially those with bilingual capabilities to fill the ever growing needs of beneficiaries in SLO.

3F	Beneficiary-run and/or beneficiary-driven programs exist to enhance wellness and recovery	PM

The MHP contracts with TMHA for three beneficiary-run wellness centers (Hope House in SLO, Safe Haven in Arroyo Grande, and Life House in Atascadero). Each center offers various recovery-oriented classes (including Wellness Recovery Action Planning), groups (both beneficiary-lead and therapy groups), and trainings.

There are three wellness centers in San Luis Obispo County: Hope House in SLO, Safe Haven in Arroyo Grande, and Life House in Atascadero. The MHP plans to open an additional wellness center in Paso Robles.

The wellness centers offer classes with a focus on whole person care. Classes such as Coping with Anxiety, Coping with Depression, Parenting Support Group, Dual Recovery, and Yoga are a few examples.

The MHP and contract providers include “lived experience” as a qualifying factor in making hiring decisions.

Stakeholder feedback indicates that beneficiaries are not aware of all available services. This is especially true for those individuals who are no longer conserved and who no longer have public guardians to help them navigate the system.

3G	Measures clinical and/or functional outcomes of beneficiaries served	PM

The MHP has implemented CANS-50 but is not able to get data. The software engineer left over a year ago. Recent interviews occurred. Approaches to next steps differ between the mental health director who is willing to contract out for this service, and the director of IT who does not want to contract this out; however, they have not yet hired to fill the position vacated over a year ago.

They were advised to consider consulting with Kings View to purchase one piece - to develop extraction software for CANS-50.

While stakeholders report that the MHP is accumulating some system-wide outcomes data, they also report that there is no analysis being done at present. The MHP confirmed this was the case due to the lack of adequate IT staffing. HSA IT currently

does not believe this is a priority and the MHP may fail to comply with DHCS mandates in this area in 2019.

The Adult Needs Strengths Assessment (ANSA) is performed at entry and annually. They also use the VI-SPDAT for service prioritization, and the Milestones of Recovery Scale (MORS) is in the queue with adult FSP as a way to rate acuity and level of care. MHP programs use the CANS-50, ANSA, and are starting to use PSC-35 in clinical assessments and re-assessments to guide treatment planning and to make authorization decisions. They are developing reports that will allow expanded utilization of outcome measures.

3H	Utilizes information from Consumer Satisfaction Surveys	PM

All clinics provide the Performance Outcomes and Quality Improvement (POQI) twice per year. In the past, the MHP entered its own results in Survey Monkey to produce reports, which were quickly disseminated to clinics and providers. On another occasion, the MHP used a Cal Poly statistics student to analyze CPS reports from a five-year period. The results were incorporated into the QST Work Plan and served as consumer input in the development of a clinical PIP. From this data, they began a PIP to address the growing dissatisfaction of beneficiaries related to service convenience. As a result, the MHP expanded managed care hours until 6 p.m. Monday through Friday. They also use the POQI to achieve board approval on new positions (timeliness and satisfaction). They did not enter the POQI in survey monkey Fall 2018, but did in the Spring 2018. The MHP reported that CIBH said they would give results to the MHP in a matter of months. The MHP does provide results to clinics.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of San Luis Obispo 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: Active and ongoing

Recommendations:

- The MHP needs to ensure that the methodologies defined within the projects are appropriate to determine if the goals of various interventions are achieved. The MHP should maintain contact with CalEQRO to secure ongoing TA as outlined in the PIP section of this report.

Access to Care

Changes within the past year:

- The MHP received approval in July 2018 from the Board of Supervisors to hire three adult case managers in FY 2018-19. They are planning to place one at each of the adult outpatient clinics.
- The new CSU began operations in April 2018. In the first 90 days, it is reported that there were approximately 90 admissions to the CSU.
- The AOT court petition process was finalized in October 2018; however, the MHP is focused on increasing engagement of beneficiaries on a volunteer basis.
- In September 2018, the MHP expanded its contract with FCNI to increase services for TAY, now providing 24-hour services with bilingual access.
- The Adult Placement Committee increased their meeting frequency, quarterly to monthly, to improve coordination of referrals between outpatient and FSP levels of care.
- In June 2018, under a Substance Abuse and Mental Health Services Administration (SAMHSA) grant for primary and behavioral health integration, the MHP began providing integrated physical health and mental health care in the health integration project SLO-HIP. Community Health Centers of the Central Coast (CHC) assigns a physician assistant to see beneficiaries on-site at the MHP.

- The MHP is working to expand telehealth capability to three additional sites. They currently have the hardware and one site staffed and operational. Under a pilot project in 2017, they began expanding telehealth for youth services, and now have it available in Atascadero and San Luis Obispo for youth, and are expecting rollout for San Luis Obispo adult service in January 2019. The MHP mostly uses locum tenens psychiatrists to provide services two to three days per week; however, they are planning a formal request for proposals (RFP) for telehealth in the summer of 2019.

- Following implementation of walk-in assessments at the San Luis Obispo adult clinic in 2017, the MHP expanded walk-in initial assessments at the North County adult clinic beginning in January 2018 and at the South County adult clinic in July 2018 to improve access to adult mental health services.

- The MHP increased its emergency mental health evaluation availability by expanding its contract with Sierra Mental Wellness in November 2018 to have one full-time clinician located at two of its local hospitals' emergency departments.

Strengths:

- The MHP now has four operational sites across the system of care to provide telehealth services.

- The expanded membership on the CCC includes representation of veterans, the LGBTQ community, those with substance use disorders, psychiatry, program managers and youth, of which five members are bicultural and four are bilingual.

- The promotores program has expanded in the past year to address increased fears in the Latino/Hispanic community surrounding immigration enforcement and deportations. Promotores held meetings throughout the county to assure people that they can seek behavioral health services without fear.

- Stakeholders had mostly positive regard for the Family Care Network FSP.

- CenCalHealth (the managed care plan) has a contract with the Hollman Group, who contracts with mental health clinicians in the community for therapy, psychiatry and assessments (this overlaps with county Network Providers) for mild-to-moderate beneficiaries who are either not assigned to an FQHC or do not want to get services from the same place as primary care. Holman will link them to another provider within ten business days for non-psychiatrist or 15 days for a psychiatrist. A memorandum of understanding dictates standardized tools (impairment ratings from CANS-50/ANSA) so that assessment at Hollman or the MHP are the same.

Opportunities for Improvement:

- With the expanded membership of the CCC, the MHP has the opportunity to receive more diverse feedback as to methods for improving the Latino/Hispanic penetration rate.
- The MHP's quality improvement plan contains the goal to increase the percentage of Latino beneficiaries served by 5 percent, measuring the penetration rate annually, and measuring the number and percentage of beneficiaries served who are Latino.
- Contractors are now required to track and report on the number of staff who are trained in cultural competence.
- The MHP needs to take the results of its staffing and capacity oversight analyses and hire appropriate specialty telehealth providers to fully staff its new telehealth sites across the system of care.
- There were reports from some stakeholders that the new four-bed CSU has had some difficulties in coordinating assessments, with reports of unnecessary duplicated assessments by the MHP upon discharge from the CSU.
- Beneficiary work history is assessed during intake; however, there is no formal protocol to assess beneficiary readiness or interest in employment or employment services. Although employment or employment services are available through TMHA, the MHP could be more proactive in identifying work-related needs.
- Although the MHP has taken steps to address disparities in the penetration rate between Latino/Hispanic beneficiaries and Whites, these differences persist.
- Promotores exceeded their minimum contract standards by 200 percent. Though laudable, the MHP should more closely monitor this contract to ensure there is adequate compensation and an appropriate balance of work throughout the contract term, so that the contract provider is not penalized for serving fewer at some times, while not having received payment for serving more at other times.
- More affordable, supportive housing is needed for beneficiaries experiencing homelessness. While TMHA accepts Section 8 vouchers, there may be limitations that burden beneficiaries, such as the availability of suitable housing appropriate for beneficiaries with children, and/or a lack of housing providers other than TMHA.
- The MHP could conduct outreach to landlords to explain the benefits of Section 8 (e.g. definite income) or train beneficiaries to self-advocate.
- The MHP continues to face limitations in the ability to track LPS conservatees after the conservatorship is terminated if the beneficiary elects to leave services. They are also limited in tracking or understanding the needs of other beneficiaries who voluntarily leave services. For the 75 beneficiaries under conservatorship, sometimes the FSPs are full and it is difficult to get services.

Recommendations:

- In keeping with the expansion of the membership of the Cultural Competence Committee, the MHP should actively document input from this committee as to methods for improving the Latino/Hispanic penetration rate.
- The MHP should adhere to the Quality Support Team's (QST) quality improvement plan goal to increase the percentage of Latino beneficiaries served by 5 percent, measuring the penetration rate annually, and measuring the number and percentage of beneficiaries served who are Latino. *(This recommendation is a carry-over from FY 2017-18.)*
- In keeping with new requirements set out by the MHP requiring contractors to report staff who are trained in cultural competence, the MHP should actively monitor contract provider staff who have been trained.
- The MHP should hire more specialty telehealth providers or explore other options to increase psychiatry capacity.
- The MHP and its CSU contractor should collaborate with stakeholders to maximize the experience of smooth transitions for beneficiaries discharged from the CSU to outpatient care to reduce the experience of redundancies in scheduling and collection of routine demographic data. While the MHP tracks referrals from the CSU to outpatient services, it only recently started tracking attendance rates at scheduled follow-up appointments and should expand this reporting.
- During intake of new beneficiaries, the MHP should have a formal (universal) plan to identify work-related needs and aspirations, including education and training.
- The MHP should work with the promotores contractor to modify the contract so that it includes adequate anticipated funds for community needs, including outreach, to avoid unreimbursed services.
- The MHP should continue to meet with community-based organizations to ensure that housing units are as accessible as possible for high-need beneficiaries with children, those leaving conservatorship, and those with Section 8 vouchers.

Timeliness of Services

Changes within the past year:

- The MHP has provided expedited post-hospitalization and post-CSU follow-up services using direct scheduling in the EHR. This enhanced scheduling was implemented in winter 2018 for the PHF and summer 2018 for the CSU. Prior to this, staff from CSU or PHF would call or fax Central Access and this complicated

and delayed discharge. The new, current process uses Scheduler in the EHR, which is independent of Central Access (although Central Access is faxed a log of scheduled appointments in order to track them).

- In October 2018, the MHP began manually entering service requests to both offered and scheduled appointments into the Access Journal to increase their ability to monitor access from request for services to first scheduled ongoing care service. This will allow detailed timeliness reports for first, second, and third service of any kind, by insurance type.

Strengths:

- The MHP tracks timeliness for offered appointments for initial assessment and follow up after an inpatient stay. The MHP meets its 10-business day benchmark for initial assessment on average and is well below the 7-day HEDIS standard for post hospital follow-up on average.

Opportunities for Improvement:

- Most of the MHP's contract providers are included in routine analyses of timeliness, except Seneca (Kinship Center). It is not entirely clear why they are not gathering data from all of their providers into the EHR for analysis.
- While the MHP began entering both offered and scheduled appointments in the Access Journal manually to allow detailed timeliness reports, a new update from Cerner may allow this to be automated rather than having to enter manually.
- The MHP is not currently meeting new requirements under SB 1291 for separately tracking FC timeliness.
- The MHP does not track percent of appointments that meet standards for initial request to first kept appointment, initial request to first psychiatry appointment, or request for urgent appointment to actual encounter.
- There are no standards for no-show rates for clinicians other than for psychiatrists. Further, discrepancies in tracking among staff yields unreliable data.

Recommendations:

- The MHP should monitor timeliness metrics for their entire system of care, including all contract providers. *(This recommendation is a carry-over from FY 2017-18.)*
- The MHP should update its EHR to allow automated tracking of timeliness when that functionality becomes available.
- The MHP needs to begin tracking and reporting timeliness data for foster children separately.

- The MHP should consider additional analyses of wait time data to measure success and further improve access. (*This recommendation is a carry-over from FY 2017-18.)*

- The MHP should bring all clinicians into compliance with using Scheduler in the EHR so that no-show rates can be accurately reported.

Quality of Care

Changes within the past year:

- The MHP established a 40-hour CIT training for law enforcement beginning May 2018 and trained over 70 officers in crisis intervention strategies.

- In spring 2018, the MHP started a birth-to-five consultation group for clinicians to expand capacity and expertise for treatment of this age group, particularly those kids with prenatal substance exposure.

Strengths:

- The contract provider TMHA provides a flexible and supportive array of supported employment services, and in coordination with the Department of Rehabilitation, these are extended beyond beneficiaries served by TMHA. This co-op is under a three-year contract agreement between Department of Rehabilitation and the MHP, who then contracts with TMHA using a cash-match from the federal government. The contract is authorized to serve 25 people and there are performance metrics, including that beneficiaries should be continuously employed for 90 days before their case is closed.

- The MHP has a robust coordination with CenCalHealth (the managed care plan) and the FQHC (CHC), including monthly meetings.

- The MHP's BH Administrator, QST Division Manager, and Managed Care Program (MCP) Supervisor meet with the MCP's clinical team monthly. The BH Medical Director joins this meeting frequently. The MCP invites the FQHC to the meeting on a quarterly basis or as needed to improve care coordination. The MHP implemented an integrated care pilot (SLO-HIP), which includes services by an FQHC Physicians' Assistant in an MHP clinic.

Opportunities for Improvement:

- The addition of contemporary QI analytics on the MHP's electronic prescribing database would assist the Medical Director in oversight and identification of clinical outliers and potential medical errors.

- The FQHC has its own assessments conducted in primary care and may refer to in-house psychiatrists or out to the MHP or Hollman for specialty mental health services. There appears to be variation in practice that depends on the individual clinician at the FQHC. The MHP is working to be able to reimburse for provider-

to-provider consultations without the beneficiary present, in order to be able to improve the quality of coordination. CenCalHealth has conducted trainings on coordination and consultation, but it is unclear whether this has had an impact on provider behavior since there has been no measurement.

- The MHP has conducted cultural sensitivity trainings over the past year, but these seems to have had a limited impact.
- The quality of interpersonal interactions between staff and beneficiaries could be improved, so that these groups can work together in a manner that reflects empathy and tolerance.
- There is a peer-to-peer speakers' bureau and regular meetings hosted by the PAAT but there is not mandatory or incentivized attendance by staff and notifications are not sent ahead of time to allow staff to attend.
- Grievance processes for concerns and complaints against county MHP and contract provider staff seem to be not well articulated or advertised.

Recommendations:

- The committee should continue to explore options for consultation and training for the MCP's primary care physicians who encounter beneficiaries in need of mental health services.
- The MHP should ensure that all staff have the opportunity to participate in mandatory cultural competence, implicit bias, trauma-informed care, and related trainings to improve the quality of interactions with beneficiaries.
- The MHP should consider strategies to incentivize staff attendance at PAAT meetings other than regular paid work time or CEUs.
- The MHP should investigate effective channels to distribute information clarifying the MHP's grievance and appeal processes, including those related to contract providers, to ensure they meet the needs of beneficiaries. The MHP should provide additional patients' rights training to housed beneficiaries, to PAAT, and to contractors.

Beneficiary Outcomes

Changes within the past year:

- The MHP revised their youth assessment and CANS-50/PSC-35 utilization in September 2018. They now use the 0-5 early childhood module of the CANS-50 at Martha's Place (an early child assessment center for high-risk children), the PSC-35 for children ages 3 to 18, the CANS-50 for children and youth ages 5 to 21. They are trying to make outcome measures a standard part of workflows.

- The Adult Placement Committee coordinates wraparound services (e.g. housing) for high-need beneficiaries using the VI-SPDAT and a multi-stakeholder meeting.

Strengths:

- The MHP administers several level of care/outcomes measures for youth and adult beneficiaries, including CANS-50, PSC-35, ANSA, VI-SPDAT. They will be adding the MORS in the next year.

Opportunities for Improvement:

- The MHP does not currently possess the clinical QI data analytics staffing necessary to provide reporting from its outcomes tool suites. Current analytics staffing is inadequate to either state mandated reporting or ongoing clinical QI investigations.
- The Adult Placement Committee process may not be addressing the needs of all high-need beneficiaries; in particular, those who become less engaged in care may need special attention.

Recommendations:

- The MHP should hire clinically competent data analytics staff to meet its reporting requirements.
- Health Agency IT should hire additional software engineering staff to create reports for the MHP's data analytics staff to analyze.
- The MHP should develop a quality improvement process to evaluate and monitor the needs of high-need beneficiaries who leave services without graduating by measuring outcomes and experiences. This process should include beneficiaries who are transitioning from conservatorship. The goal is to identify strategies to improve the experience of care and causes of leaving care. The MHP should continue to expand FSP teams to the largest degree possible at the recommendation of the MHP's stakeholders.

Foster Care

Changes:

- The MHP has provided additional trainings under Continuum of Care Reform implementation, beginning in spring 2018. They coordinate with Department of Social Services (DSS), including ongoing management of a shared database.
- Family Care Network is a local FFA who will to provide TFC pursuant to a contract with the MHP. The MHP recently approved their training material and certified them to provide TFC.

Strengths:

- The MHP conducts comprehensive metabolic screening annually using a “tickler” system that sends reminders to doctors. This includes children taking medications for ADHD. Monitoring is conducted quarterly, although reporting is not on this same schedule.

Opportunities for Improvement:

- While performing regular metabolic monitoring for FC beneficiaries the MHP’s reporting on this process appears low in state reports.
- The MHP is not currently meeting new requirements under SB 1291 for separately tracking FC timeliness.

Recommendations:

- The MHP should investigate data quality issues surrounding its metabolic monitoring reporting to the state for foster children.
- The MHP needs to begin tracking and reporting timeliness data for foster children separately.

Information Systems

Changes within the past year:

- The MHP implemented a very functional redesign of its website to further beneficiary engagement.
- The MHP took its first steps, by implementing RFID enabled badges, to bring system security up to current NIST standards.

Strengths:

- The MHP expanded its infrastructure to support enhanced telehealth capabilities.

Opportunities for Improvement:

- The MHP is not currently requiring all of its organizational providers to fully engage with its EHR either through direct entry or electronic data transfer.
- The MHP needs to partner closely with health services IT to begin the implementation of fully functional DG protocols for its clinical QI data analytics.
- The MHP should continue its efforts to enhance cost reporting functionality and lower its denial rate for claiming below state averages.

Recommendations:

- The MHP should engage with health services IT to craft and implement DG protocols.

- The MHP should continue its project to implement Dimensions Report functionality to enhance cost reporting and claiming.

Structure and Operations

Changes within the past year:

- A new Health Agency Director was hired in May 2018. He has experience in public health, environmental health, and IT.
- The MHP finalized reclassification of staff to achieve parity between job classes and divisions in summer 2018. Previously, mental health and substance use staff were paid differently. The new parity for behavioral health clinicians (with any licensure) stabilizes staffing, allows movement of staff between substance use and mental health services, and may prevent more experienced clinicians from leaving substance use services to work in mental health for the greater earning opportunity.
- The MHP's Network Adequacy proposal was submitted in April 2018 and approved by DHCS in September.
- The Health Information Exchange is nearly finalized for public health services, with an estimated completion in December 2018, with behavioral health to follow closely thereafter.

Strengths:

- The MHP's public website is user-friendly, easily navigable, and provides accessible information to beneficiaries and the public to inform the community of available services, service locations, and relevant access/engagement information.
- Many contract provider positions are filled by individuals with lived experience including wellness center staff, family advocates, behavioral health navigators, a mentoring program for FSP beneficiaries, and relapse prevention. Wraparound has four full-time family partners.

Opportunities for Improvement:

- Most of the peer support worker positions in the county are part-time (20 hours) or volunteer and not benefited. There is no career ladder for peer support workers and very few bilingual positions.

Recommendations:

- The MHP and contract providers should create more full-time and benefited peer support positions, especially those with bilingual capabilities, as well as opportunities for advancement and leadership throughout the MHP.

Summary of Recommendations

FY 2018-19 Recommendations:

- In keeping with the expansion of the membership of the Cultural Competence Committee, the MHP should actively document input from this committee as to methods for improving the Latino/Hispanic penetration rate.
- In keeping with new requirements set out by the MHP requiring contractors to report staff who are trained in cultural competence, the MHP should actively monitor contract provider staff who have been trained.
- The MHP should hire more specialty telehealth providers or explore other options to increase psychiatry capacity.
- The MHP and its CSU contractor should collaborate with stakeholders to maximize the experience of smooth transitions for beneficiaries discharged from the CSU to outpatient care to reduce the experience of redundancies in scheduling and collection of routine demographic data. While the MHP tracks referrals from the CSU to outpatient services, it only recently started tracking attendance rates at scheduled follow-up appointments and should expand this reporting.
- During intake of new beneficiaries, the MHP should have a formal (universal) plan to identify work-related needs and aspirations, including education and training.
- The MHP should work with the promotores contractor to right-size the contract for community needs, including outreach, to avoid unreimbursed services.
- The MHP should continue to work with community-based organizations to ensure that housing units are as accessible as possible for high-need beneficiaries with children, those leaving conservatorship, and those with Section 8 vouchers.
- The MHP should update its EHR to allow automated tracking of timeliness when that functionality becomes available.
- The MHP should bring all clinicians into compliance with using Scheduler in the EHR so that no-show rates can be accurately reported.
- The committee should continue to explore options for consultation and training for the MCP's primary care physicians who encounter beneficiaries in need of mental health services.
- The MHP should ensure that all staff have the opportunity to participate in mandatory cultural competence, implicit bias, trauma-informed care, and related trainings to improve the quality of interactions with beneficiaries.

- The MHP should consider strategies to incentivize staff attendance at PAAT meetings other than regular paid work time or CEUs.

- The MHP should investigate effective channels to distribute information clarifying the MHP's grievance and appeal processes, including those related to contract providers, to ensure they meet the needs of beneficiaries. The MHP should provide additional patients' rights training to housed beneficiaries, to PAAT, and to contractors.

- The MHP should develop a quality improvement process to evaluate and monitor the needs of high-need beneficiaries who leave services without graduating by measuring outcomes and experiences. This process should include beneficiaries who are transitioning from conservatorship. The goal is to identify strategies to improve the experience of care and causes of leaving care. The MHP should continue to expand FSP teams to the largest degree possible at the recommendation of the MHP's stakeholders.

- The MHP should hire clinically competent data analytics staff to meet its reporting requirements.

- Health Agency IT should hire additional software engineering staff to create reports for the MHP's data analytics staff to analyze.

- The MHP should develop a quality improvement process to evaluate and monitor the needs of high-need beneficiaries who leave services without graduating – measuring outcomes and experiences, with a goal to identify strategies to improve the experience of care and causes of leaving care.

- The MHP should engage with health services IT to craft and implement data governance protocols.

- The MHP should continue its project to implement Dimensions Report functionality to enhance cost reporting and claiming.

- The MHP and contract providers should create more full-time and benefited peer support positions, especially those with bilingual capabilities, as well as opportunities for advancement and leadership throughout the MHP. FY 2018-19 Foster Care Recommendations:

- The MHP should investigate data quality issues surrounding its metabolic monitoring reporting to the state for foster children.

- The MHP needs to begin tracking and reporting timeliness data for foster children separately.

Carry-over and Follow-up Recommendations from FY 2017-18:

- The MHP should adhere to the Quality Support Team's (QST) quality improvement plan goal to increase the percentage of Latino beneficiaries served

by five percent, measuring the penetration rate annually, measuring the number and percentage of beneficiaries served who are Latino.

- The MHP should monitor timeliness metrics for their entire system of care, including all contract providers.
- The MHP should consider additional analyses of wait time data to measure success and further improve access..

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 – San Luis Obispo 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)
Consumer Employee/Peer Employee/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Wellness Center Site Visit
Contract Provider Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Laysha Ostrow, Lead Quality Reviewer
Cyndi Lancaster, Quality Reviewer
Duane Henderson, Information Systems Reviewer
Marilyn Hillerman, 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

2180 Johnson Avenue
San Luis Obispo, CA 93401
Health Campus 2nd Floor

Contract Provider Sites

Family Care Network
1255 Kendall Road
San Luis Obispo, CA 93401

TMHA/Hope House
1306 Nipomo Street
San Luis Obispo, CA 93401

TMHA
784 High Street,
San Luis Obispo, CA 93401

Martha's Place
2925 Mc Millan Avenue #108
San Luis Obispo, CA 93401

TMHA - Growing Grounds,
3740 Orcutt Rd,
San Luis Obispo 93401

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Ackerman	Donna	BH Program Supervisor	County of San Luis Obispo/DAS
Atwell	Angela	MH Nurse III	County of San Luis Obispo BH
Atwell	Brian	BH Program Supervisor	County of San Luis Obispo BH
Bahner	Kristen	BH Program Supervisor	County of San Luis Obispo BH
Bolster- White	Jill	Executive Director	Transitions Mental Health Association
Cohen	Kathleen	BH Program Supervisor	County of San Luis Obispo BH
Collins	Cindy	Administrative Services Manager	County of San Luis Obispo BH
Epps	Sara	Administrative Services Officer II	County of San Luis Obispo BH
Ford	Patty	Division Manager MH Services	County of San Luis Obispo BH
Forgette	Gina	BH Clinician III	County of San Luis Obispo BH
Getten	Amanda	BH Program Supervisor	County of San Luis Obispo BH
Elliot	Teri	Adult Services Clinician	County of San Luis Obispo BH
Graber	Star	Division Manager DAS Services	County of San Luis Obispo/DAS
Hoffman	Christine	BH Program Supervisor	County of San Luis Obispo BH
Hopkins	Denise	Accountant III	County of San Luis Obispo BH
Ilano	Daisy	MH Medical Director	County of San Luis Obispo BH
King	Ben	Program Manager II	County of San Luis Obispo - DSS
Klassen	Dianna	BH Clinician III	County of San Luis Obispo BH
Mason	Lydie	Administrative Services Officer I	County of San Luis Obispo BH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
McGarigle	Rebecca	BH Program Supervisor	County of San Luis Obispo BH
Miller	Jackie	BH Clinician III	County of San Luis Obispo BH
Nibbio	Jonathon	COO & Director of Clinical Services	Family Care Network, Inc.
Pemberton	Teresa	BH Program Supervisor	County of San Luis Obispo BH
Peters	Josh	BH Program Supervisor	County of San Luis Obispo BH
Richardson	Julia	BH Program Supervisor	County of San Luis Obispo BH
Rietjens	Jill	BH Program Supervisor	County of San Luis Obispo BH
Robin	Anne	Behavioral Health Administrator	County of San Luis Obispo BH
Schmidt	Julianne	BH Clinician III	County of San Luis Obispo BH
Tarver	Rachel	BH Clinician III	County of San Luis Obispo BH
Troxell	Desiree	Patients' Rights Advocate, MH Therapist III	County of San Luis Obispo BH
Veloz-Passalacqua	Nestor	Administrative Services Officer II	County of San Luis Obispo BH
Vickery	Greg	Division Manager MH Services	County of San Luis Obispo BH
Cloyd	Starr	Program Manager	County of San Luis Obispo BH
Limon	Enrique	ACC II	County of San Luis Obispo BH
Koenig	Rachel	ASO	County of San Luis Obispo BH
Mendez	Louise	Senior Acct. Clerk	County of San Luis Obispo BH
Hopkins	Denise	Acct III	County of San Luis Obispo BH
Hansen	Briana	Acct III	County of San Luis Obispo BH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Hortillosa	Elaine	ASO II	DAS
Bailey	Kathy	Health Info Tech	DAS
Hibble	Norman	IT Supervisor	HA
Collins	Cindy	Admin Services Manager	County of San Luis Obispo BH
Ilano	Daisy	BH Clinician III	County of San Luis Obispo BH
Schmidt	Julianne	BH Clinician III	DAS/QST
Barnett	Cyndi	Director of Family Services	FCNI
Bohz Alvarez	Meghan	Clinical Director	TMHA
Birruciello	Christine	Program Manager	SMWG
Lehmen	Tina	Program Director	Seneca
Friedrick	Danielle	Mental Health Advocate	THMA San Luis Obispo
Clementi	Anthony	Mental Health Advocate	THMA San Luis Obispo
Vasquez	Fernando	Family Advocate	THMA San Luis Obispo
Soul	Vivian	Family Advocate	THMA San Luis Obispo

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. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB
San Luis Obispo MHP

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
Medium	550,124	19,928	3.62%	$98,243,489	$4,930
MHP	18,513	807	4.36%	$3,261,044	$4,041

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. CY 2017 Distribution of Beneficiaries by ACB Cost Band
San Luis Obispo MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	3,414	93.20%	93.38%	$13,032,697	$3,817	$3,746	57.30%	56.69%
>$20K - $30K	100	2.73%	3.10%	$2,443,058	$24,431	$24,287	10.74%	12.19%
>$30K	149	4.07%	3.52%	$7,269,438	$48,788	$54,563	31.96%	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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Luis Obispo	
PIP Title: Improving beneficiary/family satisfaction with TP development	
Start Date (MM/DD/YY): 10/26/2017 **Completion Date** (MM/DD/YY): 4/30/2019 **Projected Study Period** (#of Months): 18 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 12/04/2018-12/05/2018 **Name of Reviewer**: Laysha Ostrow, PhD	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted

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

The primary goal of the clinical PIP is to increase beneficiary and family involvement in and satisfaction with treatment plan (TP) development. The MHP postulates that increased involvement in and satisfaction with the treatment planning process will improve clinical outcomes. The intervention is the application of the Transformational Collaborative Outcomes Management (TCOM) strategy. The goal is to help youth and families participate more meaningfully in the development of the TP using the CANS-50 assessment as a communication tool. Beneficiary outcomes are measured using the tool in addition to an assessment of beneficiary satisfaction with the process.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	No primary consumers or family were included in this process. Consumer perspectives were included only using survey data that was not specifically designed for this project. Stakeholders consisted only of providers and staff, although it is not clear whether any providers were at the table. There was also a survey of youth-serving staff.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The topic was selected using anecdotes from clinicians and survey data from beneficiaries and clinicians.

Select the category for each PIP:	
Clinical: ☐ Prevention of an acute or chronic condition ☐ High volume services	*Non-clinical:* ☐ Process of accessing or delivering care

☒ Care for an acute or chronic condition ☐ High risk conditions		
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The problem the MHP is attempting to address is a lack of engagement and participation in treatment planning, which the MHP feels leads to poorer treatment outcomes; however, data on engagement was not presented. Rather, the MHP selected the focus of this PIP based upon its yearly beneficiary perceptions surveys (CPS). Youth CPS respondents have not traditionally felt included enough in the treatment planning process. In establishing needs, the MHP neither cited much literature nor their own data to show all the negative outcomes they predict from lack of engagement nor the causes of the lack of engagement. Also, data which reflects the lack of engagement was not presented (no- show, retention). The other problem with using CPS to define the problem is that is hard to say that a score of above 4 in a 5-point scale is a really low score. The significance of the identified problem is not apparent. The MHP postulates that increased involvement in treatment planning will increase investment in and satisfaction with treatment, which correlates positively with successful treatment outcomes;

		however, more data is needed which supports the correlation between improved outcomes and involvement in treatment planning to ensure that the intervention chosen is likely to have an impact.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	More information is needed to understand the scope of the applied interventions.
	Totals	**2** Partially Met **1** Not Met **1** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will ongoing youth in collaborative treatment planning using the TCOM treatment-planning strategy result in higher beneficiary satisfaction with their treatment plans? Will collaborative treatment planning improve beneficiary outcomes by reducing failure to show (FTS) for services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	SLO youth-serving staff participated in a mandatory TCOM training on 6/29/2018. The goals of the training were to provide staff with a framework and strategies for increasing collaborative treatment planning. While the PIP suggests that no-show FTS rates could be an indicator of engagement, rates were not provided as a baseline. More information on outcomes is needed. What are the poorer treatment outcomes? Where is the evidence that lack of engagement and participation in treatment planning leads to poorer outcomes? Further, what is the cause(s) of the poorer outcomes and lack of engagement? This information is paramount in order to choose the most appropriate interventions.
	Totals	**1** Partially Met

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP reports that study participants will be all youth who participate in treatment planning after implementation of the TCOM intervention; however, demographics or parameters were not provided.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Staff	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Data will be collected using the current CPS rating tool at the interval specified by DHCS. Information was not provided on those youth who do not participate in treatment planning and whether it would be useful to compare their outcomes as a control.
	Totals	**2** Partially Met
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Overall, I am satisfied with the services I received (Youth rating on CPS Question 1) • I helped choose my services (Youth rating on CPS Question 2) • I helped choose my goals (Youth rating on CPS Question 3) • CANS-50 ratings pre TCOM TP and post TCOM TP	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP listed 3 CPS questions as indicators, in addition to the CANS-50 rating. Also, a secondary measure, though not a study indicator, will be a staff survey regarding the use of the TCOM concepts and framework at various intervals after training (to insure fidelity to the model). The MHP mentioned measuring engagement through its FTS rate but did not include that in its baseline data. This measure and additional measures of engagement should be included in the PIP since this PIP's purpose is to improve engagement. .

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☒ Member Satisfaction ☒ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is measuring health and functional status through the CANS-50.
	Totals	**2** Met
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Study sampling will not be utilized.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met	

	☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**1** NA
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Some information was provided including the dates of the planned data collection period in November; however, more information is needed for the data collection and analysis plan. Also, re-measurement data needs to be collected quarterly at minimum.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☒ Claims ☒ Provider ☐ Other:	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Data will be collected using the current CPS rating tool at the interval specified by DHCS (bi-yearly). The CANS-50 outcomes data will also be collected via the EHR; however, data should be collected quarterly at minimum. If solely using the CPS questions, other sources of data should be incorporated into this PIP.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The collection instrument and directions to staff will be unchanged from prior iterations of CPS collection. Front desk staff at all youth serving sites will encourage youth and families to complete the CPS and will not know that the CPS will be used to measure the effectiveness of the first intervention. They are unlikely to know which beneficiaries have had a treatment planning session and will be blind to key aspects of the study. The CANS-50 data will be collected for each study participant. Scores will be the most recent scores rated prior to the TCOM TP compared to the first ratings collected after the TP. The methodology for using the CPS questions in a PIP needs improvement. As previously stated, the MHP needs to measure more frequently, and directly tie it to the PIP participants. As administered per state guidelines once or twice a year, it's not at all certain who gets those surveys, or actually completes them. The results of that survey will not show any impact from this PIP's intervention unless the parameters are more defined and frequent, both before and after the administration of the intervention. Otherwise, any correlation would not be reliable.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	See note in 6.3.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP is looking for a 10 percent change in baseline scores on three CPS questions. More information is needed for the data analyses plan. Who will collect the data? How often will it be collected? What tools will be used to collect the data? Who will analyze the data? How often will it be analyzed? What tools will be used to analyze the data? What do they expect the data to show? What are the plans if the data doesn't show what is expected?
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Greg Vickery/Patty Ford Title: Division Managers Role: PIP Leads	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met **4** Partially Met **1** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Collaborative Treatment Planning using TCOM tools/skills (began 6/29/18) 2. CANS-50 score graphics tool (use with beneficiary) 3. Integrated Core Practice Model (ICPM) Strategies	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP implemented the TCOM approach to treatment plan collaboration to improve engagement. TCOM is a collaborative approach which uses the CANS-50 tool as a visual aid to bridge both beneficiary and provider experiences during the development of the treatment plan.
	Totals	**1** Met
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	This PIP is not at this point yet.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

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

Ask: *At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**5** NA

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

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

Conclusions:

Met	3
Partially Met	10
Not Met	1
UTD	2
# Not applicable	12
Score	50.00%
total items in rating	28

The problem the MHP is attempting to address is a lack of engagement and participation in treatment planning, which the MHP feels leads to poorer treatment outcomes; however, data on engagement was not presented. Rather, the MHP selected the focus of this PIP based upon its yearly beneficiary perceptions surveys (CPS). Youth CPS respondents reported not feeling included in the treatment planning process. In establishing need, the MHP neither adequately cited literature that made the causal link to the negative outcomes they predict from lack of engagement, nor presented their own data on the causes of lack of youth engagement. Also, data which reflects the lack of engagement was not presented (no- show, retention). The other problem with using CPS data to define the problem is that it has not been established that a score above four in a five-point scale is meaningfully low. Therefore, the significance of the identified problem is not apparent.

Recommendations:

Going forward, both no- show rates and retention in services rates should be included as a baseline and used to measure a comparison before and after the application of the intervention. The use of the CPS rating tool as an indicator does not provide the ongoing data needed for a PIP. As an adjunct tool, it may provide relevant information, but as a study indicator, it does not capture information at sufficient intervals to yield reliable results. It would be better to utilize an indicator which can be evaluated monthly, bimonthly or on a quarterly basis after the interventions are implemented, to allow the MHP time during the PIP to address untoward

results. The MHP should identify specific skills and/or tools that it expects its staff to use, including a tracking mechanism, so that the MHP can ensure fidelity to the TCOM treatment model; further, this would provide the MHP increased confidence in the reliability of its follow-up measurement data and any correlation to its interventions.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of reviewing PIP requirements, gathering sufficient data to define the problem, its causes and identifying related interventions. CalEQRO discussed analytic design and suggested claims data to assist in clarifying the problem (beneficiary retention in services, change in no-shows) to measure engagement in services. CalEQRO also clarified that the MHP interventions were not training, but the application of a specific evidence based practice; further, CalEQRO suggested a year-to-year equivalent quarter comparison of beneficiary data pre-intervention and post-intervention. Also discussed is the need to measure which staff are using the intervention.

Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: San Luis Obispo Behavioral Health Department (SLOBHD)	
PIP Title: Improving Care Transitions from a higher level of care to outpatient services	
Start Date (MM/DD/YY): 11/01/18 **Completion Date** (MM/DD/YY): **Projected Study Period** (#of Months): 12 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 12/04/2018-12/05/2018 **Name of Reviewer**: Laysha Ostrow, PhD	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The non-clinical PIP aims to improve the follow-up appointment attendance rate of beneficiaries who were not open to services at the time of their hospitalization. The results of the MHP's FY 2017-2018 third quarter beneficiary services report shows only a 58 percent attendance rate at post-hospitalization services, with an attendance rate of 34 percent for beneficiaries not currently open to a mental health clinic for outpatient care and a 79 percent attendance rate for open beneficiaries.	

The MHP reached out to beneficiaries who have failed to show for their scheduled initial outpatient services. Transportation barriers, childcare needs, forgetting their appointment, and not feeling confident behavioral health services could meet their needs were the reasons beneficiaries gave for missing their initial appointments. The MHP's selected intervention is to provide outreach/reminder calls to closed beneficiaries from hotline staff with the intention to provide support and connection.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has a team comprised of stakeholders including the PAAT, however, their role is unclear. The idea for this PIP came out of concerns and ideas presented at QST meetings consisting of the Quality Support Team Division Manager, Adult Mental Health Services Division Director, Medical Director, Behavioral Health Board representation, the PAAT, PHF Program Supervisors, Managed Care Program Supervisor, Transitions Mental Health Association contract providers, and QST staff.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The SLOBHD QST committee reviews outpatient statistics, including the attendance rates for post-hospital follow-up services. The results of our FY 17/18 third quarter beneficiary services report data shows only a 58 percent attendance rate at these post-hospital services. The MHP only reported one quarter's data so it is unclear if the low attendance rate is an anomaly.

		Further data on readmission rates would help inform the scope of the problem.
Select the category for each PIP: *Non-clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☒ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Engagement, post-hospitalization
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **2** Partially Met
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing?	☐ Met ☒ Partially Met	The question itself is measurable.

Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will implementing an outreach telephone call intervention for beneficiaries transitioning from the PHF to outpatient services increase beneficiaries' participation in outpatient care evidenced by an increase in the show rate for post-hospitalization outpatient follow-up appointments?	☐ Not Met ☐ Unable to Determine	Readmission rates for 30-day, 60-day and 90-day should also be included in the PIP design.
	Totals	**1** Partially Met
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The baseline population is adult consumers who were scheduled for a post-hospital follow-up services at an adult mental health clinic during the third quarter of FY 17/18.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population for the performance indicator, which analyzes attendance rates at beneficiary's first post-hospital follow-up service, is consumers scheduled for post-hospital follow-up services at an adult mental health clinic (in South County, SLO, or North County) from November 1, 2018-April 30, 2019. The estimated sample size is approximately 284.
	Totals	**2** Met
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators?	☐ Met	The chosen indicator is limited and not predictive of any beneficiary outcomes associated with it.

List indicators: Attendance rate for post-hospital follow-up service	☒ Partially Met ☐ Not Met ☐ Unable to Determine	Additional indicators are needed to evaluate the scope of impact of the interventions.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Attendance rates, while informative, are incomplete. Other considerations include readmission rates, adverse medication events, suicide attempts, and crisis visits.
	Totals	**2** Partially Met
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	**3** NA
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Beneficiaries being discharged from the PHF are scheduled for a post-hospital follow-up service at their local mental health clinic in the EHR. Each appointment is resolved via a progress note by the assigned staff. More information is needed: Who will collect the data? How often will it be collected? What tools will be used to collect the data?

6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☒ Member ☐ Claims ☐ Provider ☒ Other: EHR record	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The progress note service data will be collected via a Beneficiary Services Report from the EHR. Attendance rate data will be collected and analyzed by Amanda Getten, LMFT, Managed Care Program Supervisor.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not mention a tool, just an approach of looking at progress notes in EHR.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The Managed Care Program Supervisor will analyze the data utilizing a t test to calculate the statistical significance of the difference in attendance rate between our study and baseline groups. More information is needed. What baseline groups? How often will it be analyzed? What tools will be used to analyze the data? What do they expect the

		data to show? What are the plans if the data doesn't show what is expected?
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Amanda Getten, LMFT Title: Managed Care Program Supervisor Role: PIP Lead	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**3** Met **3** Partially Met
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* Calls by SLO Hotline staff to beneficiaries discharged from PHF	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP uses iCarol, a cloud-based call-log database used by SLO Hotline to log each follow-up call request. Information recorded includes whether the caller was successful in reaching the beneficiary (iCarol) and then compare it to whether the beneficiary attended their post-hospitalization appointment (EHR).
	Totals	**1** Met
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?	☐ Met ☐ Partially Met	

This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)	☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**4** NA	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask:* *At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable	

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

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

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

Conclusions:

Met	8
Partially Met	8
Not Met	0
UTD	0
# Not applicable	12
Score	75.00%
total items in rating	28

The MHP only reported one quarter's data so it is unclear if the low attendance rate is an anomaly; further data on readmission rates would help inform the scope of the problem. Readmission rates for 30-days, 60-days and 90-days should also be included in the PIP design. Alone, outreach/reminder calls are limited and not predictive of any beneficiary outcomes. Attendance rates, while informative, are incomplete. Other indicators which could be appropriate include readmission rates, adverse medication events, suicide attempts, and crisis visits. Additional indicators are needed to evaluate the scope of impact of the interventions. Regarding the data collection and analysis plan, more detail is needed on how often the data will be collected, what tools/training the staff have

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
access to, descriptive information on baseline groups, how often the data will be analyzed, what tools will be used to analyze the data, what they expect the data to show and what plans are there in the event that the data does not show what is expected.
Recommendations: The TA provided to the MHP by CalEQRO consisted of discussions on collecting more in-depth data to determine if the show rate is an anomaly or a trend. Also discussed were approaches to barrier analysis to determine the causes so that a specific barrier-related intervention could be selected; further, CalEQRO suggested that the MHP evaluate its current approaches to discharge planning to identify where engagement and connection to services could be strengthened. Lastly, CalEQRO advised the MHP to provide additional detail on the study design and analysis plan.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time