FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Tehama

Conducted on

October 5, 2016

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Introduction

Tehama is a Small MHP located in Northern California along Interstate 5 and west of the Lassen National Forest. The MHP headquarters are in Red Bluff, California. The Tehama MHP continues to experience significant staffing issues, a challenge for service provision that was raised in the FY14-15 CalEQRO reviewed. During FY15-16, much of the MHP's efforts were to address these staffing issues and establish infrastructure to support its staff in service delivery.

Access

The MHP made significant strides in responding to the previous year's CalEQRO recommendation to address its staffing issues and identify an interim solution for clinical staff positions, particularly for a Quality Assurance (QA) Manager/Coordinator. The MHP was without a QA Manager from November of 2014 through May of 2016. The position was filled through recruitment and bringing on additional clinical staff. The MHP is focusing its efforts on promoting local candidates through a social work intern program at California State University Chico. The MHP has strong collaborative relationships with local churches and law enforcement to provide services for the homeless and Mental Health (MH) informed crisis services.

Timeliness

The MHP tracks some timeliness measures but not all. The MHP's ability to track all metrics is limited due to not having a functional electronic health record system. They did not produce detailed timeliness data and therefore cannot adequately monitor its ability to meet beneficiary needs in a timely manner. There are significant issues related to timeliness of psychiatry appointments, as well as hospitalization, follow-up and rehospitalization rates.

Quality

In response to the previous year's CalEQRO recommendation to finalize the submitted Non-Clinical Performance Improvement Project (PIP) and initiate a new data-driven Non-Clinical PIP topic, the MHP did not develop a new one. The MHP continued its PIP focused on no-shows in psychiatry and

planned a new intervention to begin in November 2016. However, after CalEQRO's evaluation, the PIP was determined to be inactive and developed in a prior year. As it stands, the MHP does not have any active PIPs as the Clinical PIP was determined to be concept-only and not yet active.

The MHP continues to be limited in its ability to gather and analyze data related to access, timeliness and quality of care. With the addition of the Information Technology (IT) and Health Services analysts (three FTE positions), the MHP has the opportunity to prioritize a Continuous Quality Improvement (CQI) approach including data collection, analysis and use to inform the system of care. However, this is dependent on the percentage of time that is allocated to mental health since the analyst positions are agency wide.

Outcomes

The MHP does not have a system-wide outcome tool in place. However, the MHP has the opportunity with its MyAvatar implementation.

INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with 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 FY 16-17 findings of an EQR of the Tehama MHP by CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four 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
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (HCB) ($30,000 or higher)

[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) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two PIPs during the 12 months preceding the review; Tehama MHP submitted two PIPs for validation through the EQRO review. The PIPs are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

- 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 serves to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

[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.

PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section we discuss the status of last year's (FY15-16) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 recommendations, which are summarized below.

Assignment of Ratings

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

Key Recommendations from FY15-16

- Recommendation #1: The MHP needs to investigate an interim solution or strategies with County or Agency Human Resources to fill all clinical staff positions, especially the QA Manager/Coordinator position, while continuing to search for suitable long term candidates.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - While the MHP continues to be challenged in recruitment of new staff in a timely manner, they have filled ten positions in the last year, five of those through internal promotions.
  - The MHP was without a Quality Assurance Manager from November of 2014 to May of 2016. This position was filled effective May, 2016.
  - The MHP is focusing its efforts on cultivating local staff through a social work intern program at California State University Chico. They have two masters level social workers/counselors employed full time, and two interns, one master

level, and one bachelor level. The MHP aims to recruit the two interns by providing a good work experience.

- In the past year, they have started requiring all clinicians to start at least one group in order to balance service capacity needs with staffing availability.
- Last year, at the time of the report, the MHP had 39 of its 63 FTE positions filled (61%). Currently, the MHP has 54 of 69 FTE positions filled (78%).

- Recommendation #2: In preparation for going live with MyAvatar, the MHP should implement rigorous and comprehensive data collection, tracking, analysis and utilization processes to guide decisions using a CQI approach.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP states that they have been actively preparing for the MyAvatar electronic health record implementation since the last EQRO review. Netsmart Technology staff was onsite for product review and needs assessment in July 2016.
  - Originally, the MHP expected to go-live with MyAvatar by December 6, 2016, but will not likely meet this target date given the need for additional testing. It is now targeting the first quarter of 2017 to go live with performance management and electronic health record functionality. The performance management system is a module of the electronic health record system.

- Recommendation #3: The MHP needs to finalize their current Non-Clinical PIP by analyzing their data and determining the effectiveness of the study interventions, and then select a new data-driven Non-Clinical PIP topic and initiate a new PIP.

  ☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP analyzed the data for its Non-Clinical PIP and it was determined that the no show rate from the recent timeliness report is currently 14% for Psychiatric Appointments. This was 2% higher than the original base line data, which indicated that the MHP did not sustain progress in this area. As a result, the MHP elected to continue the Non-Clinical PIP to resolve the high no show rates for psychiatric services with the addition of a new intervention. The "fit-in" intervention is planned for November 2016, whereby established clients who miss their appointment are asked to come back to a "fit-in" appointment.
  - While the "fit-in" intervention would allow the client expedited rescheduling, this intervention does not address any of the top three reasons identified by consumers for no show appointments (transportation, not feeling well and forgetting). This PIP, even with the new intervention, was developed in a prior year.

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

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

- Access to Care
    - Four hours per week of telepsychiatry are being provided by Kings View Behavioral Health Systems in the jail. A clinician is now located at the jail to provide ongoing services.
    - Two new board and care facilities have opened, Gilmore House and Casa Serenity # 2. The addition of these new facilities will allow the MHP to transition clients who are placed in out-of-county facilities back into Tehama County.
    - The MHP contracted with Northern Valley Catholic Social Services (NVCSS) on July 1, 2016. NVCSS will provide consumer employment; applications are due October 10, 2016. A warm telephone line is included in the contract.
- Timeliness of Services
    - The MHP reports that it has made substantial efforts in addressing barriers to timely service delivery. These include hiring locum psychiatrists, strategies to minimize the impact of no-shows, recruiting new staff, and increasing compensation for selected clinical positions.
- Quality of Care
    - The MHP added several positions including a Mental Health Assistant Director who oversees all of the direct services with the exception of medication support. The MHP also added a licensed clinical supervisor and an office assistant supervisor. The MHP also added an institutional RN/LVN who will support the Community Crisis Response Unit (CCRU) to increase services via the 24/7 Access Line as well as the CCRU to decrease hospitalization rates.
    - The MHP was without a QA Manager from November of 2014 to May of 2016. This MHP filled this position filled on May 16, 2016. The position relocated from Administration to MH Outpatient in order to provide more focused and collaborative support for MH services.
    - The Tehama county Department of Social Services (DSS) has agreed to provide staff for the Patients Right's Advocate positon to increase stability in the position and to utilize DSS bi-lingual staff to provide services in Spanish. A Memorandum of Understanding was completed and is pending final approval.

- Consumer Outcomes
    - The MHP also added three new full time (FTE) positions for FY15-16, including one FTE in IT; and two FTE Health Services Analysts. The two Health Service Analysts positions are agency wide positions and the percentage of time that is allocated to mental health varies depending on the needs of all agency divisions including mental health. This should facilitate the implementation of the EHR and ongoing tracking and trending of key metrics.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following performance measures as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four 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
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Tehama Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	12,408	1,062
Hispanic	6,751	210
African-American	157	14
Asian/Pacific Islander	330	13
Native American	310	19
Other	2,025	172
Total	21,977	1,490

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

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

Regarding calculation of penetration rates, the Tehama MHP:

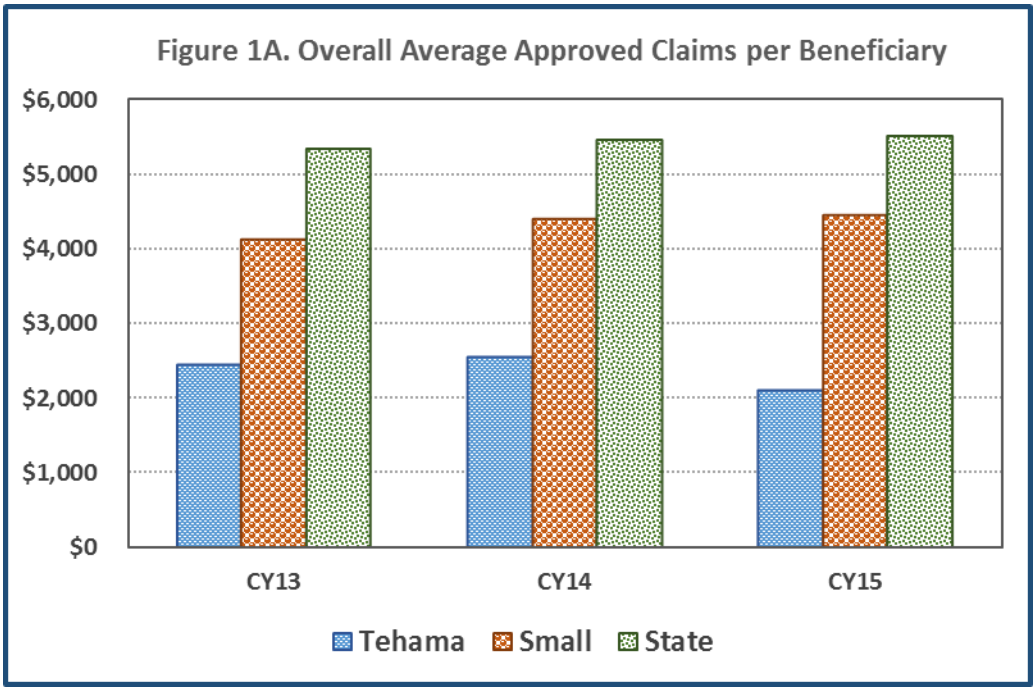
☐ Uses the same method as used by the EQRO.

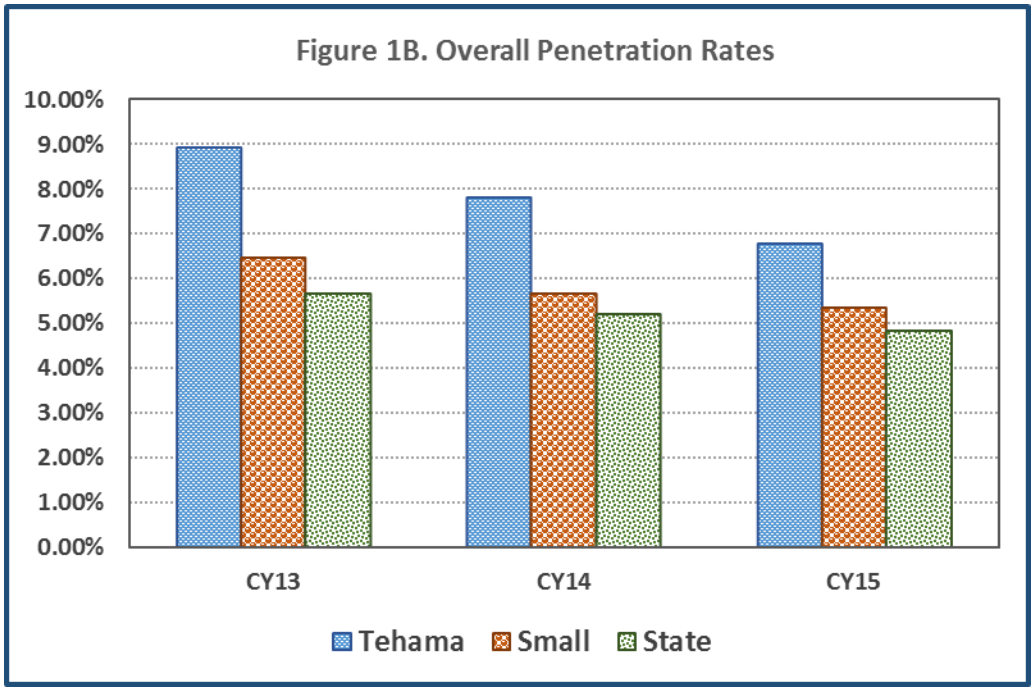
☐ Uses a different method.

☒ Does not calculate its penetration rate.

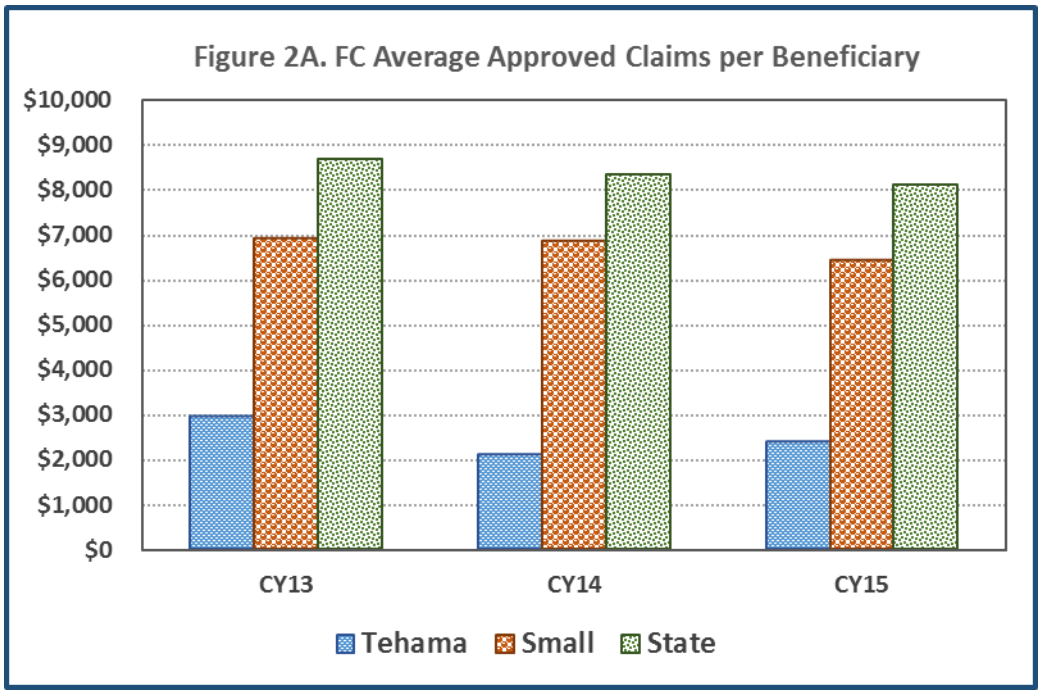
While the MHP does not regularly calculate penetration rates, County Social Services provides data regarding total Medi-Cal beneficiaries; The MHP calculates the penetration rates for those receiving Specialty Mental Health Services.

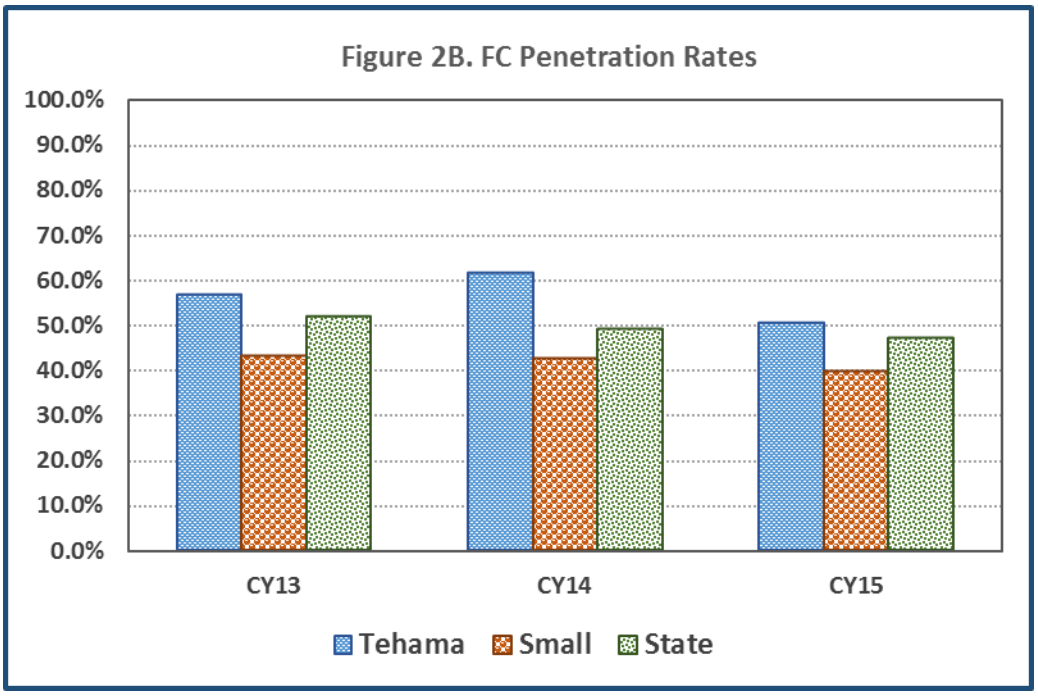
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



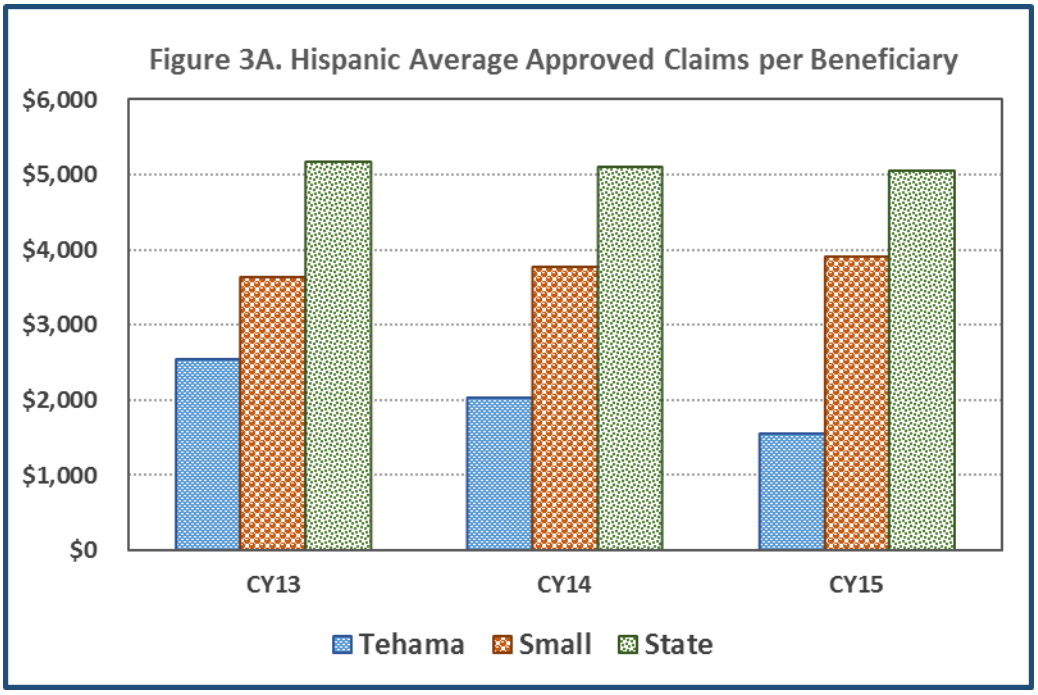


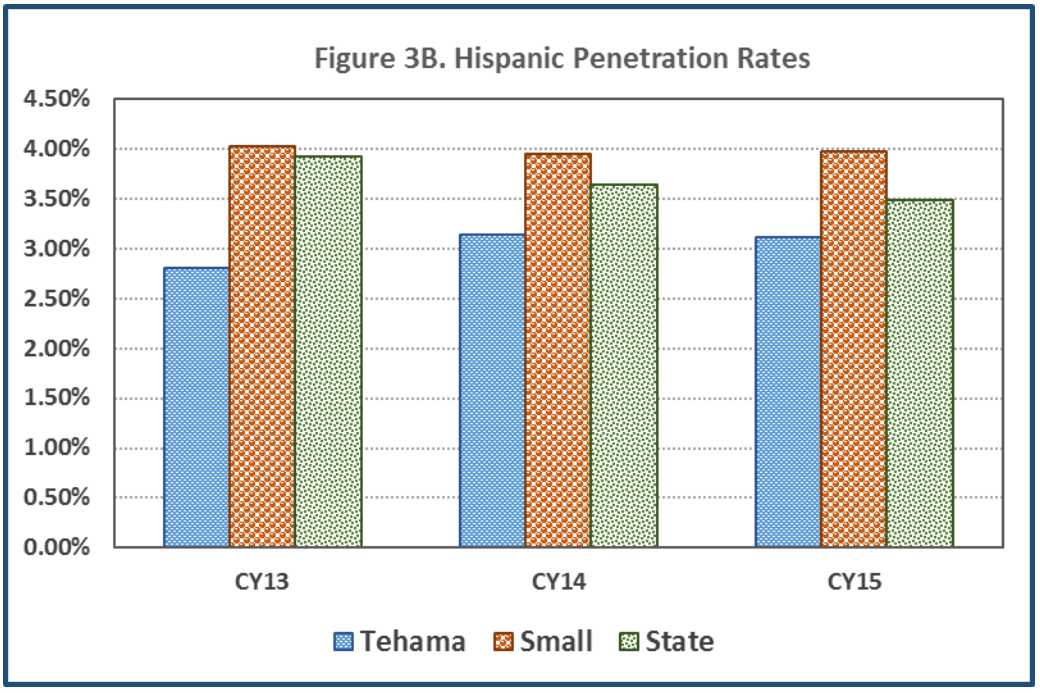
Figures 2A and 2B show 3-year trends of the MHP's Foster Care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.





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





Please see Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary.

HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

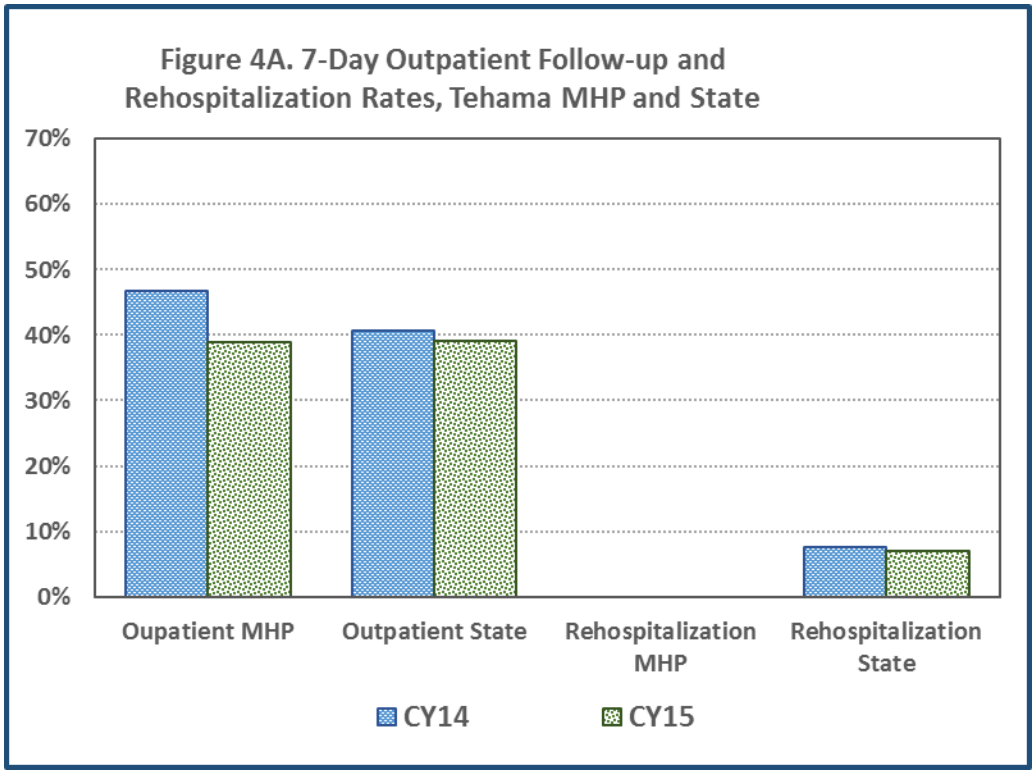
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Tehama	CY15	n<=11	1,490	n<=11	$43,451	n<=11	n<=11
	CY14	n<=11	1,678	n<=11	$37,485	n<=11	n<=11
	CY13	n<=11	1,668	n<=11	$42,927	n<=11	n<=11

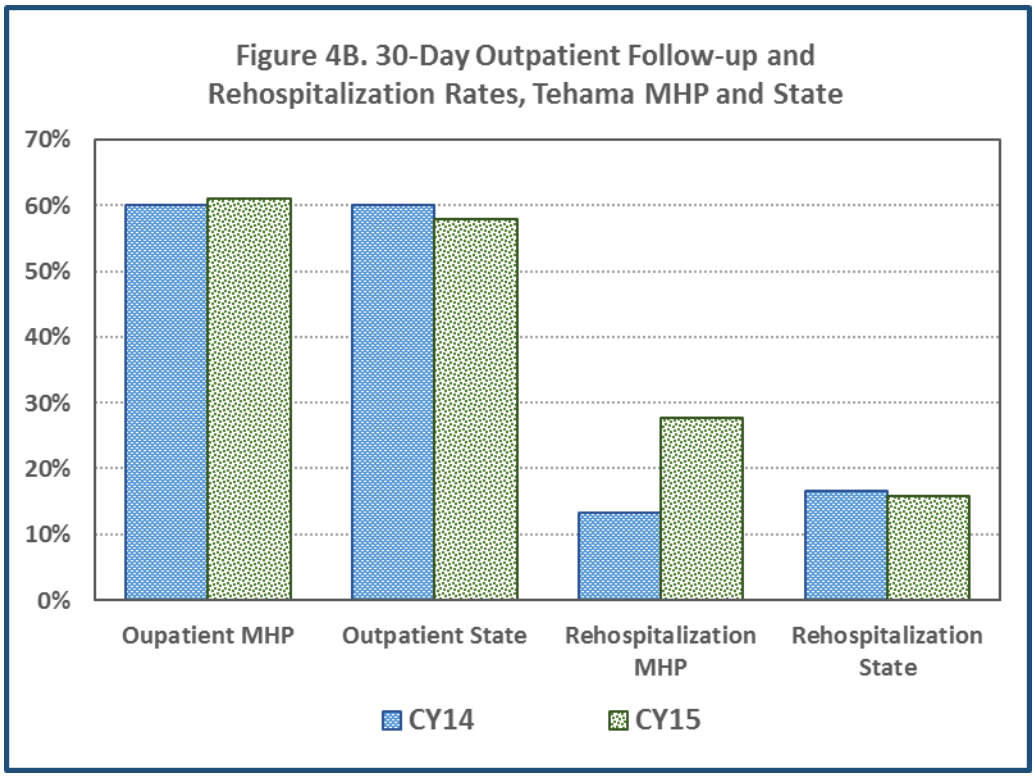
The actual counts are suppressed for cells containing n<=11.

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY14 and CY15.

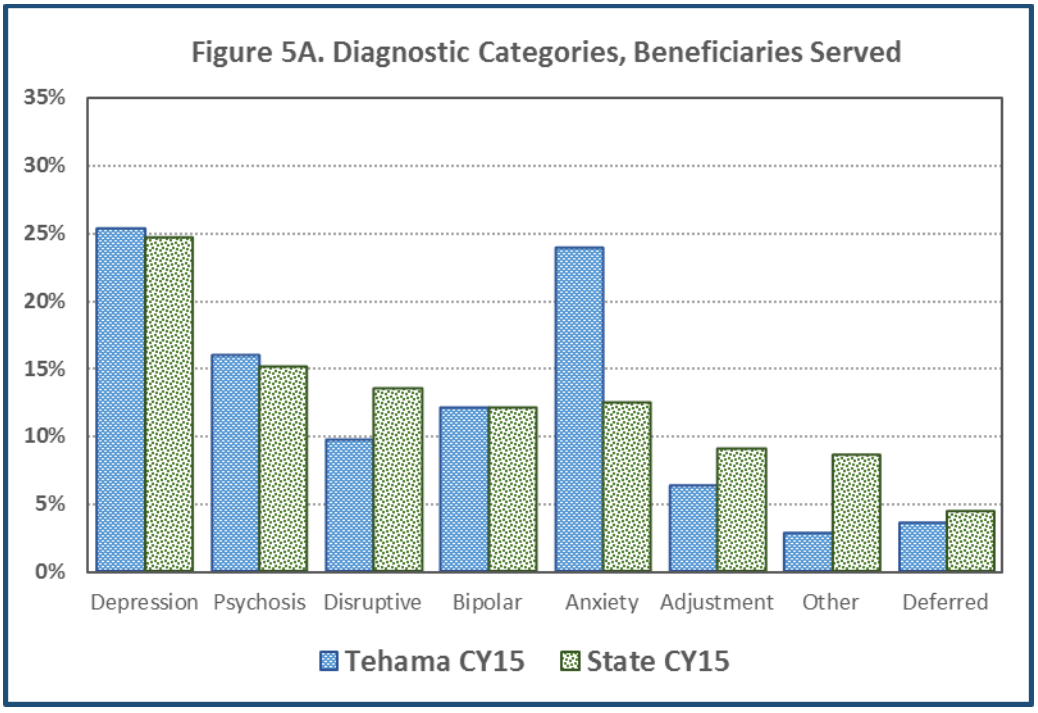


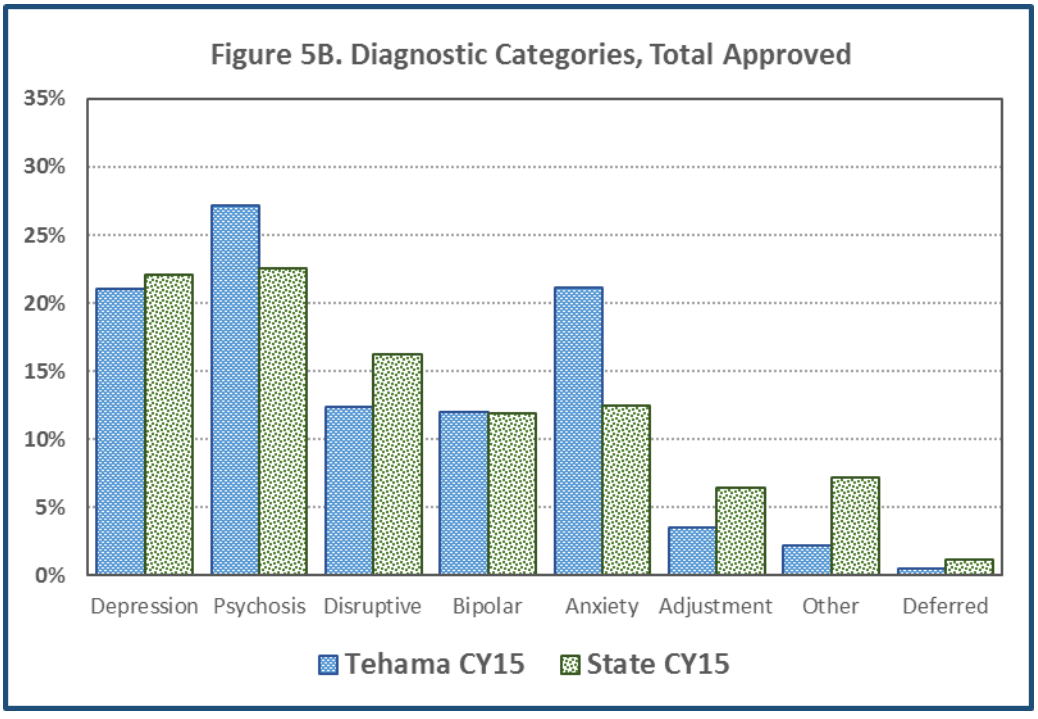


DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY15.

- MHP self-reported percent of consumers served with co-occurring (Substance Use Disorder and MH) diagnoses: 33%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - While the MHP's number of eligibles stayed relatively stable, rising from 21,559 in CY14 to 21,977 in CY15, beneficiaries served dropped from 1,679 in CY14 to 1,490 during this period. This correlates to a drop in penetration rate from 7.79% in CY14 to 6.78% in CY15. The MHP's CY15 Overall penetration rate remains greater than both the Small County (5.34%) and statewide (4.82%) averages.
    - The MHP's FC penetration rate declined from 61.51% in CY14 to 50.57% in CY15, but remains above both Small county (39.71%) and statewide (47.19%) averages.
    - The MHP's Hispanic penetration remained stable from CY14 (3.14%) to CY15 (3.11%) and remains less than both Small county (3.97%) and statewide (3.49%) averages.
    - The MHP served 289 Affordable Care Act (ACA) beneficiaries, of 3,502 eligibles in CY15 for a penetration rate of 8.25% for this sub-group (see Table C1 in Appendix C).
    - When combing the Medi-Cal and ACA data, the MHP's CY15 average monthly eligibles increased to 25,479 with 1,779 beneficiaries for a combined increase from CY14 to CY15 of 3,920 eligibles and 100 additional beneficiaries.
- Timeliness of Services
    - In CY15, the MHP's 7-day outpatient follow-up rate after discharge from a psychiatric inpatient episode decreased from the corresponding CY14 rate, but is comparable to the statewide average. The MHP's 30-day follow-up rate is comparable to CY14 and is greater than the statewide average.
- Quality of Care
    - The MHP's average Overall approved claims per beneficiary decreased from CY14 ($2,548) to CY15 ($2,096) and remains less than both the Small county ($4,460) and statewide ($5,522) averages.
    - The MHP's FC approved claims per beneficiary increased from CY14 ($2,097) to CY15 ($2,386), but remains significantly less than both the Small ($6,341) and statewide ($8,127) averages.
    - The MHP's CY15 average Hispanic approved claims per beneficiary increased from CY14 ($2,014) to CY15 (2,487), but remains less than both Small county ($4,804) and statewide ($5,045) averages.
    - Consistent with the statewide diagnostic pattern, a primary diagnosis of Depressive disorders accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a lower rate of Disruptive, Adjustment and

Other disorders and a significantly higher rate of Anxiety diagnoses when compared to statewide averages.

- Corresponding with the MHP's diagnostic pattern, the percentage of total approved claims for individuals with Depressive and Anxiety disorders were higher than that of other diagnostic categories with the exception of Psychotic disorders which had the third highest diagnostic ranking, but the highest percentage of total approved claims.

- Consumer Outcomes
  - While the MHP had no seven day re-hospitalizations in CY15, 30-day re-hospitalizations rose from CY14 and exceeded the statewide average.

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." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

TEHAMA MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3A—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Applied Suicide Intervention Skills Training (ASIST): Crisis Response Training
Non-Clinical PIP	1	Meditation Management – No-shows

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

Table 3B—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating* Clinical PIP	Item Rating* Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	NM	PM

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

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	PM	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NM	NA
		5.2	Valid sampling techniques that protected against bias were employed	NM	NA
		5.3	Sample contained sufficient number of enrollees	NM	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	UTD	M
		6.4	Plan for consistent and accurate data collection	NM	M
		6.5	Prospective data analysis plan including contingencies	NM	NM
		6.6	Qualified data collection personnel	UTD	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NA	NM
		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

Table 3B—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		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

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine; NR = Not Rated (Concept Only or None Submitted)*

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

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	7	13
Number Partially Met	3	2
Number Not Met	7	2
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	28	28
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	44.74%	70.59%

CLINICAL PIP—ASIST: CRISIS RESPONSE TRAINING

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

- "[Will implementation of] a formalized training program utilizing ASIST, to increase compliance rates of 24/7 test call quarterly reports, increase consumer satisfaction, and to decrease hospitalization rates due to suicidality."
- Date PIP began: November 2016
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☒ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

The Clinical PIP is aimed at improving the overall experience of consumers who utilize the Community Crisis Response Unit (CCRU). The MHP aims to reduce its suicidal crisis hospitalizations, improve the rate of passing test calls, and improve consumer satisfaction for those consumers who access crisis services. The MHP is participating in the ASIST provided by the California Mental Health Services Authority (CalMHSA).

This PIP is rated as Concept Only, and is not yet active. While ASIST training will be of great benefit for staff and subsequently clients, sufficient data collection was not provided to indicate that Tehama clients are being impacted by the problem areas identified by the MHP. These include staff response and interventions provided on the 24/7 Access Line, consumer grievances regarding the quality of CCRU services, as well as quantity of crisis intervention services provided. The MHP has identified possible causes related to these problem areas including shortage of supervisory staff to provide on-going training and oversight, shortage of CCRU line staff to provide coverage; and lack of formalized suicide prevention training for staff. While the MHP lists ASIST related interventions, it also includes consumer surveys for those who utilized the 24/7 Access Line and hospitalization rates. These are not interventions but rather indicators. As written, the PIP is Concept Only. For this to be a viable PIP, sufficient data should be gathered to better identify the impact of the problem on local consumers. If local consumers are not impacted, a project focused on improving passing test calls would not warrant a PIP as it is not focused on consumer outcomes. However, if the PIP was amended to better identify the impact, causes of the problem and impact of the problem on consumers (demonstrated through data), then client focused interventions related to ASIST training could potentially have a powerfully positive impact for Tehama consumers.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommendations to collect further data to identify the impact of problem, and causes and to demonstrate viable and/or appropriate interventions through data analysis. Additionally, the MHP will need to establish baselines for all indicators before application of interventions. Sampling activities will need to include methods which control for bias. Also, the data analysis plan would need to include sufficient information so that reliability and validity of results can be determined.

NON-CLINICAL PIP—MEDICATION MANAGEMENT OF NO-SHOWS

The MHP presented its study question for the Non-Clinical PIP as follows:

- "Are established clients, who do not show up for a medication support appointment and subsequently attend the "fit-in" program for their next appointment, less likely to no-show or cancel, resulting in increased capacity and timeliness of services provided?"
- Date PIP began: November 2016
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☒ Inactive, developed in a prior year *(Not Rated)*

  ☐ Concept only, not yet active *(Not Rated)*

  ☐ Submission determined not to be a PIP *(Not Rated)*

  ☐ No PIP submitted *(Not Rated)*

The Non-Clinical PIP focuses on reducing the no-show rate for medication related appointments. The MHP looked at data over the last three years. The no-show data FY13-14 indicated a 13% no-show rate, and FY14-15 indicated a 15% no-show rate, and FY15-16 indicated a 14% no-show rate. Clients were asked on a survey how many medication support appointments they missed since January 2013, with whom they had missed appointments and reasons for missing the appointment. Of those who responded, 46% reported transportation challenges, 44% were sick/did not feel well/had health issues, 22% forgot about the appointment, and 17% reported that appointment was cancelled (not considered a no-show). This PIP was developed last year. CalEQRO recommended that the MHP needed to finalize their current Non-Clinical PIP by analyzing their data and determining the effectiveness of the study interventions, and then select a new data-driven Non-Clinical PIP. Although the MHP is implementing a new intervention, a "fit-in" policy and procedure for medication related no-shows, to allow clients expedited rescheduling, it is not a new PIP. Minimal information was provided regarding the data analysis plan. Further, while allowing clients basically to reschedule, the intervention does not address the three major reasons that were indicated as major contributors to no-shows.

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

Technical assistance was provided to the MHP by CalEQRO, suggesting that the MHP use a more direct study question: "Will clients who do not show for a medication support appointment, then participate in the "fit-in" program for their next appointment, be less likely to no-show or cancel?" The MHP provided minimal information regarding the data analysis plan. Expected or estimated

numbers that would provide information to determine validity and reliability of planned data collection and analysis were not included. Possible barriers/issues were not considered; contingency plans were not described. The identified causes/barriers were not addressed.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - ASIST training for staff could provide better access for clients in need of urgent psychiatric care if it is successful in providing linkages to care.
    - If the Non-Clinical PIP on medication management is amended to address the identified barriers contributing to medication appointment no-shows, access would be improved.
- Timeliness of Services
    - ASIST training for staff could reduce hospitalizations for clients in contact with the CCRU.
    - If the Non-Clinical PIP is amended to address the identified barriers contributing to medication appointment no-shows, the MHP would likely see a reduction in medication no-shows.
- Quality of Care
    - ASIST training for staff would allow for earlier intervention for clients at immediate risk of suicide.
- Consumer Outcomes
    - If clients are currently experiencing problems related to suicidal crisis hospitalizations, ASIST training for CCRU staff could improve client outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 4—Access to Care

	Component	Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The Hispanic penetration rate (3.11%) continues to be lower than the small county (3.97%) and statewide (3.49%) averages. The MHP's outreach efforts have not been effective although they do have a mobile clinic for migrant farmers. Clinical supervisors all felt that those in the rural parts of the county are the most under-served. They said that some areas do not have bus service. There is a multi-agency jail re-entry team to assist with transition. The MHP collaborates with Faith Works, a coalition of 11 churches that supports the homeless community. The MHP goes to churches weekly during the winter season when the churches are rotating homeless shelters. The MHP provides information on services that are available including washer/dryer and showers at the wellness center. The wellness center itself is locked to all but invited MHP clients. The MHP does not formally evaluate the implementation of its outreach strategies.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	While the MHP stated they were currently 78% staffed, they have a continuing issue with attracting and retaining staff. They are using Chico State University interns to grow-their-own staff and promote from within to attract and maintain staff – however, this has not resolved their long standing staffing shortage issues. They regularly monitor caseloads, but when they are short-staffed there is little that can be done to meet increased capacity even though caseloads are being monitored. In the past year, they have started requiring all clinicians to

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
			start at least one group in order to balance service capacity needs with staffing availability. There was no evidence of evaluation and hard numbers of the additional clients receiving services due to the addition of groups.
1C	Integration and/or collaboration with community based services to improve access	FC	Two board and cares facilities were added over the past year – Gilmore House (a non-medical facility for the elderly, 22 beds) and Casa Serenity #2 (the least restrictive setting/care for individuals who meet board and care criteria, 8 private rooms). The MHP does go to churches weekly during the winter season when the churches are rotating homeless shelters. They MHP provides information on services that are available including washer/dryer and showers at the wellness center. In 2014, the MHP implemented a co-occurring program for severe and persistent mental illness – this program continues. 10 individuals are currently enrolled; the program is eight hours per week. There is a multi-agency jail re-entry team to assist with transition. The Mental Health Crisis Response Committee is an inter-agency council comprised of MH, probation, social services, law enforcement, St. Elizabeth Community Hospital. All California Highway Patrol (CHP) officers and other local law enforcement have attended MH First Aid training. Additionally Crisis Intervention Team (CIT) training for law enforcement is well attended. The first of three trainings had approximately 60 participants from the CHP, the Corning Police, Red the Bluff Police, the Tehama County Sherriff, Fish and Game, jail corrections officers and St. Elizabeth Hospital staff. The 2nd training will be in January 2017. Both trainings were paid for through MHSA funds. Law enforcement has agreed to pay for a third training in May 2017 so that all employees have training.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Timeliness of Services

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

Table 5—Timeliness of Services			
	Component	Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP sets a standard of 14 days. The average length of time from first request to assessment overall was 16 days with no difference between adults and children's appointments. Overall, 87.5% of appointments met the standard. The range for adults was 0-51 days, and 0-44 days for children. Overall, this has improved greatly over this last year, from an overall average of 27.2 days, and 44% of its appointments meeting its 14 day standard. The MHP attributes the improvement to walk-in assessments. Walk-in assessments are monitored on a weekly basis. The MHP will adjust resources as indicated by the wait times. This data is discussed weekly in the Supervisors' meeting, and resources are allocated to address concerns as they arise. Assessment appointments are double booked to reduce the impact of no-shows.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP sets a standard of 14 days. The average length of time from initial contact to first psychiatry appointment overall was 17.4 days, 15.4 days for adults, and 18 days for children. Overall, 57.6% of appointments met the standard, 57.8% for adults, and 56.7% for children. The range for children was 0-66 days, and 1-37 days for adults. Currently there are no psychiatrists on staff. There are two locum psychiatrists and a physician's assistant, and each is contracted for 40 hours per week. This includes 11 hours per week for children and four hours per week at the jail.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP did not report data on this measure. However, the MHP reported that all clients who present with urgent conditions are seen immediately at the CCRU. Their wait time for urgent appointments is less than one day because they are seen in the CCRU the same day. The MHP does not formally track and trend urgent conditions. The MHP needs to electronically track and trend urgent conditions in hourly increments.
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	There were 166 hospitalizations comprised of 144 adults and 22 children. Overall, there were 69 follow-up appointments, with 67 of those being for adults, and two for children. The average length of time for follow-up appointments was six days overall, four days for adults, and 15 days for children. The MHP sets a standard of seven days with adult follow-up appointments meeting the standard at a rate of 100%, and children at 46%. The MHP reports that it measures time to appointment with a Psychiatrist M.D. The time for follow-up appointment after hospitalization for children is higher because the MHP does not have a crisis slot appointment

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			available in children services due to utilizing a tele-psychiatrist for all children's psychiatric services. The MHP has not addressed the 46% follow-up rate for children.
2E	Tracks and trends data on re-hospitalizations	NC	The MHP reported that of the 166 hospitalizations, the total number of readmissions within 30 days was 13, producing a rate of 8%. The MHP's goal is 10%. However, they MHP did not delineate between adult and children's rehospitalizations. While the MHP uses a process to track rehospitalizations overall, tracking/trending is limited. They do not look at the data separately for adults and children. Given that two of the 22 hospitalizations for children had follow-up appointments and that there are no crisis time slots for children, it is especially important to track rehospitalization for children separately, so that the MHP can initiate improvement activities in a timely manner.
2F	Tracks and trends no-shows	PC	The average no show for clinicians/non psychiatrists was 10% and for psychiatrists 14%. The goal for both is 10%. The MHP did not provide data separately for adults and children. The MHP is conducting a performance improvement project on medication appointment no-shows.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, 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 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	NC	The MHP submitted their FY15-16 work plan and annual evaluation. However, a current FY16-17 plan was not provided. The MHP was without a QA manager from November 2014-May 2016.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	PC	While the MHP is reviewing the Child & Adolescent Needs & Strengths (CANS) Assessment and the Adult Needs & Strengths Assessment (ANSA) outcome tools, neither has been selected as a system-wide tool. The Milestones of Recovery Scale (MORS) is used in the Behavioral Health Court and is administered at entry and exit only. The MHP has a monthly peer review process for charts. The MHP does not yet have an electronic health record, so system-wide and program reporting remains limited.
3C	Evidence of effective communication from MHP administration	PC	Line staff felt communication was not bidirectional agency wide. They reported that individual supervisors listen but that it was difficult to access supervisors as they are often pulled away to meetings. There are monthly division meetings in which relevant policy and procedure updates are discussed. Additionally policy and procedure items are discussed during the weekly Clinical Meeting. All staff members attend a monthly division meeting and a quarterly agency meeting. Providers attend a weekly clinical meeting, a weekly clinical supervision meeting and a weekly individual supervision meeting. Supervisors attend a weekly supervisors meeting, a weekly systems meeting, a MyAvatar meeting and a bi-weekly administrative meeting with the agency directors. The director attends a weekly admin meeting, a weekly supervisors meeting, a weekly systems meeting, a weekly MyAvatar meeting, a monthly division meeting and a quarterly agency meeting. Consumers in the focus group reported that there is a lot of involvement of personnel with consumers. They receive information from counselors, other clients, the wellness center and the MH Board. The clinicians' team informs the public of MH services, crisis services, parenting support by way of pamphlets and flyers. There are no strategies for the outlying areas.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Supervisors feel their input is heard and they can provide thoughts/concerns at meetings they attend with leadership. They also noted that they have an open door policy. In the Consumer Focus Group, three were on the Client Council and one member is on the MH Board. In contrast, family members were unaware of the opportunities to participate on committees or provide feedback.
3E	Evidence of strong collaborative partnerships with other agencies and community based	FC	The Mental Health Crisis Response Committee has an inter-agency council comprised of MH, probation, social services, law enforcement, and St. Elizabeth Community Hospital. Additionally, all California Highway Patrol officers and many other local law enforcement have attended MH First Aid

Table 6—Quality of Care			
	Component	Compliant (FC/PC/NC)*	Comments
	services		training and CIT training. The MHP collaborates with the local churches weekly during the winter season when the churches are rotating homeless shelters. They MHP provides information on services that are available.
3F	Evidence of a systematic clinical Continuum of Care	NC	MORS is utilized in the Behavioral Health Court. However, it is administered at entry and exit only. The MHP does not have a system-wide outcome tool in use and one has not been selected, although the CANS and ANSA are being discussed. The MHP offers the Parenting Inside Out Program, an evidence based cognitive behavior therapy practice, for teaching parenting skills to incarcerated parents in the county jail. The group lasts 12 weeks, however, many who start the program do not finish due to early release from overcrowding. There is a Spanish-speaking group. In FY15-16, there were six groups with 46 inmates. There were three female and four male graduates.
3G	Evidence of individualized, client-driven treatment and recovery	FC	The MHP utilizes Mary Ellen Copeland's Wellness & Recovery Action Plan (WRAP) with its clients. They provide training each year. During August 2016, nine people were trained as facilitators. They offer several WRAP groups at the wellness center. Various supportive groups are offered at the MHP's wellness center, Vista Way Recovery Center. Group therapy is also offered by each clinician. Line staff reported that clients choose their goals for treatment planning and that they work actively with clients to determine life goals, treatment goals and life enhancement goals in addition to case management goals. However, line staff reported difficulty with clients signing treatment plans and a heavy emphasis from leadership and supervisors 'coercing' clinicians to get signatures, even for minor clients after the guardian has already signed. Clinicians expressed concern for the eroding trust between counselors and clients as a result of chasing signatures. Clinicians also had concerns about losing the billing from all of their work if they fail to get a signature. Treatment planning is reported to be client focused but once the client's file is being reviewed in triage, the identified goals have to match functional impairment, i.e. not working, and the client may not agree (i.e. if working is not a goal of the client). Client and family member focus group participants reported that they are well-satisfied with the services they receive and that they were improving. However, they were not aware of any tool that was being used to track their advancements within their programs.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	No Consumer Family Members (CFMs) regularly participate on a Quality Improvement Committee or the Cultural Competence Committee. Three client family members sit on the Mental Health Advisory Board. There are approximately 15 CFMs who receive stipends for work projects. Projects include catering and yard maintenance. However, there is not a defined career ladder for peer employment. This should change given the contract with NVCSS to provide consumer employment in FY16-17.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The wellness center is open to a limited group of consumers – those referred by a clinician. There are a variety of classes and groups. A number of CFM's indicated that without Vista Way Recovery Center, they would experience more crisis. There are several WRAP groups run for and by consumers. Clients are educated about the wellness center through pamphlets aimed at new clients which detail available resources.
3J	Measures clinical and/or functional outcomes of consumers served	NC	Behavioral Health Court utilizes the MORS at entry and exit. There is no system-wide use of outcome measures.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The Performance Outcomes and Quality Improvement (POQI) survey is administered as required, the MHP provided analysis of the November 2015 survey. However, no trending or comparison to other surveys was presented.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP continues to experience staffing capacity challenges making it difficult to meet service demand.
  - An assessment of current and potential outreach strategies might allow the MHP to better understand and address its low penetration rates and undertake improvement activities to increase access for its underserved populations.
- Timeliness of Services

- Although the MHP provided timeliness tracking information on a variety of indicators, a greater level of detail could improve the usefulness of these data. For example, while hospitalization follow-up rates were provided for both adults and children, and rehospitalization rates were presented overall, adults and children were not separated in the analyses.
- The timeliness indicators for time to initial service and time to psychiatry appointment (both from initial contact) are not reflective of the various intermediate steps to service appointments. These intermediate steps may help to explain long psychiatry wait times, low rates of follow-up appointments and high hospitalization rates.
- Urgent appointments are not tracked yet could be useful as an indicator of timeliness.

- Quality of Care
  - The vacancy of the quality assurance management position significantly impacted the MHP's ability to monitor and improve the quality of services during FY15-16. A current QI Work Plan for FY16-17 was not provided.
  - Consumer family member participation in system and program planning and their presence in key roles are lacking.
- Consumer Outcomes
  - The lack of outcome tools impacts the MHPs ability to assess consumer outcomes and effectiveness of clinical services.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 8 to 10 participants in each. However, the MHP provided two consumer family member focus groups as it had done the prior year, one for adult beneficiaries and the second for parents of minor children. The details of these groups can be found in each section below.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

CalEQRO requested a culturally diverse group of adult beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was conducted at the Vista Way Recovery Center in Red Bluff, CA.

Number of participants – 7

For the seven participants *who entered services within the past year*, they described their experience as the following:

- Participants stated that the experience was excellent and enjoyable.
- Participants reported feeling better about themselves, more outgoing and more stable.
- Participants had a variety of experiences with starting services, including waiting one to three months to begin services. Participants each felt their wait times were acceptable.

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

- Participants reported a range for how often they see their counselors from once a week to once a month.
- Overall, participants felt they were improving and managing better.
- Overall, the group expressed appreciation for the wellness center and stated they would be experiencing more crises if it were not for Vista Way.

- A concern was raised regarding staffing, in particular that the MHP needed to have a backup plan for more counselors if an assigned counselor is unavailable, especially in crisis situations.

Recommendations for improving care included the following:

- Offer more groups.
- Hire additional counselors including case managers.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

CalEQRO requested a culturally diverse group of adult beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The second focus group included parents of child beneficiaries. The focus group was conducted at the MHP's main offices in Red Bluff, CA.

Number of participants – 3

For the three participants *who entered services within the past year*, they described their experience as the following:

- Participants stated that their experience with the MHP was helpful.
- Participants' experiences varied with regard to wait times from immediately being seen to having to wait a month.

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

- All participants knew that crisis services were available.
- Overall, participants felt that wait times for services were improving for non-crisis services.
- Regarding tele psychiatry, participants felt that speaking to a doctor on a screen was not a positive experience. They stated, "It is not reality."

Recommendations for improving care included the following:

- Provide an in-person psychiatrist.
- Increase collaboration between therapists and psychiatry so that both the therapist and the doctor know the history of the client, i.e., medication history, diagnosis.
- Improve timeliness in receiving medications while in the crisis unit as well as timely assessment.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Participants prefer to have access to in-person psychiatry services.
  - Both groups of participants requested more group services.
- Timeliness of Services
  - The variation in reported timeliness makes it difficult to determine if the wait times reported are typical or representative of client experience system-wide.
- Quality of Care
  - Overall, participants' experiences with services was positive, with the wellness center being essential to their personal wellness and recovery.
  - Most participants were unaware of opportunities to provide feedback on services other than the yearly survey.
- Consumer Outcomes
  - Overall, participants felt they were improving.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 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	83.59%
Contract providers	16.41%
Network providers	<1%
Total	100%

- Percentage of total annual MHP budget is dedicated to support IT operations: (includes hardware, network, software license, IT staff)

3.65%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:
- ☐ Yes ☐ In Test/Pilot Phase ☒ No
- MHP currently provides services to consumers using a tele psychiatry application:
- ☒ Yes ☐ In-Test/Pilot Phase ☐ No
  - If yes, the number of remote sites currently operational:

2

  - Languages supported: English and Spanish

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

Table 8 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
5	2	1	0

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

Table 9 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
2	2	0	0

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

- The Fiscal Data Supervisor position was vacated in February 2016 and filled in July 2016.
- The analytical staff listed in Table 9 is referencing Health Agency staff who are currently allocating approximately 70% of their time to MH. The two Health Service Analysts positions are agency wide positions and the percentage of time that is allocated to mental health varies depending on the needs of all agency divisions including mental health.

CURRENT OPERATIONS

- The MHP continues to utilize the Community Mental Health Centers (CMHC) information system, implemented in 2001, from Netsmart Technologies.
- The MHP reports that 83.59% of services are provided by county operated/staffed clinics, 16.41% by contract providers and <1% network providers. 57.20% of services are claimed to Short Doyle/Medi-Cal (SD/MC).
- The MHP reported 63 adults and 134 children/youth were served via tele psychiatry from 6/30/15 to 7/1/16.

- The May 2016 claim file was submitted in October 2016. The MHP plans to have claiming current by the end of the 2016 calendar year. The February 2016 CSI file was submitted in October 2016. The MHP plans to have CSI file submissions current in November 2016.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10— Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
CMHC	Practice Management	Netsmart Technologies	15	Health Agency IT
Mental Health Access Tracking (MHAT)	Tracking assessments and service plans	Health Agency IT	7	Health Agency IT
Quantum Financial System	Reporting	Geneva Software	2	Health Agency IT

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MyAvatar implementation is in progress. A contract with Netsmart Technologies for MyAvatar was finalized in June 2014 and the implementation is currently in the product testing phase. The MHP plans to go-live with the MyAvatar performance management and electronic health record functionality in the first calendar quarter of 2017.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for EHR functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts				X	
Assessments				X	
Document imaging/storage				X	
Electronic signature—consumer				X	

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Laboratory results (eLab)				X	
Level of Care/Level of Service				X	
Outcomes				X	
Prescriptions (eRx)				X	
Progress notes				X	
Treatment plans				X	
Summary Totals for EHR Functionality		0	0	10	0

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

- The MyAvatar vendor, Netsmart Technologies, was onsite for product review and needs assessment on July 19-21, 2016. The product has been developed and is now in the test phase with plans for performance management and the electronic health record implementation functionality to be implemented in the first calendar quarter of 2017.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):
- ☒ Paper ☐ Electronic ☐ Combination

MAJOR CHANGES SINCE LAST YEAR

- The MHP worked collaboratively with Netsmart Technologies in a needs analysis for the MyAvatar electronic health record. The system is now in the final testing phase.
- Initial Crystal Reports training was provided to supervisors and analytic staff, via the online provider Knowledge Net, in preparation for the MyAvatar implementation.
- An upgrade of internet connectivity from T1 to fiber optic was completed at three sites: Vista Way, Walnut Street and Main Street.
- A radio-frequency identification (RFID) badge system was implemented in the Crisis Response Unit.
- The ICD10 and DSM5 transition in CMHC was completed October 2016.
- The MHP completed the connection for interface to the auditor's office for access to payroll and accounting ledgers via the MHP's Geneva software.

- Due to the Walnut Street remodel, the network hardware room was flagged for relocation. The main distribution frame/main point of entry (MDF/MPOE) network equipment relocation has been completed.
- ConnectWise, an IT ticket tracking system, was implemented.

PRIORITIES FOR THE COMING YEAR

- Complete MyAvatar testing and implement the electronic health record for MH and AoD.
- Provide Information System (IS) and data analytical staff additional Crystal Report training in preparation for the MyAvatar implementation.
- In preparation for the MyAvatar implementation, complete set-up of a new back-up infrastructure. Back-up functionality will be upgraded from tape to disk technology.
- Set up a mobile device management server in order to manage MHP Apple IOS devices remotely.
- Develop a five year IS strategic plan.
- Begin Voice-Over Information Protocol (VOIP) analysis in order to transition the phone system from analog to digital technology.
-

OTHER SIGNIFICANT ISSUES

- While the MHP has collaborated with Netsmart technologies and the MyAvatar product is now available in a test system, the anticipated implementation date has been extended until the quarter of 2017. The MyAvatar contract was signed by the Board of Supervisors in June 2014.
-

MEDI-CAL CLAIMS PROCESSING

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

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

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

☒ Yes ☐ No

If yes, product or application:

Electronic data interchange (EDI) utilizing Notepad.

-
- Method used to submit Medicare Part B claims:
- ☐ Clearinghouse ☒ Electronic ☐ Paper

Table 12 - Tehama MHP Summary of CY15 Processed SDMC Claims

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
16,806	$2,661,879	$24,872	0.93%	140	$2,637,007	$278	$2,636,729

Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Four hours per week of telepsychiatry provided by Kings View Behavioral Health Systems is now provided in the jail.
  - The MHP continues to utilize telepsychiatry with both child/youth and adult consumers. The MHP reported 63 adults and 134 children/youth were served via tele psychiatry from 6/30/15 to 7/1/16.
- Quality of Care
  - Data analysis and reporting remains limited due to the lack of an electronic health record.
  - The MHP has worked collaboratively with Netsmart Technologies in a needs analysis for the MyAvatar electronic health record. The system is now in the final testing phase.
  - In preparation for the MyAvatar electronic health record implementation, fiber optic internet connectivity was installed at three Agency sites: Vista Way, Walnut Street and Main Street.
- Consumer Outcomes

- The MORS, utilized in the Behavioral Health Court, is not available in the CMHC information system.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers encountered for this review.

CONCLUSIONS

During the FY16-17 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - Two board and care providers were opened over the past year.
  - The MHP has been expanded its use of telepsychiatry.
  - The MHP has made improvements in its staffing capacity, with 78% of its positions currently filled, as compared to 40% last year.
  - The MHP demonstrates strong collaboration with community churches in service of the homeless population.
- Opportunities:
  - The MHP continues to be challenged in the recruitment and hiring of new staff.
  - The MHP has the opportunity to develop mechanisms for ongoing monitoring of its outreach and to address its low penetration rates.

Timeliness of Services

- Strengths:
  - The MHP is addressing access issues by hiring locum psychiatrists and taking steps to decrease the impact of no-shows.

  - The walk-in assessment option seems to be a reasonable option for decreasing wait times to assessment.

- Opportunities:
  - Tracking of timeliness metrics could be expanded to include separate tracking of adults and children, tracking urgent appointments and more details about no-shows. To account for the MHPs triage process, tracking should also include time from assessment to availability of assigned service.

Quality of Care

- Strengths:
  - The MHP now has a QA Manager as of May 16, 2016.
  - Vista Way Recovery Center provides consumers with support groups and activities focused on wellness and recovery.
  - The MHP has a strong partnership with law enforcement and as such was able to provide a robust and well attended CIT training in addition to MH First Aid training.
- Opportunities:
  - With the addition of the three staff positions, IT and Health Services analysts, if sufficient analyst time is allocated to MH, the MHP is poised to become a data driven system once its EHR is in place.
  - Data analysis and reporting remains limited due to the lack of a sufficiently functional electronic health record system.
  - Consumer family member participation in program planning is lacking

Consumer Outcomes

- Strengths:
  - The MORS is utilized in the Behavioral Health Court and administered at program entry and exit.
  - ASIST training for staff could lead to improvements in quality care for clients in need of urgent psychiatric care.
- Opportunities:
  - Currently no system-wide outcome measure in use for children/youth or adults.
  - The MORS is not available in the CMHC information system.

RECOMMENDATIONS

- Diligently monitor the implementation timeline and personnel resources allocated to the MyAvatar implementation in order to assure on-time implementation in the first quarter of 2017.
- Expand timeliness tracking to include regular reporting on all timeliness measures indicated in the timeliness self-assessment for the MHP, including separate analysis of adult services and children's services. To account for the MHPs triage process, tracking should also include time from assessment to availability of assigned service. Demonstrate meaningful use of timeliness reports by applying information to identify and solve timeliness issues.
- Develop two data driven PIPs, one Clinical and one Non-Clinical. PIPs should identify local needs, have a clear study question and apply them to a broad range of MHP beneficiaries. The MHP should consult with the EQRO early in the process for technical assistance on topic development and methodology to ensure that sufficient data is gathered to determine the scope of the problem identified, possible causes and appropriate interventions.
- Select and implement system-wide child/youth and adult outcome measures. Incorporate these tools into the MyAvatar electronic health record in order to permit data collection, analysis and reporting.
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ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Behavioral Health Concepts, Inc. - California EQRO
5901 Christie Ave., Suite 502, Emeryville, CA94608 (855) 385-3776
www.caleqro.com

Tehema County MHP
CalEQRO Agenda
Wednesday, October 5, 2016
All sessions located at 1860 Walnut Street, Bldg. D Red Bluff, CA 96080 unless otherwise noted.

Time	Activity		
8:30am – 9:50am	**Opening Session** • Introduction to BHC • MHP Team Introductions **Review of Past Year** • Significant Changes and Key Initiatives • Responses to Last Year's Recommendations • Use of Data in the Past Year • State Survey (#s, use of) **Participants:** MHP Leadership, Quality Management Staff, Key Stakeholders Val Lucero, Jayme Bottke, Deanna Gee, Betsy Gowan, Maureen Greer, Mike Gonzales, Amy Green, Faith Cole, Lori Strahan, Linda Russell, Joann Jeffery, Michaele Brown, Michele Brousseau, Genie Brogden **Location:** Shasta Room (1860 Walnut Street) **BHC Staff:** All		
9:50 am -10:00 am	**Break**		
10:00 am – 11:15 am	**MHP Clinical Staff Group Interview** 6-8 Clinical line staff, representing various geographical regions of the county, including crisis staff, with no supervisory level staff included. **Participants:** Talia Shirer, Jennifer Chaney, Stacie Loyd, Mark Morlan, Xochitl Cepeda, Roy Dyer, Colter Diehl, Rachel Chavez, Gisela Sandoval.	**Billing/It Key Staff Group Interview** • Recommendation FY15-16 • ISCA Review • Continuous Training Initiative • CHAT Program Implementation • Analysis & Use of Data • EHR Dashboards • Process to Review Denied Claims and	**10:00 am – 10:30 am Vista Way Visit** **10:30 am to 11:45 am Consumer Focus Group** Diverse group of 8-10 adult consumers representing both high and low utilizers of services. **Participants:** 7 **Location:** Vista Way **BHC Participants:** JL

Tehama EQRO Final Agenda FY16-17 CE 1

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Cyndi Eppler – Lead Quality Reviewer
Lisa Farrell – Information Systems Reviewer
Janyce Leathers – Consumer/Family Member Consultant

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

Sites of MHP Review

MHP SITES

MHP and YES Center
1860 Walnut Street, Bldg. D
Red Bluff, CA

818 Main Street
Red Bluff, CA

Vista Way Recovery Center
1445 Vista Way
Red Bluff, CA

Participants Representing the MHP

Name	Position	Agency
Amy Green	Quality Assurance Mgr.	TCHSA
Cindy Sumpter	Office Assistant II	TCDSS
Colter Diehl	MFT I	TCHSA MH
Deanna Gee	Asst. Exec. Director, Admin.	TCHSA
Elizabeth Gowan	MH Director	TCHSA
Faith Cole	Lic. Clinical Nurse Sup.	TCHSA
Genie Brogdin	Lic. Clinical Sup.	TCHSA MH
Gisela Sandoval	MFT	TCHSA MH
Grant Watkins	Fiscal Data IS specialist	TCHSA

Name	Position	Agency
Jayme Bottke	Asst. Exec. Dir., Program	TCHSA -Admin
Jennifer Chaney	Case Manager II	TCHSA MH
Laurie Barnes	Fiscal Data Supervisor	TCHSA
Linda Russell	Business Ops. Sup.	TCHSA
Lori Strahan	Lic. Clinical Sup. OP	TCHSA
Mark Morlan	Case Resource Specialist II	TCHSA MH
Maureen Greer	Compliance Officer	TCHSA
Melissa Williams	Not Provided	TCHSA
Michele Brousseau	Lic. Clinical Sup.	TCHSA MH
Michele Brown	Lic. Clinical Sup. YES	TCHSA MH
Phillip Hernandez	DA Director	TCHSA
Rachel Chavez	Clinical Social Worker I, bilingual	TCHSA MH
Roy Dyer	MFT	TCHSA MH
Sherry Wehbey	Program Manager	TCDSS
Stacie Loyd	Psychiatric Aide II	TCHSA MH
Talia Shirer	MFT I	TCHSA MH
Valerie Lucero	Executive Director	TCHSA
Xochitl Cepeda	Case Manager/Case Resource Sp.	TCHSA MH

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands.

Table C1 shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

Table C1 - CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	2,001,900	131,350	6.56%	$533,318,886	$4,060
Small	93,417	6,478	6.93%	$21,306,066	$3,289
Tehama	3,502	289	8.25%	$353,792	$1,224

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

Table C2 - Tehama MHP CY15 Distribution of Beneficiaries by ACB Range

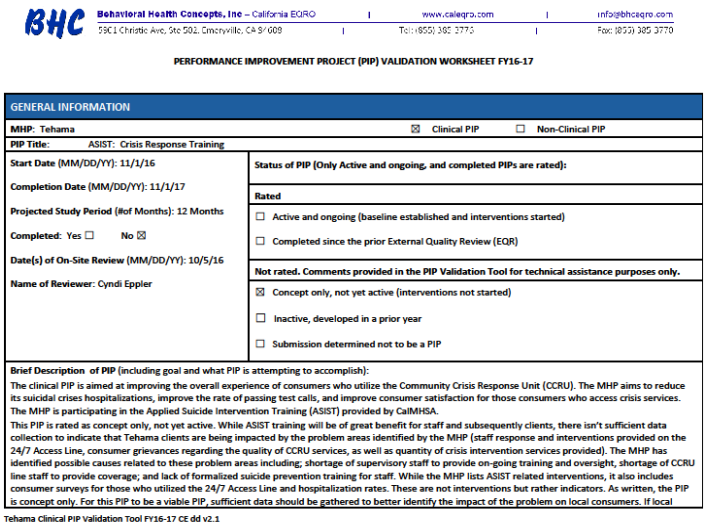
Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
$0K - $20K	1,476	99.06%	94.46%	$2,615,763	$1,772	$3,553	83.74%	61.20%
>$20K - $30K	n<=11	n<=11	2.67%	n<=11	n<=11	$24,306	n<=11	11.85%
>$30K	n<=11	n<=11	2.86%	n<=11	n<=11	$51,635	n<=11	26.96%

The actual counts are suppressed for cells containing n<=11.

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION

MHP: Tehama ☒ Clinical PIP ☐ Non-Clinical PIP

PIP Title: ASIST: Crisis Response Training

Start Date (MM/DD/YY): 11/1/16

Completion Date (MM/DD/YY): 11/1/17

Projected Study Period (#of Months): 12 Months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 10/5/16

Name of Reviewer: Cyndi Eppler

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

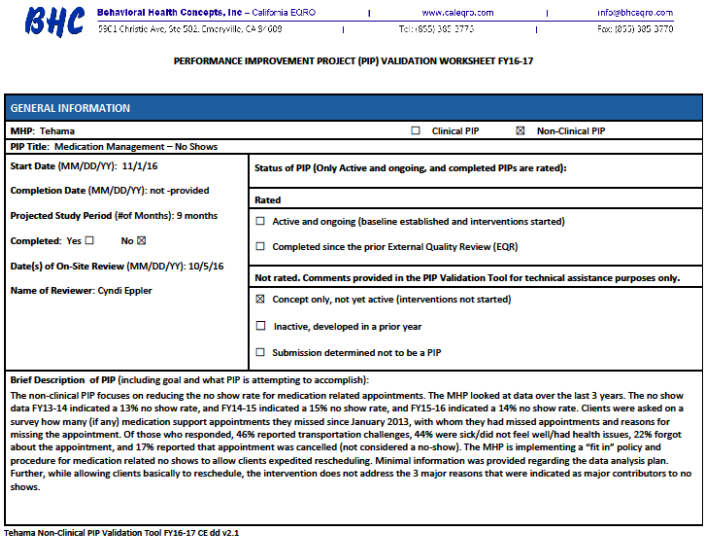
Brief Description of PIP (including goal and what PIP is attempting to accomplish):

The clinical PIP is aimed at improving the overall experience of consumers who utilize the Community Crisis Response Unit (CCRU). The MHP aims to reduce its suicidal crises hospitalizations, improve the rate of passing test calls, and improve consumer satisfaction for those consumers who access crisis services. The MHP is participating in the Applied Suicide Intervention Training (ASIST) provided by CalMHSA.

This PIP is rated as concept only, not yet active. While ASIST training will be of great benefit for staff and subsequently clients, there isn't sufficient data collection to indicate that Tehama clients are being impacted by the problem areas identified by the MHP (staff response and interventions provided on the 24/7 Access Line, consumer grievances regarding the quality of CCRU services, as well as quantity of crisis intervention services provided). The MHP has identified possible causes related to these problem areas including; shortage of supervisory staff to provide on-going training and oversight, shortage of CCRU line staff to provide coverage; and lack of formalized suicide prevention training for staff. While the MHP lists ASIST related interventions, it also includes consumer surveys for those who utilized the 24/7 Access Line and hospitalization rates. These are not interventions but rather indicators. As written, the PIP is concept only. For this PIP to be a viable PIP, sufficient data should be gathered to better identify the impact of the problem on local consumers. If local

Tehama Clinical PIP Validation Tool FY16-17 CE dd v2.1

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION

MHP: Tehama ☐ Clinical PIP ☒ Non-Clinical PIP

PIP Title: Medication Management – No Shows

Start Date (MM/DD/YY): 11/1/16

Completion Date (MM/DD/YY): not -provided

Projected Study Period (#of Months): 9 months

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 10/5/16

Name of Reviewer: Cyndi Eppler

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

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

The non-clinical PIP focuses on reducing the no show rate for medication related appointments. The MHP looked at data over the last 3 years. The no show data FY13-14 indicated a 13% no show rate, and FY14-15 indicated a 15% no show rate, and FY15-16 indicated a 14% no show rate. Clients were asked on a survey how many (if any) medication support appointments they missed since January 2013, with whom they had missed appointments and reasons for missing the appointment. Of those who responded, 46% reported transportation challenges, 44% were sick/did not feel well/had health issues, 22% forgot about the appointment, and 17% reported that appointment was cancelled (not considered a no-show). The MHP is implementing a "fit in" policy and procedure for medication related no shows to allow clients expedited rescheduling. Minimal information was provided regarding the data analysis plan. Further, while allowing clients basically to reschedule, the intervention does not address the 3 major reasons that were indicated as major contributors to no shows.

Tehama Non-Clinical PIP Validation Tool FY16-17 CE dd v2.1