FY 16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Madera

Conducted on

September 1, 2016

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MADERA MENTAL HEALTH PLAN SUMMARY FINDINGS

Summary Findings for CalEQRO FY16-17 review. This may serve as a stand-alone document that provides only the overarching significant findings for each section of this MHP Report. MHP Information as follows:

- Beneficiaries served in CY15— 2,345
- MHP Threshold Language(s)—Spanish
- MHP Size—Small
- MHP Region—Central
- MHP Location—Madera
- MHP County Seat—Madera

Prior Year Review Findings from FY15-16

Fully Addressed: 1 Partially Addressed: 2 Not Addressed: 2

MHP-Reported Significant Changes

- The MHP reports that there are significant staff compliance issues with data collection and documentation. Additionally, the data analyst is on-leave.

Performance Measurement Findings from CY15 Claims Data

- The MHP's percentage of high-cost beneficiaries was less than half of statewide. The MHP's corresponding percentage of total approved claims was half of statewide.
- The Number of Medi-Cal beneficiaries served increased from 2,122 during CY14 to 3,060 during CY15 – an increase of 44%. Much of the increase is attributed to Affordable Care Act (ACA) expansion, which accounted for 715 beneficiaries.

Performance Improvement Project (PIP) Validation

- Status of Clinical PIP:

☐ Active and ongoing

☐ Completed

☒ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

- Status of Non-Clinical PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☒ Submission determined not to be a PIP

☐ No PIP submitted

Performance and Quality Management Key Components

Fully Compliant: 8 Partially Compliant: 7 Non-Compliant: 5

Consumer and Family Member Findings

Number of Focus Groups: 1 Total Number of Participants: 9

Information Systems Findings

- The MHP, in collaboration with Kings View, has installed a new pilot electronic timeliness tracking form program via a new assessment form. It is currently in testing phase and the MHP plans to implement in October 2016.
- The MHP is collaborating with Kings View to develop outcome reports based on the Children's Assessment of Needs and Strengths (CANS) outcome tool and Adult Needs and Strengths Assessment (ANSA) outcome tool. CANS and ANSA have been operational since Fall 2015. The MHP plans to implement the outcome reports in Spring or Summer 2017.

Strengths and Recommendations Findings

Strengths

- The MHP assesses and strategizes capacity by reviewing caseloads, penetration and prevalence rates and demographic reports and has increased their psychiatric staff accordingly.
- The MHP added 12 full time positions for people with lived experienced, six of which are filled.
- The MHP developed a successful partnership with Probation and the Department of Corrections in the establishment and operation of a forensic program funded through Mentally Ill Offender Crime Reduction (MIOCR) funds.
- The MHP developed a contract with WestCare Foundation to provide mobile crisis services with the Madera Police Department from 3 pm-12am Wednesday through Sunday.

Recommendations

- As recommended in the CalEQRO FY15-16 MHP report, the MHP should complete the implementation of its timeliness tracking program.
- The MHP should develop two data driven PIPs, one Clinical, one Non-Clinical.
- The MHP should collaborate with Kings View regarding the process for tracking, trending and reporting on both adult and children's outcome tools.

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. CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

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

This report presents the fiscal year 2016-2017 (FY 16-17) findings of an external quality review of the Madera mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **eight (8) Mandatory Performance Measures** (PM) 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 TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

[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.

- High Cost Beneficiaries ($30,000 or higher)

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

CalEQRO also conducted one 90-minute focus group 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 serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

Key Recommendations from FY15-16

- Recommendation #1: Implement a fully functioning EHR system, including appropriate staffing, to track all timeliness

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP, in collaboration with Kings View, has installed a new pilot electronic timeliness tracking form program via a new assessment form. It is currently in the testing phase and the MHP plans to implement it in October 2016.
  - The MHP has not established goals, policies or procedures for reducing no-shows.
  - While staff was trained on the Call Log in Scheduler in February 2016, the Call Log is not yet operational.
- Recommendation #2: For assuring access, timeliness and quality of services, it will be important for the MHP to be adequately and appropriately staffed. Therefore filling clinical and case manager vacancies should be a priority.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP provides telepsychiatry services through American Tele-psychiatrists, and more recently Iris Telehealth. The MHP has increased their psychiatry staff from 2.4 FTE last year to 3.8 FTE. There is 1.40 FTE on site. There are two part time bilingual Spanish child psychiatrists, one male and one female.
- The MHP has been actively filling vacancies throughout the Department. As of July 15, 2016, the MHP did not have any clinician positions to be filled, with only 2 case management positions remaining open. The MHP is in the active process of hiring the two case management positions.
- Also, during the year, the MHP was able to add additional permanent full-time County positions for persons with lived experience. A total of 12 positions were added. Currently six of those positions are filled and it is anticipated the other six positions will be filled by January 1, 2017.

- Recommendation #3: Implement Intensive Home Based Services (IHBS).

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP met with the Department of Social Services who holds the contract with Uplift Families for wrap around services. Additional language was added to the contract for in IHBS services. The contract was approved by the Board of Supervisors and the transition was completed April 2016.
  - The MHP now has the capability to provide and bill for IHBS but no children have been identified for this service. Alternatively, the MHP has its contractor providing therapeutic behavior service (TBS) to one subclass member. The MHP has 20 identified subclass members. The MHP meets with its contractor monthly, and there is an interagency placement meeting (IPC) to discuss care and services for Katie A.

- Recommendation #4: Regarding the Clinical PIP, refine the study question to better define the PIP population and interventions to better integrate health care and behavioral health care needs of the beneficiaries. Next the MHP will need to carry out the data gathering and analysis to determine the most appropriate target group for the PIP. Design the intervention to better integrate the health care with behavioral health needs of its consumers.

  ☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - For FY15-16, the MHP had submitted a single PIP written to fulfill the requirement for both clinical and nonclinical categories. The revised question for FY16-17 is not much different than that of the previous year, and the MHP has not made progress on refining the question or making it measurable.
  - Relevant details of these issues and recommendations are included within the PIP validation section of this report and also in the PIP validation tool.

- Recommendation #5: Develop and implement a Non-Clinical PIP.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

Last year, the MHP submitted a single Performance Improvement Project (PIP) which had both clinical and non-clinical components. Because two separate PIPs are required, CalEQRO accepted and rated the PIP under the clinical category only. For this year, the MHP submitted two PIPs – clinical and nonclinical, however, the information submitted was the same as submitted last year, albeit was broken out into two submission forms.

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

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

- Access to Care
    - The MHP provides telepsychiatry services through American Tele-psychiatrists, and more recently Iris Telehealth. The MHP has increased their psychiatry staff from 2.4 FTE last year to 3.8 FTE. There is 1.40 FTE on site. There are two part time bilingual Spanish child psychiatrists, one male and one female.
    - Telepsychiatry is offered at Chowchilla and Oakhurst and is set up at Pine Recovery but not being utilized at that location.
    - The MHP developed a contract with WestCare to provide mobile crisis services with the Madera Police Department from 3 pm-12am Wednesday through Sunday. These services will start in mid-August and will provide a licensed clinician to be on call for Madera Police Officers. The goal is to have available on-site mental health interventions which may prevent a person/situation from escalating to the point where incarceration or hospitalization are necessary.
- Timeliness of Services
    - The MHP, in collaboration with Kings View, has installed a new pilot electronic timeliness tracking form program via a new assessment form. It is currently in the testing phase and the MHP plans to implement it in October 2016.
    - The MHP has not yet established goals, policies or procedures for reducing no-shows.
    - The staff was trained on the Call Log in Scheduler in February 2016, however, the MHP states that the Call Log is not operational as yet because they have added a field for the beneficiary's preferred provider gender and staff needs additional training.
- Quality of Care

- The MHP developed a successful partnership with Probation and the Department of Corrections in the establishment and operation of a forensic program funded through Mentally Ill Offender Crime Reduction (MIOCR) funds. At the midyear point the forensic program had served 51 individuals, two thirds of the projected 70 participants by year-end.
- BHS received additional monies for FY 1617 to continue its Mental Health Block Grant (MHBG) First Episode Psychosis (FEP) program. The MHP will expand the program from one to two (2) full time equivalent (FTE) Community Service Liaisons staff and also expand the targeted age group up to age 30.

- Consumer Outcomes
  - The MHP is collaborating with Kings View to develop outcome reports based on Children's Assessment of Needs and Strengths (CANS) outcome tool and Adult Needs and Strengths Assessment (ANSA) outcome tool. CANS and ANSA have been operational since Fall 2015. The MHP plans to implement the outcome reports in Spring or Summer 2017.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average 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—Madera MHP 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	9,705	789
Hispanic	39,345	1,150
African-American	1,180	126
Asian/Pacific Islander	909	28
Native American	352	16
Other	4,648	236
Total	56,138	2,345

**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.

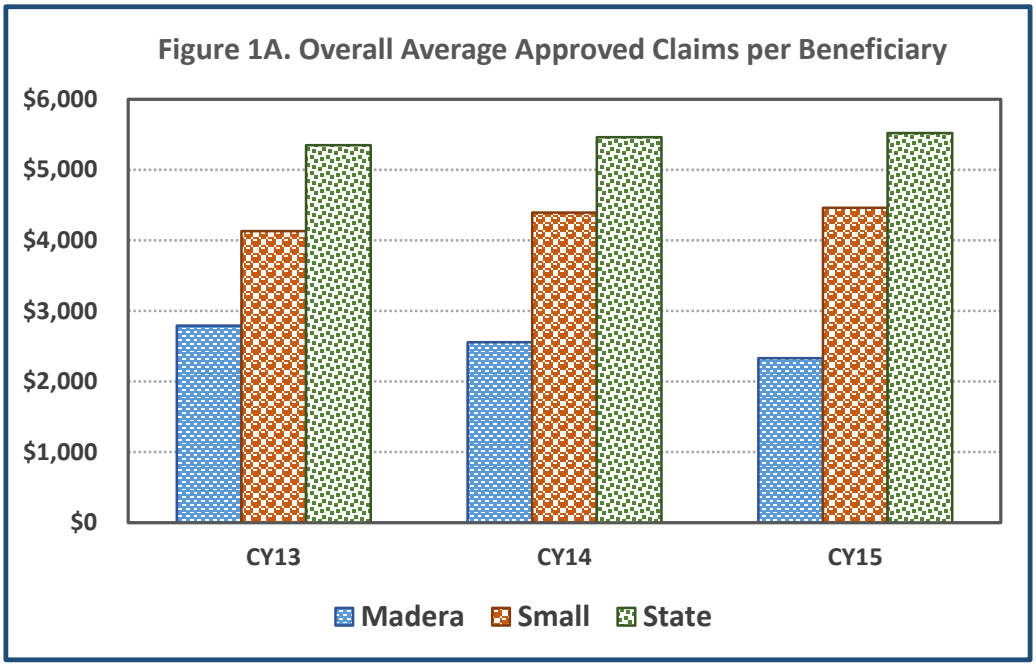
Regarding calculation of penetration rates, the Madera MHP:

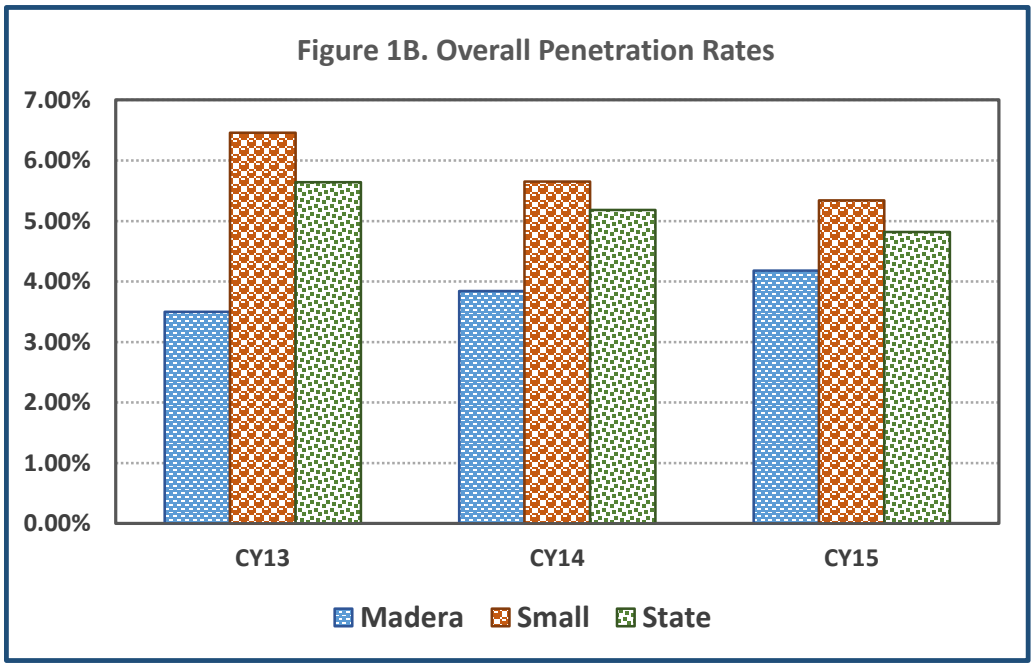
☒ Uses the same method as used by the EQRO

☐ Uses a different method

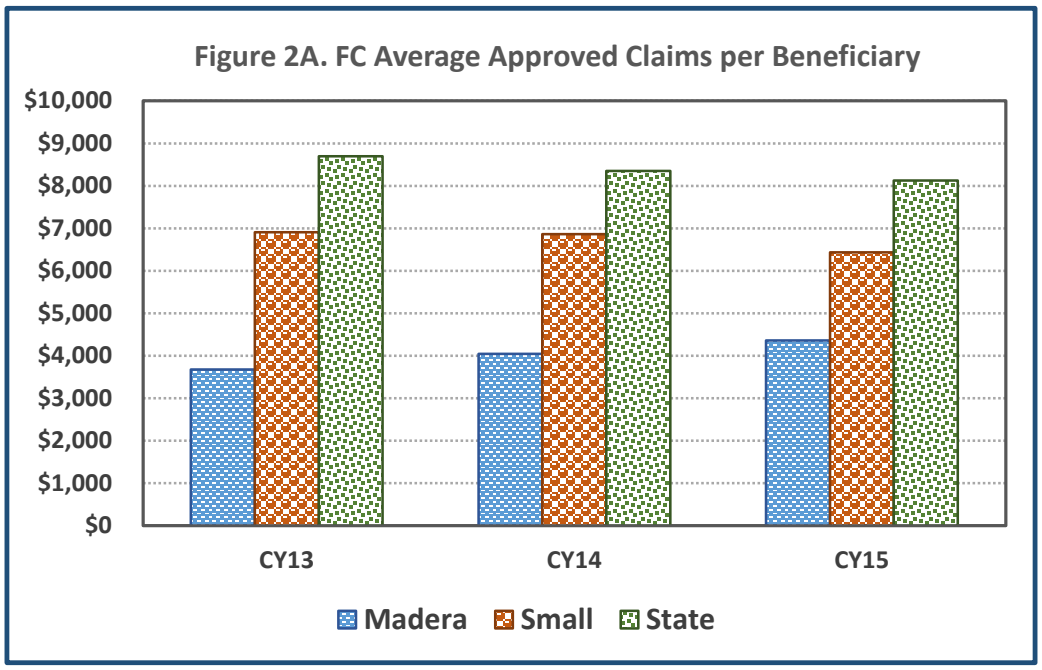
☐ Does not calculate its penetration rate

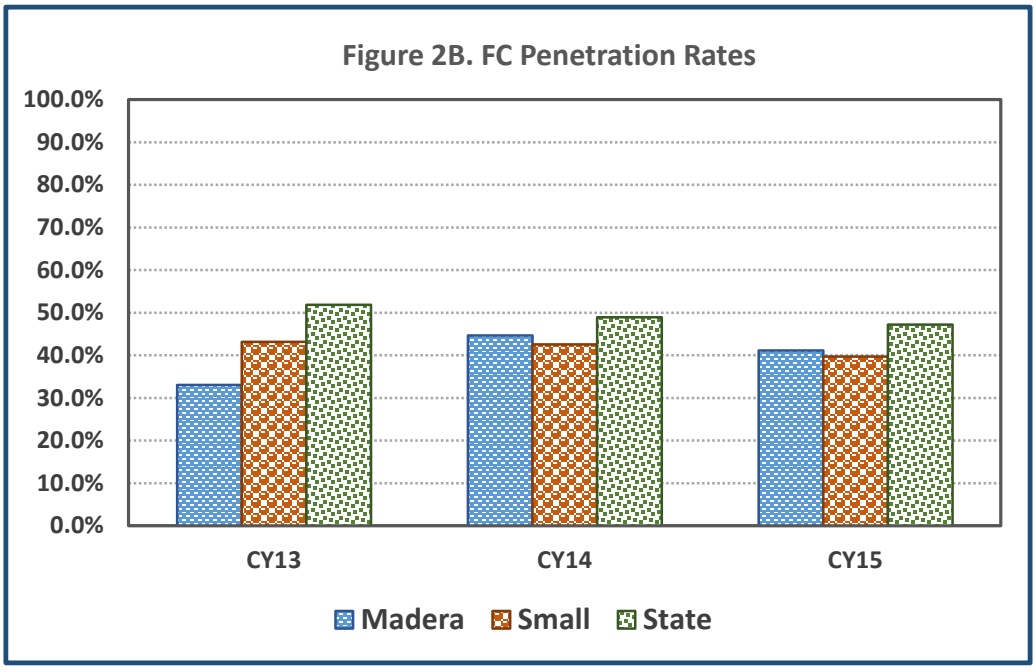
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



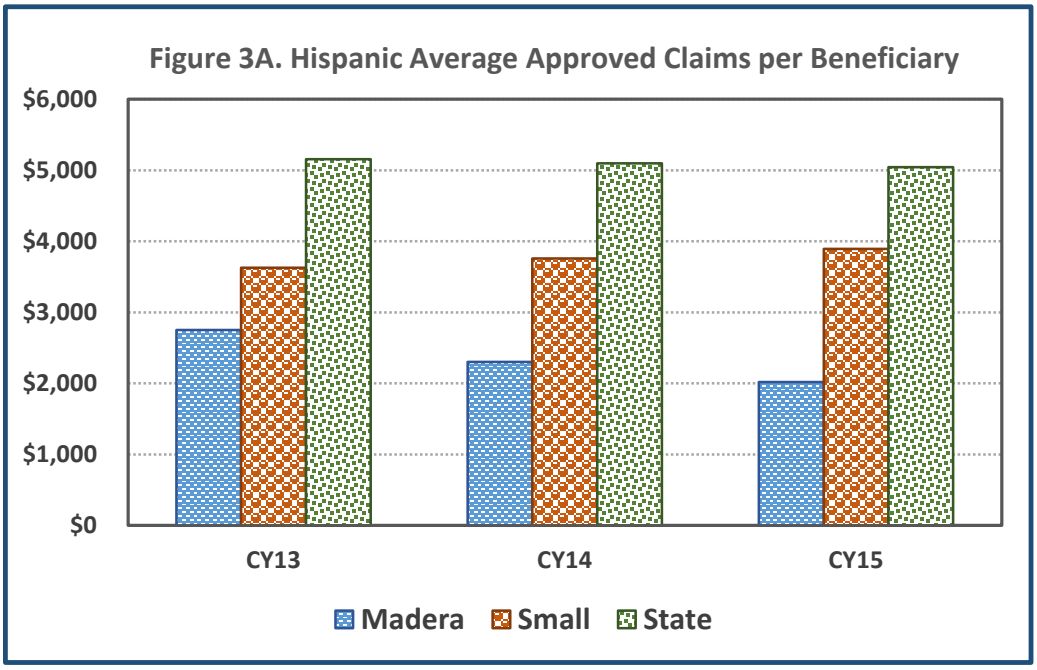


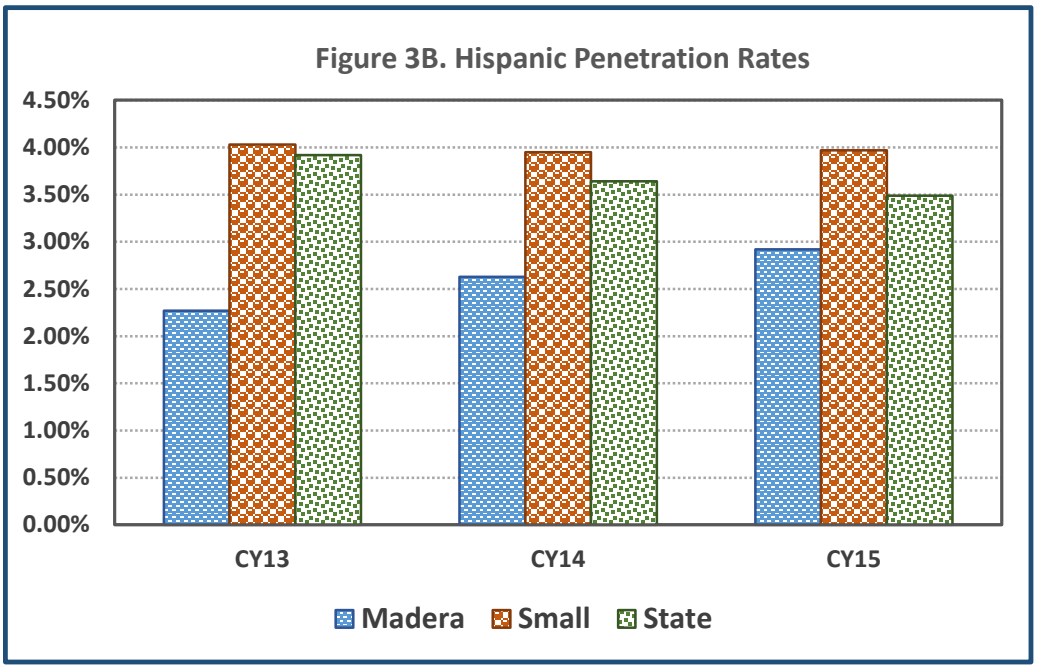
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.





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





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for 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

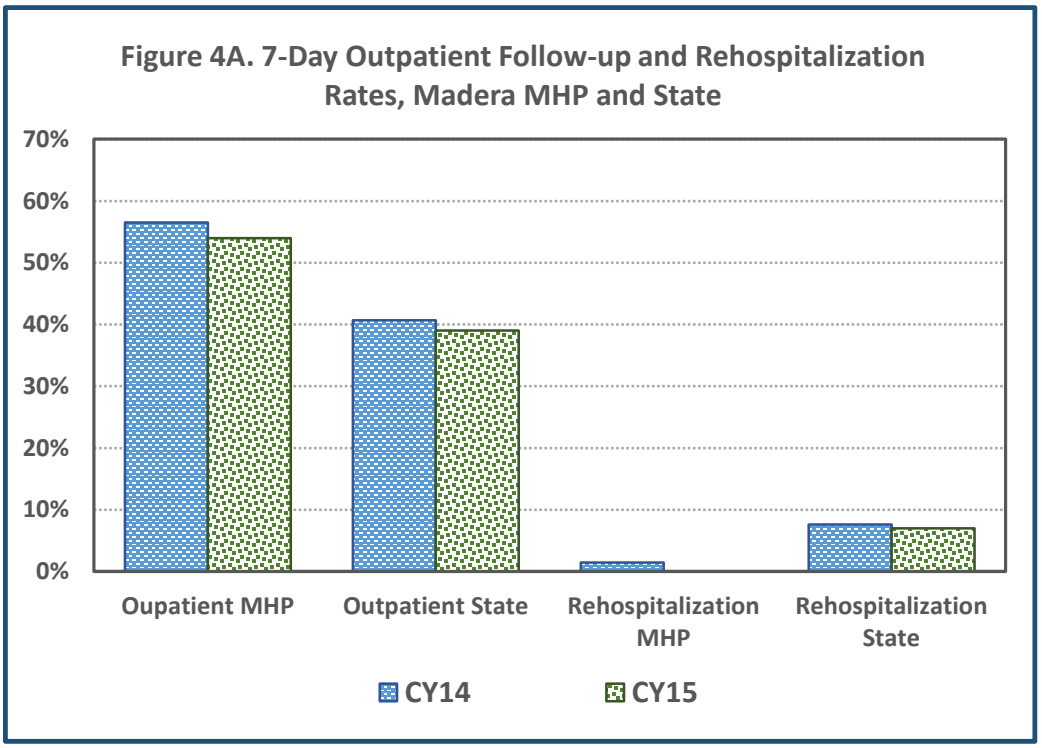
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Madera	CY15	14	2,345	0.60%	$54,253	$759,543	13.92%
	CY14	6	2,117	0.28%	$51,886	$311,317	6.66%
	CY13	10	1,775	0.56%	$49,191	$491,908	9.92%

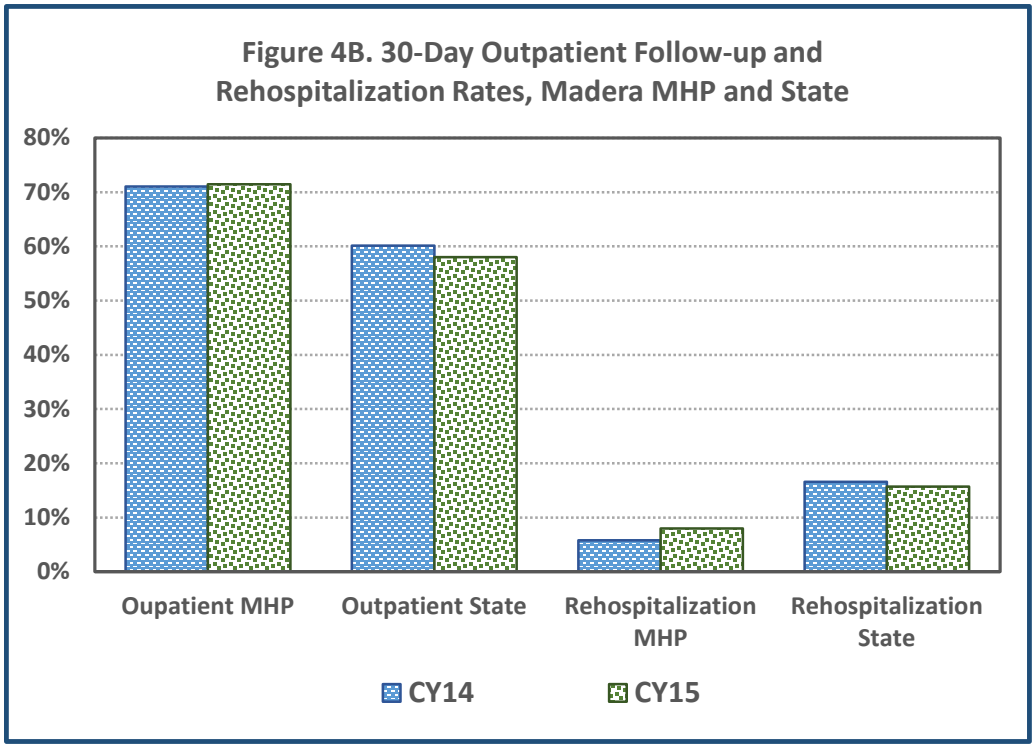
Table C1 (Attachment C) shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (Affordable Care Act [ACA]) Penetration Rate and Approved Claims per Beneficiary.

Table C2 (Attachment C) show the distribution of the MHP CY15 Distribution of Beneficiaries by Approved Claims per Beneficiary (ACB) Range for the various 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.

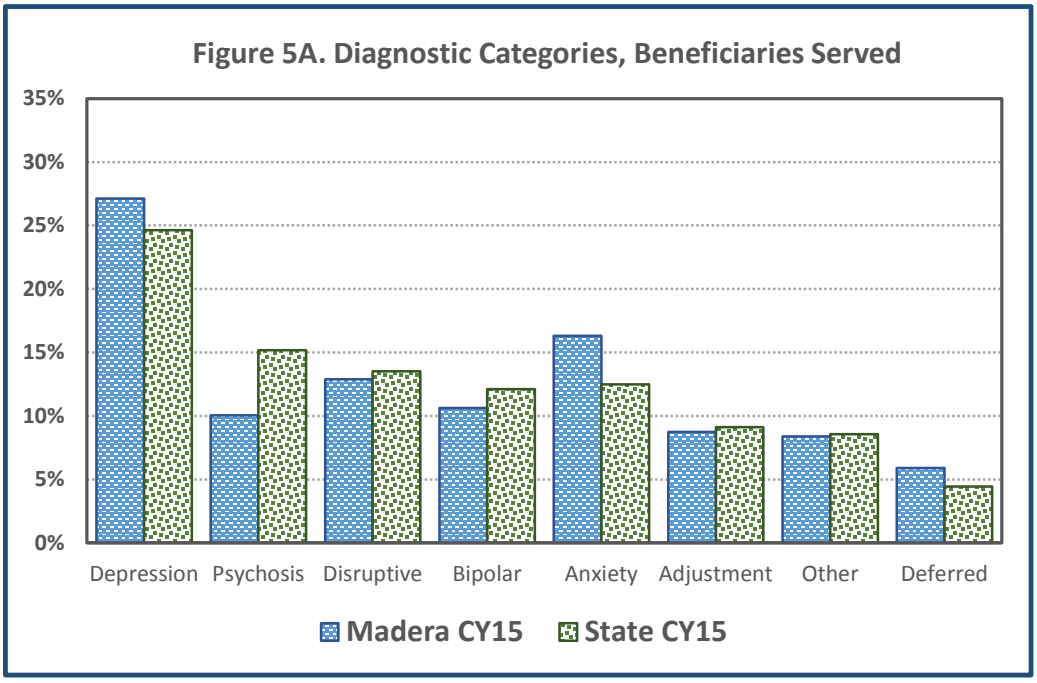


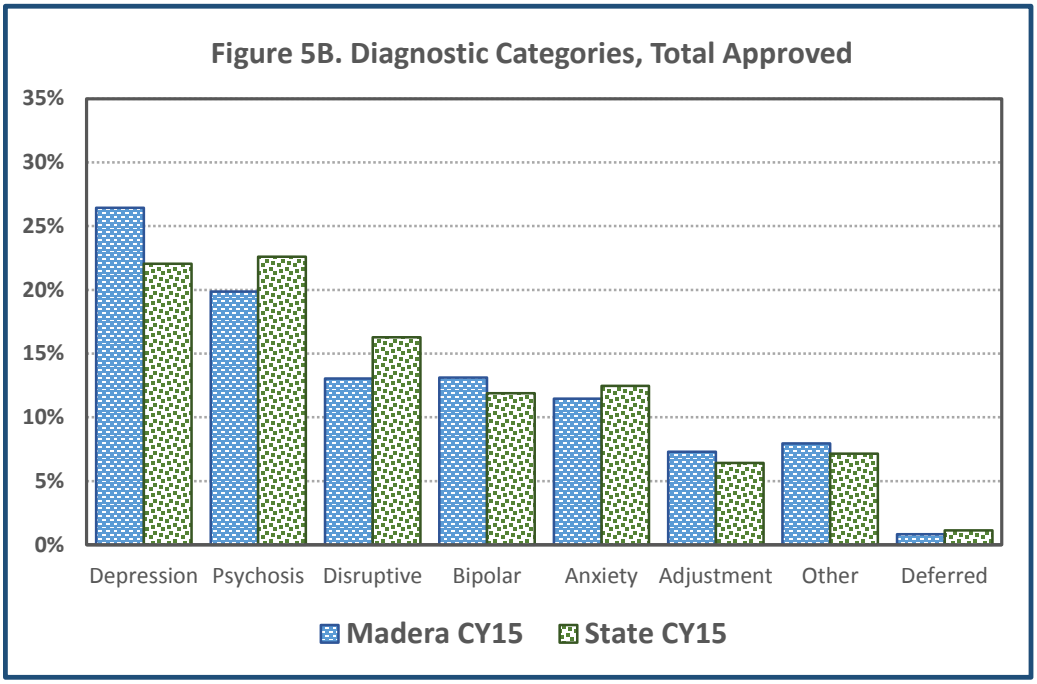


DIAGNOSTIC CATEGORIES

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 abuse and mental health) diagnoses: 19.5%





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate has increased slightly each year between CY13 and CY15. The MHP's rate is lower than both statewide and small MHPs. The overall penetration rates for both statewide and small MHPs has declined slightly for the same period.
  - The MHP's foster care penetration rate is similar to small MHPs and slightly lower than statewide.
  - The MHP's Hispanic penetration rate is lower than both small MHPs and statewide. However, the MHP's Hispanic rate has experienced a gradual upward trend between CY13 and CY15.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from psychiatric inpatient episodes were higher than statewide.
  - The MHP's 7 and 30 day inpatient recidivism rates are lower than statewide and small MHPs.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries was less than half of statewide. The MHP's corresponding percentage of total approved claims was half of statewide.
  - The MHP's overall, foster care and Hispanic average approved claims are all lower than statewide.
  - The MHP's distribution of diagnostic categories is similar to the statewide distribution. The MHP has a slightly higher percentage of bipolar disorder diagnosis and depressive disorder diagnosis that statewide.
  - The MHP had a higher percentage of deferred diagnosis but similar percentage of total approved claims for the same diagnosis.
- Consumer Outcomes
  - None noted.

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.

MADERA MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3A—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Increased Access to Healthcare
Non-Clinical PIP	1	Increased Access to Healthcare

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

Table 3B—PIP Validation Review

Step	PIP Section		Validation Item	Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NM	NM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NM	NM
		1.3	Broad spectrum of key aspects of enrollee care and services	NM	NM
		1.4	All enrolled populations	M	NM
2	Study Question	2.1	Clearly stated	NM	NM
3	Study Population	3.1	Clear definition of study population	M	NM
		3.2	Inclusion of the entire study population	NM	NM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	NM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	NM

[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					
				Item Rating*	
Step	PIP Section	Validation Item		Clinical PIP	Non-Clinical PIP
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NM	NM
		5.2	Valid sampling techniques that protected against bias were employed	NM	NM
		5.3	Sample contained sufficient number of enrollees	NM	NM
6	Data Collection Procedures	6.1	Clear specification of data	M	NM
		6.2	Clear specification of sources of data	M	NM
		6.3	Systematic collection of reliable and valid data for the study population	PM	NM
		6.4	Plan for consistent and accurate data collection	UTD	NM
		6.5	Prospective data analysis plan including contingencies	PM	NM
		6.6	Qualified data collection personnel	NM	NM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NM	NM
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	NM
		8.3	Threats to comparability, internal and external validity	NA	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NM
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NM
		9.3	Improvement in performance linked to the PIP	NA	NM
		9.4	Statistical evidence of true improvement	NA	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NM

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

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

Table 3C—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	6	NM
Number Partially Met	2	NM
Number Not Met	10	NM
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	19	NM
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	28%	0 %

CLINICAL PIP—INCREASED ACCESS TO HEALTHCARE

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

- "Can we get clients to obtain a physical health examination on an annual basis? As a result of obtaining a physical health examination on an annual basis, will this increase the number of persons who have a specific source of on-going care? Will this reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care? Can we get the results of the physical/lab work included in the EHR?"
- Date PIP began: 7/1/16 (this was updated from last year, which was 7/1/15)
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☒ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

Despite the start date of this PIP, this PIP focusing on collaboration with primary care, has been submitted three years in a row with very little progress. Also, last year, the MHP submitted this same PIP as both the Clinical and Non-Clinical PIP. At that time, CalEQRO had accepted the PIP as

only a Clinical PIP and the MHP was asked to submit two different PIPs for this year. This year, the MHP submitted the same PIP as last year with only minor edits to the document.

Aside from the above mentioned submission issues, the MHP intends to improve coordination with primary care by working with a federally qualified health center to offer evening and weekend primary care appointments and by having staff invite or provide linkage to the primary care provider. The MHP intends to collect data and hopes to show improved collaboration by the number of medication only clients and AOD clients having a primary care doctor, having a physical exam and accompanying lab work, with data in the electronic health record. For the second year of this PIP, the county will also include any client receiving medication and clinical services having a physical health examination completed yearly and the results included in the EHR. Year three of this clinical PIP will focus on every client receiving behavioral health services to have a physical examination completed yearly and have the results included in the EHR.

Based upon last year's feedback and recommendation to collect more information in order to better identify the service patterns and health needs of consumers to better define the target population, and subsequently appropriate interventions. However, it is unclear why they chose to focus on medication-only, and AOD clients. During the onsite review, the MHP stated that because they are a small county, their staff are resistant to change, that time is needed to obtain staff buy-in and get staff to complete the needed documentation.

There is no evidence that the MHP conducted additional analysis of its target population. This is a necessary step before the MHP can figure out a systematic implementation plan. The MHP states that it does not have the ability to tally how many clients have primary care doctors or physical diagnoses. Staff are resistant to completing Axis 3.

Even with the selected populations, baseline data is not provided. This is the third year of this PIP, even though the MHP dated this PIP with a more current date. At a minimum, baseline data should be included in order to determine the best interventions. No progress has been made.

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

Despite technical assistance and feedback over the last two reviews, there has not been progress in addressing the issues through the PIP process. The MHP's approach to improving collaboration with primary care through the PIP process is too global. The MHP's PIP question is not answerable until basic staff and EHR issues have been resolved, which would then inform whether this is an actual problem impacting the MHP's consumers.

NON-CLINICAL PIP—INCREASED ACCESS TO HEALTHCARE

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

- "Can we get the client, to complete with staff, a health questionnaire on an annual basis? What type of staff is best to work with client to help complete the form, e.g., clinical staff (clinician, case manager) peer staff, clerical staff, etc.? "
- Date PIP began: 7-1-16
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☒ Submission determined not to be a PIP

  ☐ No PIP submitted

Last year, the MHP submitted a single PIP which had both clinical and non-clinical components. Because two separate PIPs are required, CalEQRO accepted and rated the PIP under the clinical category only. For this year, the MHP submitted two PIPs – Clinical and Non-Clinical. However, the information submitted was the same as submitted last year, albeit was broken out into two submission forms.

That aside, the information provided here as a Non-Clinical PIP is aimed at improving the process for recording data in the EHR regarding client's physical health status and aims to have clients complete an annual health questionnaire. The MHP experiences documentation issues. The MHP reports that limitations in the EHR prohibit the notation of health status other than on the DSM IV TR Axis III. The MHP reports that this field is not reliable. Staff were not completing Axis III in the Diagnosis form. Staff erroneously thought they were diagnosing the client with the illness (out of their scope of practice) rather than just recording what the client reported. The MHP reports that even with staff training, they still were not always completing this. As a result, the MHP is attempting to address this issue as a PIP as a precursor to its clinical PIP (clients having a yearly exam with primary care physician).

The overall goal for this Non-Clinical PIP is to have the client complete a physical health questionnaire. This Heath Questionnaire includes current medical conditions, name for a primary care physician, when last seen by primary care. Base line data hasn't been collected because of the unreliability of documentation. The MHP is waiting for approval of this PIP before implementing and gathering base line data. They have not decided on how to move forward – i.e. who will assist the client in filling out this questionnaire. The MHP reports that staff are resistant to change, and that time is needed for buy-in in order to get staff to implement.

After a clarifying discussion with the MHP, during the on-site review, this submission is still determined to not be a PIP. Aside from being rewritten and being submitted as its own PIP this year, this PIP topic was submitted last year, and the year before. The MHP cites that the prior EQRO

had accepted it in FY13-14. However, this is the third year that CalEQRO has not accepted this information as a PIP. The MHP did not provide any data which demonstrates that its own consumers are experiencing a significant problem as a result of staff not entering the health care data. Also, functionality for collection of baseline data (EHR) should be in place to determine the significance and pervasiveness of the problem, so that 1) the actual problem can be identified and 2) appropriate interventions can be implemented. While there may be a problem with staff being resistant to change, the onus for correcting this issue should not fall to the client being required to complete the questionnaire, but rather on leadership in the management of staff. As such, this problem does not justify a PIP.

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

Despite technical assistance and feedback over the last 2 reviews, there has not been progress in addressing the issues through the PIP process. The MHP's approach to improving collaboration with primary care through the PIP process is too global. The MHP's PIP question is not answerable until basic staff and EHR issues have been resolved, which would then inform whether this is an actual problem impacting the MHP's consumers.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP needs to collect data to better identify the target population most in need of intervention.
- Timeliness of Services
    - It is unclear how this performance improvement project will impact timeliness of service.
- Quality of Care
    - Based on the described method of data collection, data collection and/or input could not be guaranteed to be systematic or the same every time.
- Consumer Outcomes
    - System-wide implementation of a comprehensive health questionnaire form in Cerner Community Behavioral Health (CCBH)
    - CCBH will allow the MHP to track and trend important key parameters indicative of clients' experience with wellness and recovery.

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 MHP receives penetration data from Kings View. The MHP added bilingual services for specific indigenous dialects of Mexico through resources within the consulate and binational health. The MHP has a Promotores program through its contract with Camarena Health Services, which is a local federally qualified health center (FQHC) healthcare provider. The MHP identifies its underserved populations as mono-lingual Spanish speakers and its Native American population. They are partnering with Indian Health Services in Fresno, who recently gave permission for behavioral health to attend community gatherings. They are also offering parenting classes in Spanish. The MHP is not evaluating the impact of its strategies at this time.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP monitors caseloads. For children's services, caseloads approximate 60 clients. For adults, caseloads approximate 80 clients. Full services partnerships were less. The MHP also collects data reports on how often clients are seen. The MHP productivity standard is 100 billable hours per month for clinicians, and 120 billable hours per month for case managers. The MHP reports they are in growth mode. Strategies to address gaps in service have not been identified, implemented or evaluated.
1C	Integration and/or collaboration with	FC	The MHP developed a successful partnership with Probation and the Department of Corrections in the

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
	community based services to improve access		establishment and operation of a forensic program in October 2015. The MHP contracted with the Community Action Partnership of Madera County to provide property maintenance services to two Mental Health Service Act (MHSA) housing units. The MHP also developed a contract with the WestCare Foundation to provide mobile crisis services with the Madera Police Department. Additionally, the MHP worked with the Camerena Health Center to set aside Saturday or weekday appointments for SUD and MH clients in need of health physicals, lab tests, or a PCP. The MHP is working with the Madera Community Hospital to create an inpatient hospitalization wing, and mental health crisis stabilization unit. The MHP is working with the Department of Social Services to create an operational plan to decrease group homes and increase the number of foster families.

**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	NC	The MHP did not complete this item on the CalEQRO timely self-assessment form. Discussions revealed that the MHP was not collecting formalized timeliness data prior to August 2016. They recently implemented the form in CCBH system and will begin reporting on this measure in August. In its document submission, the MHP did produce January 2016 results in a "Dashboard 2016 file". Therefore, they do have CCBH data and the capability to produce the Intake – 1st Service data monthly for 2016. There is walk-in availability if there is a higher need or

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			level of urgency. The MHP's goal is 2 weeks (if not in crisis) for both children and adults. For those needing urgent assessment, the goal is 3 days.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NC	The MHP did not complete this item on CalEQRO timely self-assessment form. Discussions revealed that if the hospital discharges a client or if a client is in crisis or is reporting active psychosis, the MHP will get them in either the same day or within 5 days. The "Dashboard 2016.xlsx" file shows that they can collect "Med Ref – 1st Med Svc." The reported average 15.4 days. It is unclear why this information wasn't contained in the timeliness self-report. If client does not meet the criteria above, a group or individual treatment service clinician will complete request for medication evaluation. If completed, clients generally receive approval on that day or within 2 weeks. The MHP reports that the medical director is on leave so there is a 2 week delay for adults in addition to its goal of two weeks. For children's services, there is a 2-3 week wait.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP sets a minimum standard of 3 days for urgent conditions, and reports that it meets the standard 100% of the time, with an average of 3 days. The MHP reports that it suspects a training issue with staff, as only 1 appointment was marked as urgent in the CCBH system for FY15-16. The MHP does not evaluate this component through routine data analysis nor does it initiate performance improvement activities to address identified issues.
2D	Tracks and trends timely access to follow up appointments after hospitalization	NC	The MHP reports that there were 295 hospitalizations overall, comprised of 231 adults, and 64 children respectively. 100 of these hospitalizations received follow up appointments, 93 adults and 7 children. The MHP sets a goal of 7 days, and reported that 100% of its follow up appointments meet this standard. The MHP reports that it has a high rate of hospitalization because it includes both non-Medi-Cal and Medi-Cal clients, and that the reason that only 100 clients had follow up appointments was due to clients refusing to come in.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			Data on hospitalization follow up appointments is not reported on often enough to allow for trending and initiating performance improvement activities.
2E	Tracks and trends data on re-hospitalizations	PC	The MHP tracks and trends rehospitalizations within 30 days with 36 of its 295 clients being re-hospitalized within 30 days, 28 adults, 8 children. The rehospitalization rate is 12%. The MHP's goal is 10 % or less. No performance improvement activities related to hospitalizations were indicated.
2F	Tracks and trends No Shows	PC	The MHP was able to obtain reports by service, adult/children's/psychiatric appointments for FY 15-16. During FY 15-16, management made the decision to have all clinical staff utilize CCBH system scheduler for their appointments, however, there still may be training issues for consistency in entering data. The MHP reports a no show rate for clinicians and non-psychiatrists to be 8%, 9% for adults, and 7% for children. For psychiatrists, the MHP reports a no show rate of 19% overall, 20% for adults, and 17% for children.

**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	FC	The quality improvement committee (QIC) meets twice per year, with quality improvement goals addressed monthly in subcommittees i.e., chart review, supervisors meeting. The QIC committee goes over hospital stays that go

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			over fourteen days and our one day stays. Clinicians, case manages, and peer employees are trained as trainers in Mental Health First Aid. They also provide training for community members, county staff, and CalWorks.
3B	Data are used to inform management and guide decisions	FC	The MHP monitors caseloads and productivity, and how often clients are seen. They also evaluate chart review elements required by the State. As of July 2015, they implemented Children's Assessment of Needs and Strengths (CANS) outcome tool and Adult Needs and Strengths Assessment (ANSA) and aggregate data. When the MHP analyst returns from leave they will begin an in-depth look at the data. The MHP uses data dashboards, productivity, number of cases open, and hospitalization numbers for decision making. Most recently, the MHP added a question regarding new allergies into its notes section for providers.
3C	Evidence of effective communication from MHP administration	FC	The MHP monitors caseloads and productivity, and how often clients are seen. They also evaluate chart review elements required by the State. As of July 2015, they implemented the CANS and ANSA outcome tools and began to aggregate data. When the MHP analyst returns from leave they will begin an in-depth look at the data.
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	The MHP participates in the MHSA stakeholder planning process regularly. They have an active presence in the community – farmers markets, town hall meetings, swap meetings, health fairs. The MHP also posts a survey on the MHP website to seek input. The MHP's quality management committee includes two peer staff.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	The MHP collaborates with many organizations in the community. These include health clinics, Madera Community Action Partnership, Salvation Army, Rescue Mission, First 5, as well as tribal council meetings and DSS staff. The MHP continues to collaborate with the Department of Corrections with its Behavioral Health Court. In Oakhurst, the faith based organizations work with the homeless population. The MHP also holds a monthly contract providers meetings.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP provides for evaluating level of care, treatment goals, progress and outcomes in its QI work Plan. The MHP also monitors and trends medication prescribing, use and effectiveness monthly. It also utilizes genetics testing to determine appropriateness of medication prescribing and effectiveness for each individual. The MHP also utilizes evidenced based practices cognitive behavioral therapy, dialectical behavior therapy (CBT, DBT) for individuals prior to medication services per its QI work plan.
3G	Evidence of individualized, client-driven treatment and recovery	PC	The MHP provides both educational and service linkages to consumers, family members and the community at large. There are two wellness centers, Hope House and Mountain Wellness. Peer services are offered in Madera through Turning Point. Hope House is located next to the Pine Recovery Center. The Mountain Wellness Center is located in Oakhurst, next to the Oakhurst Counseling Center. The degree to which consumers are engaged in their own treatment planning and care, as well as consumer use of level of function tools is unclear.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The MHP received county approval to hire peer support workers into county positions classified as vocational assistant/drivers. The classification is broad enough to allow individuals to work in the clinical as well as the clerical components of our BHS programs. Although the MHP does not have a defined career ladder per se for peers, the peer position descriptions will allow peers to gain applicable experience toward higher level classifications. There are 12 full time benefited positions. As of August 1, 2016, 6 of those positions are filled and it is anticipated the other six positions will be filled by January 1st, 2017.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The Hope House program and the Mountain Wellness Center are consumer/family member run and driven. Clients learn about the wellness centers from staff when they first enter into services. There is a monthly calendar of program services/events. There are no restrictions about who can and cannot attend. Hope House Wellness Center is open 7 days a week 8:30am-4:30pm. Mountain Community Wellness Center in Oakhurst is open Tue-

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			Fri 9:00am-4:00pm.
3J	Measures clinical and/or functional outcomes of consumers served	NC	As of July 2015, they implemented Children's Assessment of Needs and Strengths (CANS) outcome tool and Adult Needs and Strengths Assessment (ANSA) and can aggregate data. When the MHP analyst returns from leave they will begin an in-depth look at the data. The MHP, as part of its PIP, implemented a Health Questionnaire Assessment in CCBH system for all clients receiving services. However, system wide data on outcomes is not currently being reported on.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP participates in the State survey provides results semi-annually to their Behavioral Health Board. They also report the results to our Quality Management Committee. The results are used to set annual goals in their quality management plan. For FY15-16, the MHP collected 176 surveys for the October 2015 survey, with 93% in English and 7% in Spanish. For the Spring 2016 survey, the MHP collected 216 surveys, with 93% in English and 7% in Spanish. The MHP also provides system satisfaction surveys to its contract providers and primary care physicians. The most recent survey indicated that 94% consumers Liked and/or were satisfied with services, which is an increase of 3% from the previous 94% 6 months prior.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - While the MHP provides outreach services and attempts to reach underserved populations, the effectiveness of its efforts are not evaluated. Along with the MHP's underutilization of data reporting and analysis related to access and timeliness, it is difficult to understand how the MHP evaluates the effectiveness of its system.
- Timeliness of Services
  - The MHP did not complete the Timeliness Self-Assessment. The MHP had concerns about the accuracy of its preliminary results.

- The MHP has not demonstrated that it regularly produces timeliness reports nor uses timeliness data to evaluate and identify capacity issues.

- Quality of Care
  - The MHP has the opportunity to develop and implement a formalized method of evaluating the level of consumer participation in their own treatment planning, as well as helping clients utilize level of function scales, tools, testing and lab results to shape their own clinical treatment.
- Consumer Outcomes
  - The MHP does not regularly report on client outcomes.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 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 (1) focus group with 8 to 10 participants each, the details of which can be found in each section below.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP

CalEQRO requested a culturally diverse group of adult beneficiaries and parents/caregivers of child/youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group was held at the MHP offices, located at 209 E. 7th Street, Madera CA 93637.

The group was comprised of six women and three men.

A Spanish Speaking interpreter was present for one of the participants.

Number of participants: 9

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

- Some participants felt that initial services could have been provided more quickly, including eligibility assessment and referrals.
- Staff were friendly, helpful and welcoming.
- All were generally satisfied with the frequency of appointments with therapists and psychiatrists. If extra appointments are needed they are accommodated pretty quickly.

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

- Overall, participants were satisfied with access to care.
- Support groups were valued among focus group participants. Many of the participants learned about services through social media websites and the county website.

Recommendations for improving care included the following:

- Make available some type of childcare services would make it easier for parents to make and keep appointments.
- Address the need for in county mental health hospitalization.
- A monthly county newsletter notifying members of changes, updates, and upcoming events would help keep consumers apprised of what is available.
- Find an additional site for a teen wellness center.

Interpreter used for focus group 1: ☐ No ☒ Yes Language(s): Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Overall, participants indicated that services were easy to access.
  - Participants perceived that there is a bed shortage for crisis needs and that the MHP sends clients sent out of county when needed.
  - It was reported that Hope House Wellness Center is cutting back adult access hours to make activities and support groups available for teenagers. Participants felt that many adults will have no place to go as the Wellness Center is the only place they have.
- Timeliness of Services
  - Participants indicated that if there were a need for additional services/appointments, they could be accommodated.
- Quality of Care
  - Participants felt that they had an active role in their treatment plan. Additionally, participants were aware of and/or have a wellness recovery action plan (WRAP).
  - Foster parents experienced support, guidance and are offered in home therapy.
  - Hope House Wellness center is cutting back adult access hours to make activities and support groups available for teenagers. Participants felt that many adults will have no place to go as Wellness Center is only place they have.
- Consumer Outcomes
  - Information related to consumer outcomes was not provided.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 8—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	89.8%
Contract providers	4.2%
Network providers	6%
Total	100%

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

  7%

- 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 provide services to consumers using an tele-psychiatry application:

  ☒ Yes ☐ In Test/Pilot Phase ☐ No

  - If yes, the number of remote sites currently operational:

    2

  - Languages supported: Spanish, Portuguese, English

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

Table 9 – Summary of Technology Staff Changes			
Number IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
27	2	2	0

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

Table 10 – Summary of Data Analytical Staff Changes			
Number Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
7	0	0	0

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

- The MHP relies on Kings View for IS technology and EHR support.

CURRENT OPERATIONS

- The MHP continues to implement the Cerner Behavioral Health System (CCBH) via an Application Service Provider (ASP) contract with Kings View Behavioral Health.
- The MHP utilizes the reconciliation report developed by Kings View in conjunction with Excel reporting to reconcile with Explanation of Benefits (EOB) files.
- The MHP provides telepsychiatry services through American Tele-psychiatrists, and more recently Iris Telehealth. The MHP has increased their psychiatry staff from 2.4 FTE last year to 3.8 FTE. There is 1.40 FTE on site. There are two part time bilingual Spanish child psychiatrists, one male and one female.
- Telepsychiatry services are provided at Chowchilla and Oakhurst sites.

- The MHP completed transition to the BHIS data system for reporting Client Service Information (CSI) data in May 2016.
- Fourteen laptops and seven signature pads were purchased in November 2015.
- The MHP provides new employee training every month and established employees are also invited to attend as the need arises.
- The MHP revised EHR security settings in May 2016 to re-establish access by job role/function.
- The MHP is planning to use telemedicine equipment in the hospital so communications can occur between the hospital, clinic and family members (Innovation Project). Outpatient providers will be able to converse with inpatient providers.
- The MHP's supervisors were trained in running standard reports in February 2016.

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 electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 11— Primary EHR Systems/Applications

System/Application	Function	Vendor/ Supplier	Years Used	Operated By
Cerner Community Behavioral Health (CCBH) Client Data	Practice Management	CCBH	9	Kings View
CCBH – ATP	Assessment and Treatment Plan	CCBH	5	Kings View
CCBH – Scheduling	Appointment Scheduler	CCBH	3	Kings View
CCBH - Doctor's Homepage	Clinical and ePrescribing	CCBH	5	Kings View
CCBH-Clinician's Homepage	Clinical information & functionality	CCBH	5	Kings View

PLANS FOR INFORMATION SYSTEMS CHANGE

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

ELECTRONIC HEALTH RECORD STATUS

Table 12 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 12—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH		x		
Assessments	CCBH	x			
Document imaging/storage	CCBH	x			
Electronic signature—consumer	CCBH	x			
Laboratory results (eLab)	CCBH			x	
Level of Care/Level of Service	CCBH			x	
Outcomes	MORs, CANS	x			
Prescriptions (eRx)	CCBH	x			
Progress notes	CCBH	x			
Treatment plans	CCBH	x			
Summary Totals for EHR Functionality		7	1	2	0

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

- The MHP reconfigured their alerts in August 2016. Their substance abuse alerts and timelines were added. At the time of the review, notifications were sent to the staff that alerts were installed and automatically updating.
- The MHP has expanded client electronic signatures to additional assessments, collecting signatures on treatment plans, assessments and on financial documents.
- The staff was trained on the Call Log in Scheduler in February 2016, however, the MHP states that the Call Log is not operational as yet because they have added a field for the beneficiary's preferred provider gender and staff needs additional training.
- The MHP states that CCBH version of eLabs released in Promotion 222 in February 2016 allows manual entry of lab orders and lab results. The MHP is collaborating with Kings View and discussing implementation formally.
- The MHP does not plan to install level of service into the EHR. Kings View reports that they do not have the approval to install the form as it is copyrighted and only the score can be entered into the system.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☐ Paper ☒ Electronic ☐ Combination

MAJOR CHANGES SINCE LAST YEAR

- The MHP has completed its transition to the BHIS system for CSI in April 2016.
- During the ICD 10 transition there was influx of suspended CSI claims. Suspended service records totaled 3,700. The MHP has thus far cleared 400 errors and plans to resolve the remaining records by December 2016. The MHP states that these were an internal staff error during the transition.
- Converted from ICD-9 to ICD 10 and submitted claims and CSI files on-time.
- Completed transition to BHIS system for CSI (submitting current files through the new system.
- Receiving Monthly Penetration and Prevalence information from Kings View.
- Expanded client electronic signatures to additional Assessments.
- Collecting electronic signatures on Treatment Plans, Financials, and Assessments.
- Decreased backlog of CSI suspended services by approximately two-thirds.
- Revised EHR security settings to re-establish permissions by job role/function.

PRIORITIES FOR THE COMING YEAR

- The MHP is collaborating with Kings View to develop outcome reports based on Children's Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) data. CANS and ANSA have been operational since Fall 2015. The MHP plans to implement the outcome reports in Spring or Summer 2017.
- Revisit Action Schedules (Document Due Date tracking) and reactivate Notifications.
- Expand MCO product to capture additional authorized services.
- Clear remaining CSI suspended services.
- Develop outcomes reports based upon ANSA and CANS information (currently collecting)
- Revisit staff EHR security settings (e.g. Categories of Treatment)
- Upgrade system with new Progress Note functionality (planned for August-September 2016)
- The MHP plans to upgrade its system with CCBH new progress note functionality. This new functionality increases the current five progress note versions to an unlimited

number of versions, allows completion of multiple documents simultaneously and permits customization. The MHP plans to install and implement in November 2016 when it is released by Kings View.

OTHER SIGNIFICANT ISSUES

- No other significant issues were noted.

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:

Local Excel Worksheet or Access Database

- Method used to submit Medicare Part B claims:

☐ Clearinghouse ☒ Electronic ☐ Paper

Table 13 - Madera 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
30,879	$4,670,928	$273,333	5.85%	1,659	$4,397,595	$152,572	$4,245,023

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
    - The MHP assesses and strategizes capacity by reviewing caseloads, penetration and prevalence rates and demographic reports and have increased their psychiatric staff accordingly.
- Timeliness of Services
    - The MHP in collaboration with Kings View has installed a new pilot electronic timeliness tracking form program via a new assessment form. It is currently in testing phase and the MHP plans to implement in October 2016.
    - The MHP has not established goals or policy and procedure for No Shows. The MHP also states that the staff is not consistently entering correct information.
    - The staff was trained on the Call Log in Scheduler in February 2016, however, the MHP states that the Call Log is not operational as yet because they have added a field for the beneficiary's preferred provider gender and staff needs additional training.
- Quality of Care
    - The MHP collected beneficiary surveys for AOD, CalWorks, grants, hospital stays, outreach for education and safe talk. The MHP hired an evaluator for rating performance.
- Consumer Outcomes
    - The MHP utilizes the Health Related Quality of Life (HRQOL) with beneficiaries requiring medications to assess functioning.
        - The MHP is collaborating with Kings View to develop outcome reports based on Children's Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) data. CANS and ANSA have been operational since Fall 2015. The MHP plans to implement the outcome reports in Spring or Summer 2017.
    - The MHP conducts the POQI and analyzes the data prior to submitting to the State.

SITE REVIEW PROCESS BARRIERS

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

- The CalEQRO lead reviewer became ill on-site during the day of the review. As a result, follow up sessions for Katie A. and PIPs were conducted by phone.

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:
  - The MHP assesses capacity by reviewing caseloads, penetration and prevalence rates, and demographic reports, and has increased their psychiatric staff accordingly.
  - The MHP has developed a contract with WestCare Foundation to provide mobile crisis services with the Madera Police Department from 3 pm-12am Wednesday through Sunday.
- Opportunities:
  - Once the new pilot timeliness program is fully operational and Call Log data is available in October 2016, the MHP should begin usage and analysis of that data to assess capacity and workflow issues.

Timeliness of Services

- Strengths:
  - The MHP, in collaboration with Kings View, has installed a new pilot electronic timeliness tracking form program via a new assessment form. It is currently in its testing phase and the MHP plans to implement in October 2016.
  - Focus group members indicated that services were easy to access and that referrals were accommodated.
- Opportunities:
  - While the staff received basic training on the Call Log in Scheduler in February 2016, the Call Log is not operational because the staff needs additional training to be able to use it appropriately.

Quality of Care

- Strengths:
    - The MHP added 12 full time positions for people with lived experienced, six of which are filled, with the remainder to be hired by January 2017.
    - The MHP developed a successful partnership with Probation and the Department of Corrections in the establishment and operation of a forensic program funded through Mentally Ill Offender Crime Reduction (MIOCR) funds.
- Opportunities:
    - The MHP has the opportunity to develop a formalized method of tracking and trending client involvement in treatment planning and implementation, including the use of level of functioning tools.

Consumer Outcomes

- Strengths:
    - The MHP is collaborating with Kings View to develop outcome reports based on CANS outcome tool and ANSA outcome tool data. CANS and ANSA have been operational since Fall 2015.
- Opportunities:
    - Although the MHP plans to implement the outcome reports in Spring or Summer 2017, it would be beneficial to expedite the process to track, trend and report on outcome tools to facilitate MHP decision-making regarding consumers and MHP programs.

RECOMMENDATIONS

- As recommended in CalEQRO FY15-16 MHP report, complete the implementation of timeliness tracking program to include the following activities:
    - Produce policy and procedures to support standardize use across programs; and provide training to staff.
    - Establish reasonable baseline standards for each timeliness tracking element.
    - Collect timeliness data monthly and produce results either monthly or at minimum, every other month.
    - Report timeliness results to senior management and share results with the quality improvement committee (QIC) and program managers, at a minimum.

- Monitor timeliness performance to baseline standards.
- For timeliness performance elements outside baseline standards consider implementing a Performance Improvement Project (PIP) to investigate the reason(s) for variance from baseline standards.

- Develop two data driven PIPs, one Clinical and one Non-Clinical. PIPs should identify local needs, have a clear study question and apply 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. Utilize consumer input, including sufficient base line data and re-measurement data, which focused on consumer outcomes.
- Collaborate with Kings View on process to track, trend and report CANS outcome tool and ANSA outcomes to facilitate MHP decision-making regarding consumers and MHP programs.

ATTACHMENTS

Attachment A: Review Agenda

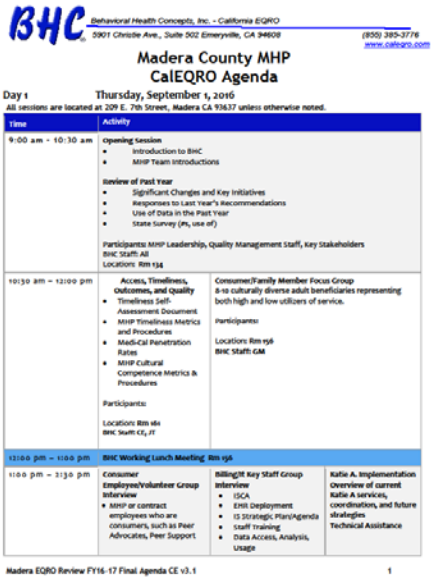
Attachment B: Review Participants

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:



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Madera County MHP
CalEQRO Agenda

Day 1 **Thursday, September 1, 2016**
All sessions are located at 209 E. 7th Street, Madera CA 93637 unless otherwise noted.

Time	Activity		
9:00 am - 10:30 am	**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 BHC Staff: All Location: Rm 134		
10:30 am – 12:00 pm	**Access, Timeliness, Outcomes, and Quality** • Timeliness Self-Assessment Document • MHP Timeliness Metrics and Procedures • Medi-Cal Penetration Rates • MHP Cultural Competence Metrics & Procedures Participants: Location: Rm 161 BHC Staff: CE, JT	**Consumer/Family Member Focus Group** 8-10 culturally diverse adult beneficiaries representing both high and low utilizers of service. Participants: Location: Rm 156 BHC Staff: GM	
12:00 pm – 1:00 pm	**BHC Working Lunch Meeting Rm 156**		
1:00 pm – 2:30 pm	**Consumer Employee/Volunteer Group Interview** • MHP or contract employees who are consumers, such as Peer Advocates, Peer Support	**Billing/IT Key Staff Group Interview** • ISCA • EHR Deployment • IS Strategic Plan/Agenda • Staff Training • Data Access, Analysis, Usage	**Katie A. Implementation Overview of current Katie A services, coordination, and future strategies** Technical Assistance

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Cyndi Eppler – Lead Quality Reviewer
Judith Toomasson – Information Systems Reviewer
Gloria Marrin – 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

209 E. 7th Street, Madera CA 93637

Participants Representing the MHP

Name	Position	Agency
Annette Presley	Division Manager	BHS
Carolina Lemus	MH Clinician	BHS
Crystal Segura	MH Clinician	BHS
Debbie Dinoto	Division Manager	BHS
Debby Estes	Assistant Director	BHS
Dennis P. Koch	Director	BHS
Eric Cardoza	Director of Research Development	Kings View IT
Grace Mahoney	MH Clinician	BHS
Janet Mesiah	Staff Services Manager	BHS
Judith Martinez	MH Clinician	BHS
Kaela Stephens	MH Clinician	BHS
Kristine Emi Takeshita-Doty	MH Clinician	BHS
Michelle Richardson	MHP Supervisor	BHS
Robert Mason	MH Clinician	BHS
Sarah Wiens	MH Clinician	BHS

Name	Position	Agency
Shanell Wingfield	MH Clinician	BHS
Sonja Bentley	Compliance/Privacy Officer	BHS
Terri Becker-Denney	MH Clinician	BHS

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

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
Madera	7,739	715	9.24%	$1,355,688	$1,896

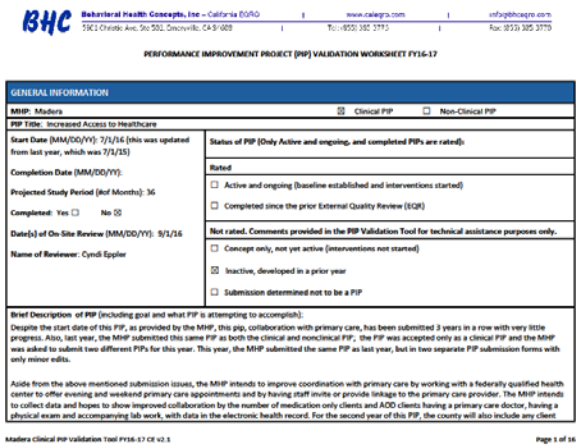
Table C2 - Madera MHP CY15 Distribution of Beneficiaries by ACB Range

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	2,310	98.51%	94.46%	$4,189,497	$1,814	$3,553	76.77%	61.20%
>$20K - $30K	21	0.90%	2.67%	$508,005	$24,191	$24,306	9.31%	11.85%
>$30K	14	0.60%	2.86%	$759,543	$54,253	$51,635	13.92%	26.96%

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: Madera ☒ Clinical PIP ☐ Non-Clinical PIP

PIP Title: Increased Access to Healthcare

Start Date (MM/DD/YY): 7/1/16 (this was updated from last year, which was 7/1/15)

Completion Date (MM/DD/YY):

Projected Study Period (#of Months): 36

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 9/1/16

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

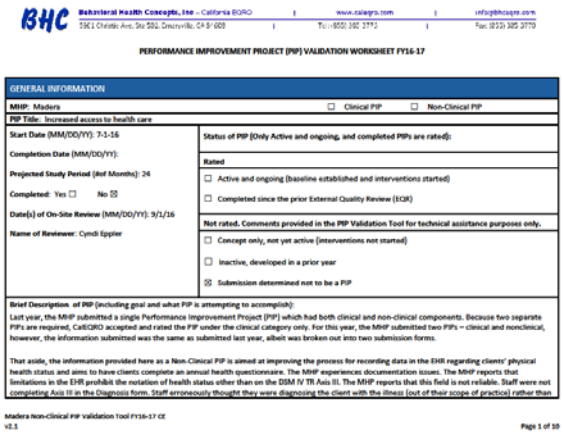
☐ Submission determined not to be a PIP

Brief Description of PIP (including goal and what PIP is attempting to accomplish):
Despite the start date of this PIP, as provided by the MHP, this pip, collaboration with primary care, has been submitted 3 years in a row with very little progress. Also, last year, the MHP submitted this same PIP as both the clinical and nonclinical PIP, the PIP was accepted only as a clinical PIP and the MHP was asked to submit two different PIPs for this year. This year, the MHP submitted the same PIP as last year, but in two separate PIP submission forms with only minor edits.

Aside from the above mentioned submission issues, the MHP intends to improve coordination with primary care by working with a federally qualified health center to offer evening and weekend primary care appointments and by having staff invite or provide linkage to the primary care provider. The MHP intends to collect data and hopes to show improved collaboration by the number of medication only clients and AOD clients having a primary care doctor, having a physical exam and accompanying lab work, with data in the electronic health record. For the second year of this PIP, the county will also include any client

Madera Clinical PIP Validation Tool FY16-17 CE v2.1 Page 1 of 16

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

GENERAL INFORMATION

MHP: Madera ☐ Clinical PIP ☐ Non-Clinical PIP

PIP Title: Increased access to health care

Start Date (MM/DD/YY): 7-1-16

Completion Date (MM/DD/YY):

Projected Study Period (#of Months): 24

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): 9/1/16

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):
Last year, the MHP submitted a single Performance Improvement Project (PIP) which had both clinical and non-clinical components. Because two separate PIPs are required, CalEQRO accepted and rated the PIP under the clinical category only. For this year, the MHP submitted two PIPs – clinical and nonclinical, however, the information submitted was the same as submitted last year, albeit was broken out into two submission forms.

That aside, the information provided here as a Non-Clinical PIP is aimed at improving the process for recording data in the EHR regarding clients' physical health status and aims to have clients complete an annual health questionnaire. The MHP experiences documentation issues. The MHP reports that limitations in the EHR prohibit the notation of health status other than on the DSM IV TR Axis III. The MHP reports that this field is not reliable. Staff were not completing Axis III in the Diagnosis form. Staff erroneously thought they were diagnosing the client with the illness (out of their scope of practice) rather than

Madera Non-clinical PIP Validation Tool FY16-17 CE v2.1 Page 1 of 10