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FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SOLANO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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Beneficiaries Served in Calendar Year 2016 — 5,039

MHP Threshold Language — Spanish

MHP Size — Medium

MHP Region — Bay Area

MHP Location — Fairfield

MHP County Seat — Fairfield

Introduction

Solano County is the easternmost county of the North Bay area of the San Francisco Bay area, with a portion of the county extending into the Sacramento Valley. It is a medium-sized county spanning a total area of 906 square miles with a total population of 413,344 residents. There are three metropolitan areas with outpatient clinics; Fairfield (the county seat), Vallejo and Vacaville.

Solano County is the fifth most racially diverse county in the United States. Solano County has the largest percentage Filipino population of any county in the United States. Spanish is the only threshold language in Solano County.

The MHP is comprised of a group of engaged professionals dedicated to quality improvement. They strive to meet the Medi-Cal mental health needs for this diverse community.

During the fiscal year 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The number of beneficiaries served in Solano County increased from 3,742 in CY15 to 5,039 in CY16.

Continuing issues with access to follow-up services post discharge from Exodus, the crisis stabilization unit (CSU), were not resolved through the efforts of the clinical PIP.. The MHP continues to work closely with its CSU vendor, though is mindful that alternate contractual considerations may need to be made.

Open Access systems are now in place in both Fairfield and Vallejo outpatient clinics. The two clinics have received positive feedback from consumers. There are plans to implement this same system at least two days a week in the Vacaville outpatient clinic. The MHP created a focused adult unit for high end services requiring more intense monitoring and service delivery.

However, lack of availability of clinicians competent in the consumers' cultures and preferred languages was a commonly reported issue. The MHP has made progress and continues to work toward solving this issue.

When beneficiaries are discharged from inpatient care, there is often difficulty finding a suitable placement for those not ready to go directly home. While the new residential facility in Vallejo that is scheduled to open the first half of this year will help, much more in the way of placement is needed to meet requirements for consumers.

Adequate psychiatrist capacity continues to be an issue the MHP endeavors to resolve. Child psychiatrists are stretched in the number of appointments available. The MHP has expanded telepsychiatry in the three cities in the county with telepsychiatry equipment (Fairfield, Vallejo, and Vacaville) to begin to address the issue. This is in both the adult and children's clinics. Ongoing recruitment continues.

Timeliness

Timely access to child psychiatrists was frequently reported to be an issue. Long wait times to initial appointments, with time between appointments sometimes being a difficulty for the consumer. The MHP does not report timeliness to first psychiatrist appointment for children, thus missing the opportunity to track any timeliness issues and possible resolutions.

The MHP tracks timeliness to first psychiatric appointment for adults receiving MHP direct services. The MHP does not comprehensively track no-show rates for psychiatrists and non-psychiatric clinicians in both MHP directly-operated sites and community based organization (CBO) sites. This does not give a full picture of timeliness to services.

Quality

The MHP has experienced numerous staff changes in the past year, including mental health director, key administrators, managers, supervisors and clinicians.

The absence of Mobile Crisis Services is a gap in the continuum of care in Solano County. The cost effectiveness of mobile crisis service in prevention of hospitalizations, the opportunity for de-escalation of an acute situation, and overall response to consumers' needs with an appropriate level of care (LOC) at the right time, are all lost without mobile crisis response.

Outcomes

The MHP continues to focus on the need to create more step-down residential choices for consumers who no longer meet medical necessity for higher levels of care.

While the MHP continues to utilize both the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA), and is positioned for the California mandate, as outcome tools, they find shortcomings in these tools for use in aggregate systems analysis of outcomes of programs. The MHP has created a new set of Reason for Discharge selections that they believe will give them better information about beneficiary flow through the System of Care (SOC) and their status at the time they leave care or transition to a new level of care.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care 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 State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan.

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 FY17-18 findings of an EQR of the Solano MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS. The eight PMs 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 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);

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[1] *Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.*

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- 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; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO 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 a review of the MHP's reporting systems and methodologies for calculating PMs.

Validation of State and County Consumer Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

[3] 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.

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY16-17

Recommendation #1: To significantly expand data-driven clinical QI initiatives, the MHP needs to address the issue of additional data analytical capacity through any (or a combination) of the following options:

- Engaging with human resources staff to actively recruit and hire qualified information systems (IS) staff and data analysts;
- Hiring entry-level staff persons and providing classroom and onsite training, and direct supervision to develop in-house data analytical expertise; and/or
- Investigating the feasibility of contracting data analytical services to a contractor or vendor with significant experience analyzing healthcare data, preferably with behavioral healthcare data, and prior experience with Avatar.

Status: Met

- The MHP has made progress in this area, particularly where they had decision-making authority.

- While the MHP worked to resolve the issue of analytical capacity, there have been difficult barriers to overcome. All allotted positions are filled, and funding was restored for an FY17-18 contracted position (previously removed). The preponderance of barriers remains as a result of lack of Information Technology (IT) capacity. The MHP continues to request an increase in the allotment for IT staff and data analysts.

- The MHP's IT is fully staffed and providing training to grow in-house expertise. At one point four of the eight IT positions that support Health and Social Services were vacant. A reclassification of IT positions that led to more competitive salaries was likely a factor in the successful recruitment effort.

- The MHP is replacing Enlighten Analytics (EA) with the KPI Dashboard, both of which are from Netsmart. The KPI Dashboard is a more user-friendly business intelligence tool that, once set up, puts considerable analytic resources in the hands of MHP leadership. EA was unable to incorporate user-defined fields in the Avatar database into its analysis routines; these user-defined fields are often essential to reporting on local and State priorities.

- Onsite staff training is ongoing to enhance analytic capacity. The MHP has been training clinical program supervisors and managers to run routine reports inAvatar so that they can analyze the data themselves so they are less dependent upon IT resources for reports they use regularly.

- Program leaders in the Utilization Management Committee are using reports to analyze program capacity and utilization. Program leaders received targeted training on how to run Avatar reports and the use of pivot tables to drill down to more detailed information.

Recommendation #2: Leveraging the new five-year contract with UC Davis to implement the MH Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM), the MHP needs to explore its penetration and retention rates to:

- Determine if unintended factors are causing consumers to exit services prematurely; and
- Identify and correct geographic service biases through:
    - Improved engagement and outreach;
    - Expanded telepsychiatry;
    - Expanded community mobile and field-based services; and
    - Improved strategies to recruit Spanish and Tagalog-speaking clinical staff.
- Assure utilization of language-appropriate translation services throughout the SOC, and particularly in the CSU.

Status: Met

- UC Davis completed their surveys. Phase 2 of the study begins February 2018 and will include training, followed by creation of quality improvement programs for Spanish-speaking, Tagalog-speaking, and/or LGBTQ beneficiaries.

- To explore beneficiary penetration rates and engagement, the MHP researched data that provided information as to the reasons for discharge of clients to determine how many might have withdrawn or been prematurely discharged from services. They found that categories for discharge were somewhat confusing and involved overlaps and room for interpretation.

- The MHP established a new set of discharge codes that will be released in FY17-18. The new codes will allow for analysis of ethnicity and reasons for discharge. This will provide valuable information such as "Goals Met – stepping down level of care" or "Goals Partially Met." This allows for the individualized determination of whether treatment goals were achieved, which is a highly relevant outcome that also drives successful termination or transition to a lower level program. MyAvatar Report 326 allows aggregate data to be assessed for ethnicity and reason for discharge, which will add further clarity on the issue of premature discharge.

- The MHP noted that over 80 percent of the adult client population receives only psychiatric care (medication support), and the most stable of these are seen every three months. Therefore, many adult clients are seen four times each year by design. The MHP is working on a method to separate this aspect from analysis in order to more accurately identify clients who for other reasons are only receiving four services a year.

- The MHP expanded telepsychiatry in the three cities in the county with telepsychiatry equipment (Fairfield, Vallejo, and Vacaville). This includes both adult and children's clinics. While the MHP expressed a preference for in-person psychiatric providers, they agree that technology makes it possible to avoid gaps in service in this area.

- The MHP is increasing their field service delivery next year, including Full Service Partnership (FSP) which is primarily field based. MyAvatar Report 101PM allows for analysis by location of service delivery to capture field-based services information.

- The MHP was scheduled to release a RFP for a five-year mobile crisis services contract early this year. That effort was placed on hold over concerns about funding of the contract in years four and five. The city of Fairfield (county seat) and Fairfield Police have expressed an interest in collaborating with this program.

- The MHP continues to explore strategies to ensure language appropriate service delivery. A vacant position was moved (to cover a position cut at the county level) to address the need for a bilingual Tagalog-speaking clinician in Vallejo. After a several-year vacancy, the MHP hired a Tagalog-speaking mental health (MH) clinician who will work in Vallejo, primarily in children's programs but also in adult programs when the

language is needed. While most of the Filipino population speaks English, some beneficiaries show up for services who speak only or have a language preference of Tagalog.

- While the MHP has recruited for Spanish-speaking providers, they also concentrated on moving eligible staff into programs and locations that have more need. One example was moving a bilingual children's clinician to the Children's Assessment Team. This will allow for Spanish-speaking back-up coverage of the Access line when this person is cross-trained. The current Medical Director is bilingual in Spanish and provides services in the adult clinics in both Vacaville and Fairfield.

- The MHP implemented culturally and linguistically appropriate national standards (CLAS) to ensure disparities are addressed in service delivery.

Recommendation #3: The MHP needs to prioritize aggregate level analyses of the large LOC database and use results to drive clinical practice throughout the SOC.

Status: Met

- The MHP has not fully analyzed the CANS and ANSA data available in Avatar. They are proceeding under the State guidelines for CANS and ANSA now that there is a State mandate.

- These tools create linkages between the assessment process and individualized service plans, however the MHP's research into these tools suggests that there are significant limitations in their use as aggregate outcome measures for systems.

- An alternative and likely more informative strategy was chosen by the MHP through revision of discharge codes to serve as outcome indicators (see Recommendation #2, fifth and sixth bullets). This will provide essential information such as "Goals Met-stepping down level of care" or "Goals Partially Met." This allows for the individualized determination of whether treatment goals were achieved, which is a highly relevant outcome that also drives successful termination or transition to a lower level program.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- The MHP made noteworthy progress in addressing linguistic and cultural needs of their client population through hiring clinicians with needed language skills, and moving staff within the organization who have those skills to locations where they were most needed.
- Fairfield has had Open Access for adults in their outpatient clinic since June 2016, and is showing a 20 percent higher rate of engagement. Consumers do not have to schedule appointments or orientation, but are seen the same day they walk-in. Vallejo began piloting Open Access in October 2017. There are plans to initiate this system two days a week in Vacaville later this year.
- Improvements to reporting, as the result of filling vacant IT positions, make it possible for MHP employees to review reports to find treatment vacancies and examine flow of clients through the system (e.g., clients inactive, but not yet closed.)
- The MHP improved the two-way referral process between MH and County Primary Care. The Medical Director provided an in-service to primary care providers (PCP) and the MHP is initiating Memorandums of Understanding (MOUs) with the three Federally Qualified Health Centers (FQHCs) in the county.
- The MHP contracted with Progress House, Inc. for residential treatment of beneficiaries with co-occurring diagnoses of mental health and substance abuse.
- The MHP is negotiating a contract with a new augmented Board and Care for more Institutions for Mental Disease (IMD) step-down options.
- An additional residential facility is soon to open in Vallejo.
- All three sites with adult and child outpatient clinics have telepsychiatry equipment and Masters (MA/MS) degree or Registered Nurse (RN) staff trained to support the process.
- The Fairfield Wellness Center (Circle of Friends) expanded to Vacaville two days per week.

Timeliness of Services

- The centralized assessment team for children's programs continues to provide timely access to services. There was a decrease in performance during the summer of 2017 due to multiple staff vacancies. The MHP has sustained efforts from the prior year PIP to address this issue.
- Through a recruitment process driven by the Medical Director, all existing psychiatry positions have been filled using a mix of employees, contractors, and locums. The Medical Director continues to pursue filling positions with County employees. A retention bonus included in the most recent contract for psychiatrists is expected to improve provider continuity.
- Three Nurse Practitioners were hired and the MHP continues recruitment and interviews for more.
- The MHP has established the Open Access system for the adult clinics in Fairfield and Vallejo. Fairfield began Open Access in June 2016, demonstrating an increase of approximately 20 percent in engagement rates. Vallejo began Open Access in October 2017 and shows progress in timeliness and engagement as a result. Consumers can walk-in until 3:30 pm, and most are seen the same day or the following day. The adult clinic borrows Tagalog- or Spanish-speaking clinicians from the children's program as needed. Consumers report that they appreciate this approach as services can be accessed when needed. The MHP is exploring the opportunity to provide at least some days of Open Access at the Vacaville clinic.
- Children's assessments are now centralized, with two clinicians assigned to facilitate the initial assessment and referral to services, resulting in meeting or exceeding timeliness standards.

Quality of Care

- The Children's Bureau supervisors review therapy cases lasting greater than one year for appropriateness of care and possible discharge or stepdown to a Beacon provider.
- A MHP clinician is being reassigned to work half-time as the Ethnic Services Coordinator, overseeing the Cultural Competence Committee and related activities.
- Caseloads and beneficiary flow are reviewed in the monthly Utilization Management Committee (UMC) meeting; also reviewed are timeliness of assessments, inpatient utilization, re-admissions, and subacute step-downs.
- The MHP created a training curriculum to teach staff to identify youth at risk for Commercially Sexually Exploited Children (CSEC). The MHP provided a train-the-trainer session to 29 individuals to become adept at providing the CSEC 101 training and then

to teach use of the CSE-IT screening tool. Staff were trained from mental health, child welfare, probation, education, and county mental health assessors.

- New fields were added to the EHR system to collect sexual orientation, gender assigned at birth and current gender identity. Additionally, the MHP worked to create a self-reporting tool that will be used to collect the LGBTQ status for all active clients. In September 2017, Solano County partnered with Solano Pride to provide training on how to dialogue with consumers about their sexual orientation and gender identity for all levels of staff from both County and Contractor programs.

- In February 2018, three cohorts of 20-30 staff will be trained by UC Davis on the Culturally Linguistically Appropriate Services (CLAS) standards and will develop action plans to address unserved/underserved communities (Latino, Filipino, and LGBTQ). This is a continuation of the five-year contracted project that the MHP has with UC Davis.

- The Clinical Quality Review subcommittee, under the direction of the Medical Director, meets quarterly to review serious incidents, clinical outcomes, patient satisfaction, and clinic workflows that impact quality.

- Hospital liaisons are now also responsible for the discharge planning for hospitalized children; previously they dealt only with adult inpatients. The team developed relationships with Child Welfare Services (CWS), and multiple youth have been seamlessly transitioned from CWS into the mental health system upon exiting CWS.

- Hospital liaisons now conduct intake assessments during consumer hospitalization (adult and child) to reduce barriers upon discharge, and to facilitate consumers seeing a psychiatrist sooner upon return to the community.

- The Institutional Care Services (ICS) team shifted its approach and began taking the lead in placing clients at community-based housing prior to linking them with a case manager. This improved the transition process for clients moving toward greater independence, allowing for a longer warm-handoff between ICS and the receiving community-based program.

Consumer Outcomes

- IMD step-downs have been highly successful, with 92 percent remaining in a lower level of care. Of those stepped-down, 56 percent have been supported through a community based program, and 44 percent are at an Achievable Benchmarks of Care (ABC) level of care. Only two consumers were hospitalized more than once after being discharged from a sub-acute facility.

- The MHP certified hospital emergency department social work staff to initiate and release Letterman-Petris-Short (LPS) 5150 holds. This resulted in less reliance on law

enforcement and county clinical staff to initiate and/or release holds, and reduced transfers to the CSU. Subsequently, overstays in the CSU have decreased.

- The MHP developed an Adult Specialty Unit under one manager to promote collaboration in the care of consumers as they transition from CSU/Inpatient/ICS/FSP levels of care. This structure improved coordination and resulted in faster placements from inpatient psychiatric units into ABC/IMDs.
- Hospital Liaisons are engaging beneficiaries while they are hospitalized to promote outpatient engagement post hospitalization.

PERFORMANCE MEASUREMENT

As noted above, 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 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 LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1: Solano MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	28,389	22.4%	1,650	32.7%
Latino/Hispanic	30,813	24.3%	668	13.3%
African-American	25,520	20.1%	1,208	24.0%
Asian/Pacific Islander	24,263	19.1%	470	9.3%
Native American	727	0.6%	53	1.1%
Other	17,185	13.5%	990	19.6%
Total	**126,895**	**100%**	**5,039**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

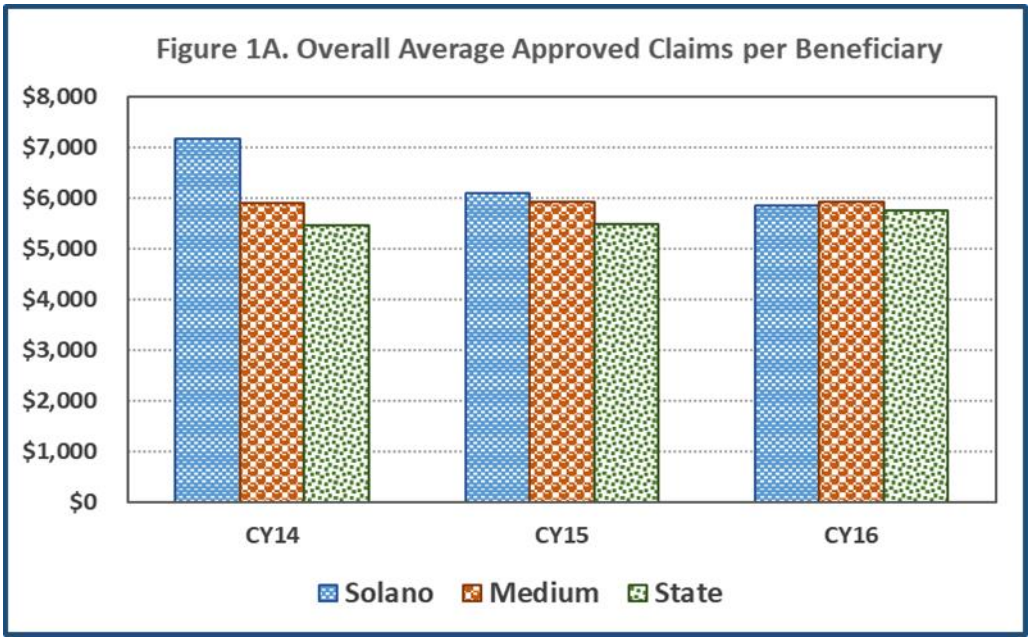
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

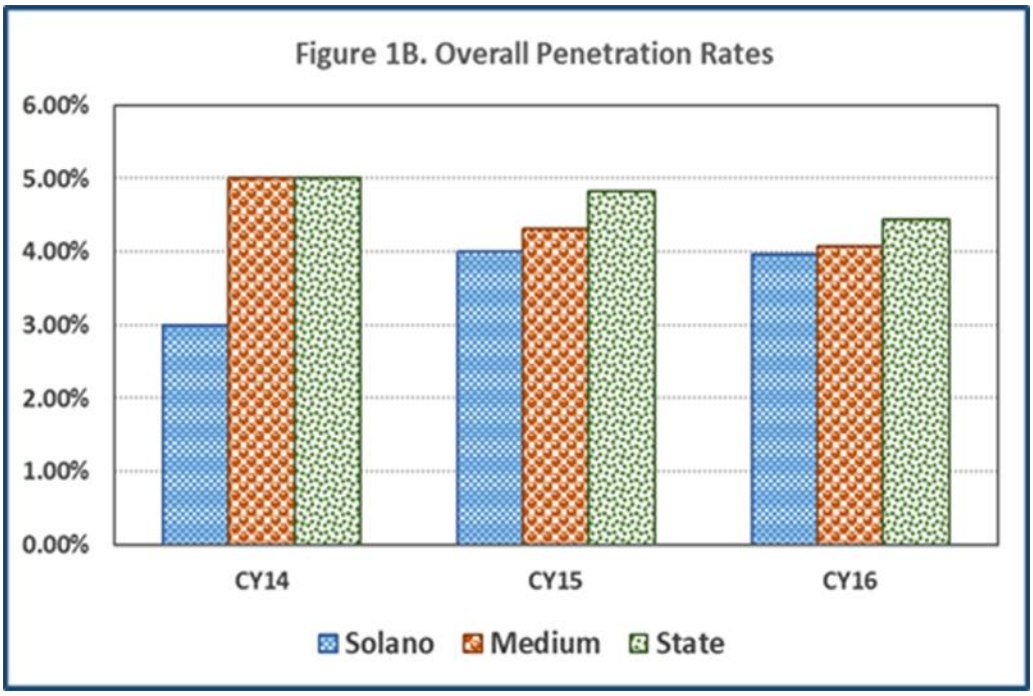
Penetration Rates and Approved Claim Dollars per Beneficiary

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.

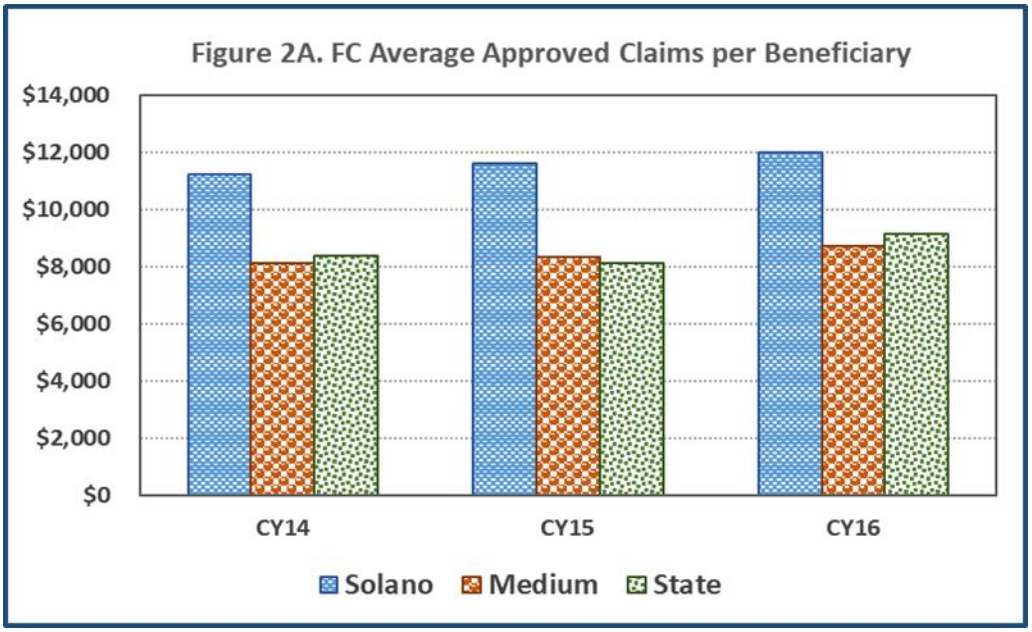
Regarding calculation of penetration rates, the Solano MHP uses a different method than that used by CalEQRO.

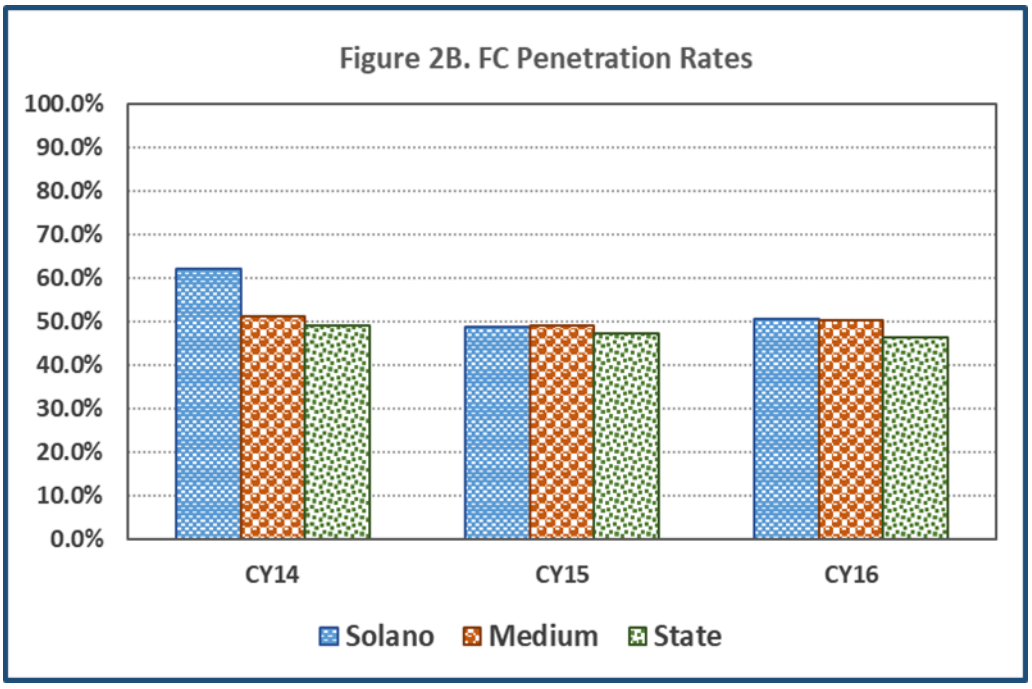
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for medium MHPs.



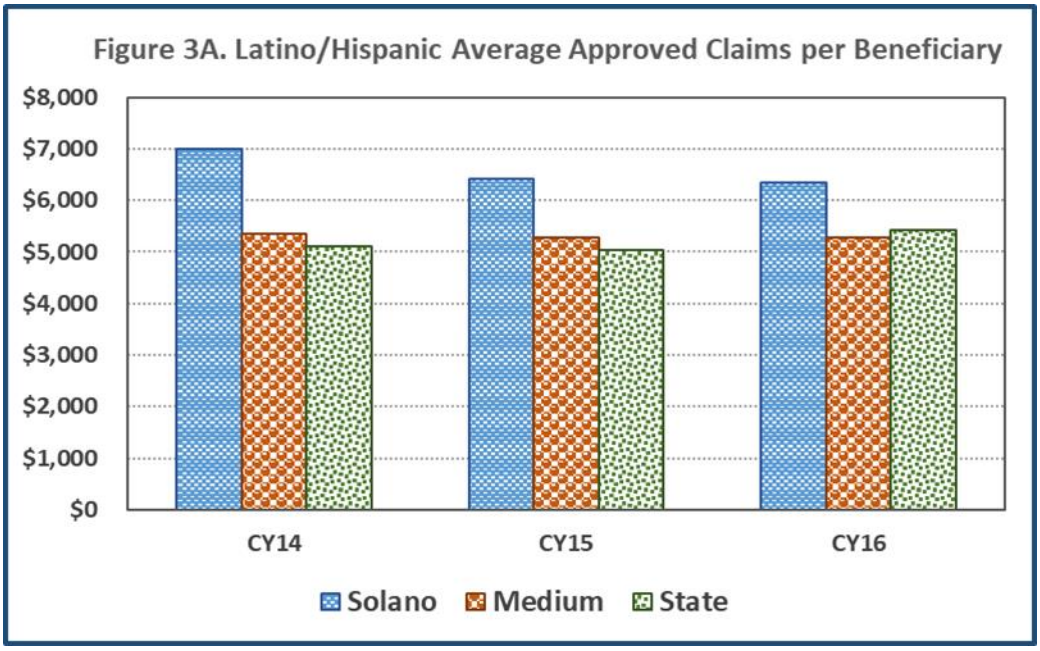


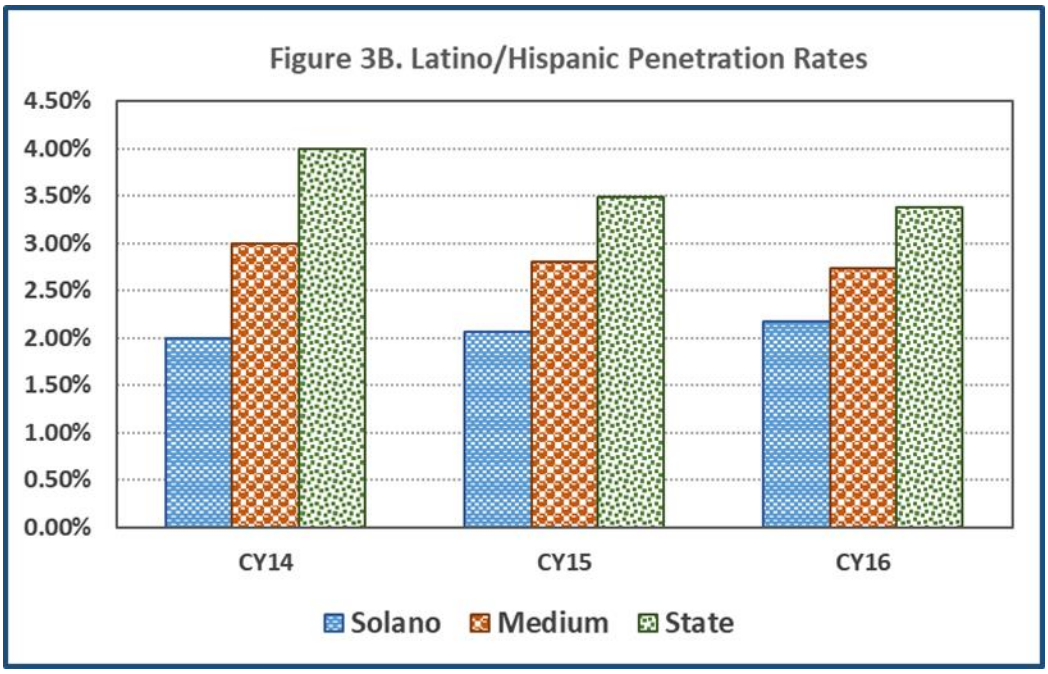
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for medium MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for medium MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

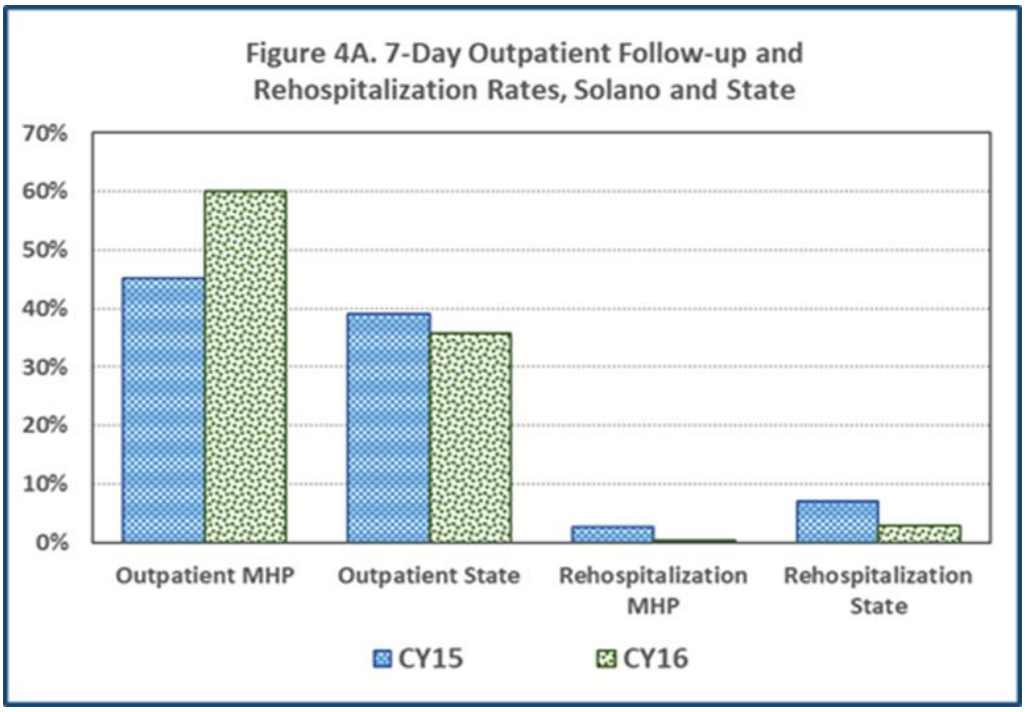
Table 2: Solano MHP High-Cost Beneficiaries

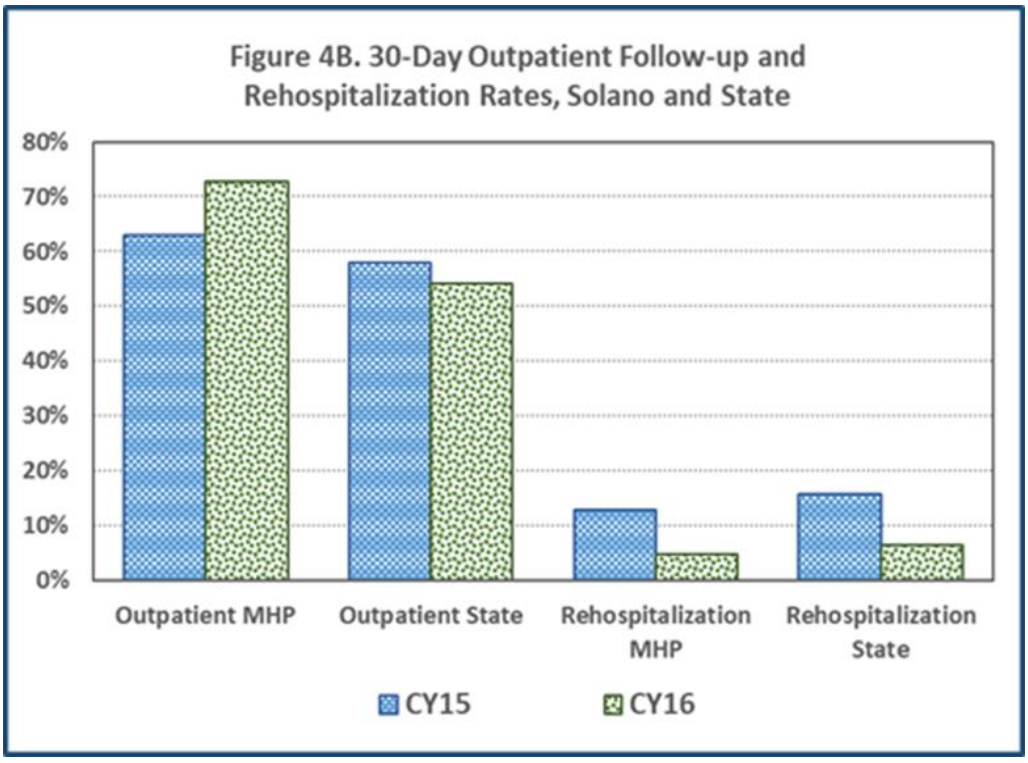
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Solano	CY16	181	5,039	3.59%	$46,713	$8,455,005	28.71%
	CY15	151	3,742	4.04%	$50,812	$7,672,552	33.67%
	CY14	144	2,992	4.81%	$47,126	$6,786,211	33.74%

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 CY15 and CY16.

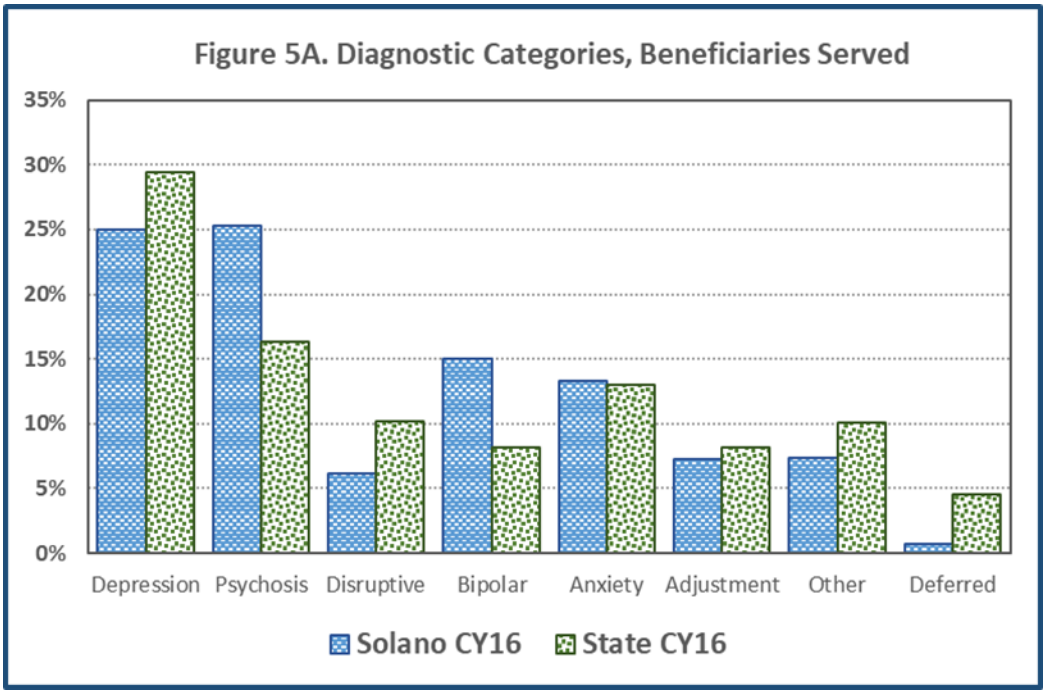


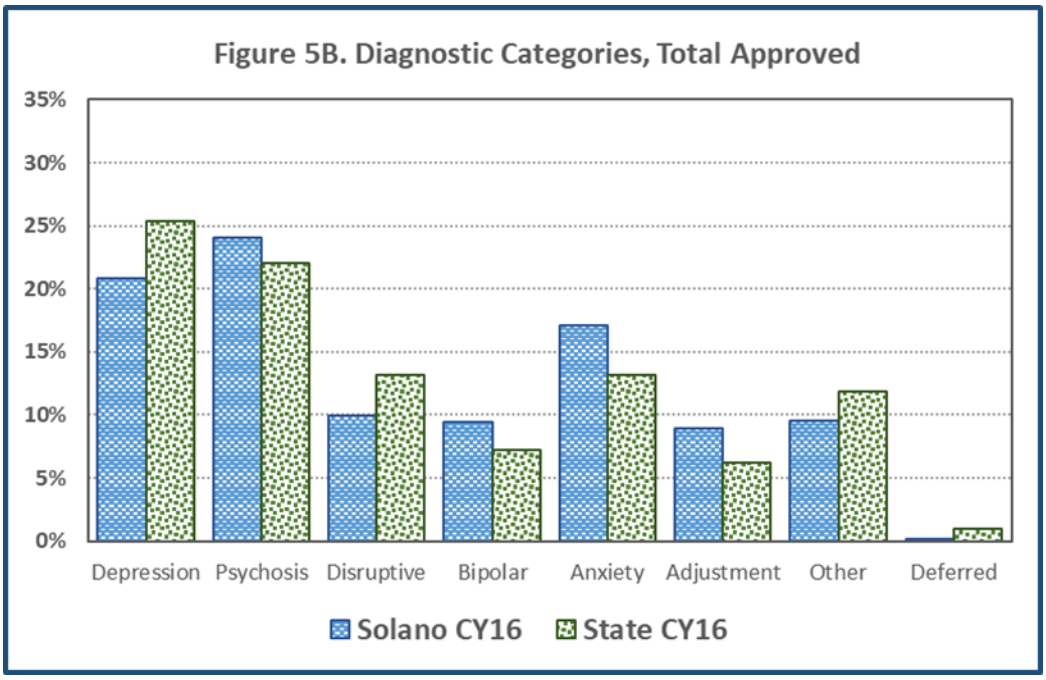


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP total number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 24.2 percent.





Performance Measures Findings—Impact and Implications

Access to Care

- Analysis of penetration rates in the Solano MHP is complicated by the "Kaiser Carve-Out;" a group of Solano County Medi-Cal eligibles who receive their primary care and mild-to-moderate mental health services from Kaiser Permanente. However, services for Kaiser Medi-Cal enrollees declared seriously mentally ill are provided by the Solano MHP, so the Kaiser Carve-Out cohort are still among the potential beneficiaries of MHP service delivery and, for this report, still included in the denominator for penetration rate calculations.
- Overall, using MHP claims data only, penetration rates remain slightly below the average for medium counties and statewide results; Approved Claims per Beneficiary (ACB) are in the same range as averages for medium counties and Statewide.
- The Hispanic/Latino penetration rate lags medium county and statewide averages; while the ACB for Hispanic/Latino beneficiaries is significantly higher.
- High Cost Beneficiaries (HCB), as a percentage of beneficiaries, are just slightly above the State average while the Approved Claims per Beneficiary are just slightly below the State average.

Timeliness of Services

- Both 7-day and 30-day outpatient follow-up rates after discharge from psychiatric inpatient care increased from comparable rates in CY15 and are greater than comparable CY16 statewide averages.

Quality of Care

- Overall average approved claims per beneficiary remained stable from CY15 to CY16 and is comparable to both medium counties and statewide averages in CY16.
- Foster Care approved claims per beneficiary increased each year from CY14 to CY16 and was approximately 25 percent greater during CY16 than medium counties and statewide averages.
- Latino/Hispanic approved claims per beneficiary remained stable from CY15 to CY16 and was approximately 15 percent greater during CY16 than medium county and statewide averages.

Consumer Outcomes

- Rehospitalization rates following inpatient treatment remain below the statewide averages.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (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.

Solano 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 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Solano MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Engagement After CSU Visit
Non-clinical PIP	1	Adult Timeliness Project

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review

				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	PM
		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	PM	NM
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	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	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	M
		6.6	Qualified data collection personnel	M	PM
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	PM	PM
		8.2	PIP results and findings presented clearly and accurately	M	M
		8.3	Threats to comparability, internal and external validity	PM	PM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	UTD	M
		9.3	Improvement in performance linked to the PIP	UTD	M
		9.4	Statistical evidence of true improvement	PM	M
		9.5	Sustained improvement demonstrated through repeated measures	NM	M

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	14	16
Number Partially Met	8	8
Number Not Met	1	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Rating ((#Met*2) +(#Partially Met))/(AP*2)	**72%**	**80%**

Clinical PIP—Engagement After CSU Visit

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

"Can we work with the CSU to create more consistent referrals and pathways for engagement in outpatient services after a CSU service? Can this also reduce the number of clients with frequent CSU admissions?"

Date PIP began: January 2017

Status of PIP: Completed

The PIP topic was selected as an extension of successful strategies in the previous clinical PIP focused on timely follow-up from inpatient discharge. The goal of the PIP is to assure timely follow-up post CSU discharge to prevent unnecessary re-admissions to either the CSU or a hospital. The hypothesis of the PIP is that consistent referrals from CSU at discharge will facilitate engagement in outpatient services as well as reduce the number of clients with frequent CSU admissions. This PIP is considered complete since engagement of the CSU in the PIP has been less than successful in resolving the problem it was designed to address. The contract with the CSU vendor is ending within a few months and further efforts are judged by the MHP to be best saved for the new vendor.

The PIP had difficulty in bringing on participation by CSU discharge staff to work on the PIP, even with repeated requests.

A surprising finding was that the Bay Area Community Services (BACS) aftercare program was not represented in the data of post discharge referrals generated through the PIP. There is a possibility that they are seeing post-acute clients, but are not the first service after discharge. This needs further inquiry for clarification.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of discussion during the review of wording of original study questions to include clear clinical outcomes for consumers. There is a need for the study question to be measurable and quantifiable. Study questions need to focus on client improvements/outcomes. The second study question is closer to a PIP study question. One suggestion was to rephrase the question to "Will consistent referrals and pathways for engagement following CSU reduce the number of clients with frequent CSU admissions?" EQRO reminded the MHP that there needs to be two PIPs (one clinical and one non-clinical) active each year. TA was offered and suggested to be scheduled as the MHP creates and implements the next PIP. The MHP was encouraged to consult with EQRO early and often during PIP formulations.

Non-clinical PIP—Adult Timeliness Project

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

"How can we provide more timely service delivery to adults? Will implementing open access improve timely service delivery and a higher rate of engagement?"

Date PIP began: July 2016

Status of PIP: Completed

The goal of the PIP is to increase timeliness for adult services. Solano County has a history of sporadic performance with timeliness to service delivery for adults. Timely service delivery is a value that the Solano MHP's entire adult service system of care has determined is an important characteristic of quality service delivery. The clinic staff is committed to providing clinical service that is both timely and clinically meaningful. The challenge is that the children's system of care is more richly resourced, in which each children's clinic has roughly the same number of clinical staff as all three adult clinics combined.

Timely adult intake has been complicated by referral to an orientation prior to intake assessment. This orientation was implemented a few years ago primarily to reduce the impact of no-shows for assessment. No-shows negatively impact the efficiency of the work operation in that a clinician's schedule is held for at least two hours for the intake appointment. By scheduling a group orientation once or twice a week, no clinical staff time would be negatively impacted a client no-show. The hypothesis was also that clients who are unlikely to show up for intake would instead no-show to the orientation appointment. The data shows that if a client does come to the orientation appointment, there is an 85 percent chance that they also will come to the assessment appointment. Thus, the clients who are scheduled for an intake appointment tend to keep the appointment. However, the MHP had not determined whether the orientation served as a barrier to service – either because the two-step process is overly burdensome, or because if the client understands that the orientation is not a clinical service, perhaps they choose not to follow through.

Over 30 percent of clients referred to orientation do not attend orientation. This PIP is designed to address timeliness and engagement of adult consumers to services and resolve the orientation issue at the same time.

The PIP was successful in increasing timeliness in different percentages at distinct locations and for different services. It also pointed out issues to resolve such as whether to include orientation versus open appointments. More analyzation of the charts and tables presented in the narrative would be useful in understanding the outcomes they represent.

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 discussion of the study question to include the need for measurable consumer outcomes. The first sentence of the study question is not measurable. The second is more measurable, however there is no discussion of engagement as an issue in why this is a question. There is also no operationalization of the term "timely service delivery" in order that it could be measured. This begs the question what are the rates now and how much does the MHP hope to improve them through this PIP?

The differences in the outcomes of different outpatient clinics during the study was discussed. EQRO recommended that the MHP follow-up on the unexpected results in different clinics that were encountered. It was noted that consumer input would have made the PIP stronger in validity.

EQRO reminded the MHP that there needs to be two PIPs (one clinical and one non-clinical) active each year. TA was offered and suggested to be scheduled as the MHP creates and implements the next PIP. The MHP was encouraged to consult with EQRO early and often during PIP formulations.

PIP Findings—Impact and Implications

Access to Care

- The clinical PIP is designed to increase access to follow-up services post discharge from CSU. Due to lack of CSU response to the PIP, this was not completely successful.
- Open access as an alternative to an orientation session was designed in the non-clinical PIP to improve access to consumers when they desire it. Although the orientation session was part of a PIP a few years ago, with the intention of lowering no-shows and freeing up more capacity of staff, this is being reviewed by the MHP as possibly creating unforeseen delays in access and engagement.

Timeliness of Services

- The non-clinical PIP attempts to increase timeliness to first clinical outpatient appointment. The study interventions sought to remedy barriers by eliminating the orientation requirement and implementing walk-in (open access) services. The data

showed that this was partially successful with more work to be done around analyzing the data.

- Providers are often unaware of the fact that their clients were admitted to CSU, therefore timeliness to post discharge follow up appointments is poor. The clinical PIP attempts to remedy this issue. Wait times improved 18 percent to 73 percent across the various measures. Wait time for assessments decreased across all clinics, with the average meeting the MHP's ten-day goal. The MHP believes this change will improve with a new vendor for CSU and increase in collaboration with the CSU.

Quality of Care

- The clinical PIP goal is to affect quality improvement of services through ensuring engagement in follow-up post discharge from CSU. The prediction is that if the consumer receives adequate post discharge referrals and services, there would less frequent re-admissions to CSU and/or hospitals.

- The non-clinical PIP increases quality by reducing the amount of staff time lost due to no-shows by making open appointments an option for the client.

Consumer Outcomes

- The clinical PIP's plan for coordination of referrals post discharge from CSU offers the opportunity for care support to consumers to maintain stability gained during a CSU stay. This is an area where at this time the MHP is not successful.

- Both PIPs need study questions that have clearer consumer benefits as outcomes. In the case of the clinical PIP, there needs to be a clearly stated, quantifiable clinical outcome for the consumer.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 6 lists the components that CalEQRO considers 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 6: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M
In February 2018, three cohorts of 20-30 individuals will be trained by UC Davis on the Culturally Linguistically Appropriate Services (CLAS) standards and will develop action plans to address unserved/underserved communities (Latino, Filipino, and LGBTQ). This is the next step in the MHP initiated MHSA Innovations contract with UC Davis. The MHP continues to recruit for culturally competent, bilingual clinicians and staff. Collaboration with Solano Pride resulted in service provision for the LGBTQ community which was not previously available.		
1B	Manages and adapts its capacity to meet consumer service needs	PM
While the MHP has extremely limited access to increasing staff due to both fiscal restrictions and recruitment difficulty, they have designed a system to move staff who have the skills to another program that is short-staffed and experiencing capacity issues. This strategy of utilizing staff to meet the needs of capacity have been successful insofar as they can be without more staff available to meet capacity needs. Access to lower levels of care, particularly residential care, after release from inpatient care, appears to be a continuing challenge in the Solano MHP. There were repeated reports during EQRO onsite sessions about difficulty getting timely access to child psychiatry.		
1C	Integration and/or collaboration with community-based services to improve access	M

Evidence was made available to EQRO to support integration and collaboration with community based services. The Faith-Based Initiative is an example of establishing relationships with non-clinical community resources to facilitate access to care. There are regular meetings with CBO representation looking at utilization of resources and beneficiary progress towards wellness. CBOs play a significant role in all step-down strategies for consumers, whether from inpatient or outpatient care in the MHP. Work continues in the collaboration with Public Health (PH) on the development of the Health Information Exchange (HIE).

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components

Component		Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	M
The MHP utilizes a 10-day standard. Adult services are reported as averaging 8.26 days (73 percent meeting standard) and children/youth services averaged 9.52days (68 percent meeting standard). This does not include the small set of children's services clients who self-refer to a contract provider and do not get screened by Access. First appointment is defined as an assessment with a clinician. The MHP also tracks timeliness to the first post-assessment service (clinician or psychiatrist) A PIP addressing timeliness of adult access to services was completed this year.		
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PM
The MHP utilizes a 30-day standard for adult services. An average of 25.97 days (81 percent meeting standard) was reported. The MHP does not track time from initial request to first psychiatry appointment for children's services. This creates a barrier to assessing access to services as well as misses an opportunity to evaluate outcomes for this population (see narrative comments in Timeliness section). This was discussed in last year's EQRO onsite review.		
2C	Tracks and trends access data for timely appointments for urgent conditions	M
The MHP utilizes a 3-day standard. Adult services are reported as averaging 5.38 days (49 percent meeting standard) and children/youth services averaged 4.2 days (60 percent meeting standard).		

The MHP tracks urgent request to offered appointment and to actual encounter. The new crisis residential program, originally scheduled for 2017, will open in Vallejo this year.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
The MHP utilizes a 7-day standard for both adults and children. They report averaging six days (44 percent meting standard). This data includes all indigent and Medi-Cal admissions, as well as all Medicare admissions for which the MHP receives information. Follow-up services tracked includes any outpatient services delivered. The MHP reports a total of 566 hospital admissions (not separated by adults and children/youth) and 247 follow-up appointments within the 7-day standard (approximately 44 percent).		
2E	Tracks and trends data on rehospitalizations	M
The MHP reports no standard for rehospitalization rates. There is an overall rehospitalization rate of 12.9 percent within 30 days, 12.4 percent for adults and 15.8 percent for children/youth. There were 566 admissions and 73 re-admissions within 30 days. This data includes all indigent and Medi-Cal admissions, as well as all Medicare admissions for which the MHP receives information. These rates are higher than last year's 8.8 percent overall, with 9.7 percent for adults and 8.6 percent for children.		
2F	Tracks and trends no-shows	PM
The MHP reports that tracking no-shows is a new report and not yet fully implemented across the system. The standard for psychiatric no-shows is 19 percent for adults (with average of 12-28 percent depending on program) and 10 percent for children (average of nine percent). No other data is currently available. The MHP has a robust reminder call system in place and transportation is available as needed.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	M
The MHP has a QI work plan for FY17-18 and documented meeting minutes. A work plan evaluation was completed for FY16-17. Supervisors report that they participate in QIC and quality improvement activities as well as have access to and use of data and reports produced by the IT department on an ongoing and daily basis. The MHP submitted two PIPs for evaluation that are now considered complete. Two new PIPs will be developed within the next few months. Consumers and family members participate in the QIC and are active on the California Family Advisory Council, Suicide Prevention Committee, and Mental Health Advisory Board (MHAB). (Consumer and Family Members {CFMs} comprise 50 percent of MHAB). QI focused data analyst staff continue to be insufficient to engage in system-wide clinical data analyses, and much of this work is performed by upper mid-level managers and the executive team. While competency of these staff is improving, it is not a substitute for data analytically oriented staff.		
3B	Data are used to inform management and guide decisions	M
The MHP uses data widely and effectively to inform decision making. There are management dashboards that make key indicators available in an easily consumed format as well as a wide variety of reports available to managers, supervisors, and line staff to assist with their work. Reports are also routinely provided to CBOs. Supervisors reported that they have weekly care transition meetings to assess quality of service delivery and whether a LOC change is warranted.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM
The MHP Director sends out monthly all staff emails to ensure staff is informed of current MHP projects and changes. The MHP has instituted town hall all staff meetings. These do not include contractors. In interviews with diverse levels of staff and areas of service, it was noted that communication and transparency diminish as you move away from the executive administration staff. The Consumer Family Advisory Committee, reinitiated last year, attends various program and committee meetings with the purpose of promoting service accountability and giving a voice to the CFM perspective. Parents and foster parents are informed through therapists and/or psychiatrists regarding changes, and some report accessing the county website. Consumers reported that they receive information at the outpatient clinics, in group sessions (DBT), and from their therapists and psychiatrists.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
3D	Evidence of a systematic clinical continuum of care	PM
A continuum of care exists within the Solano MHP, but is not without gaps and capacity issues. The clearest gap is the lack of Mobile Crisis Services. Child psychiatrist capacity appears to be a choke-point in services for children, particularly with respect to access to appropriate step-down services post-hospitalization. Issues with the CSU and lack of post-discharge engagement with services continues to be an issue. The MHP is contracting with a new augmented Board and Care for more IMD step-down options. An additional adult residential facility is opening in Vallejo early this year.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
The MHP has three peer positions established within Behavioral Health. Most peers are employed and/or volunteer through contract provider agencies. A Consumer Affairs Liaison reports to Executive Management and oversees peer run activities. There is little evidence of an existing career ladder within contract provider agencies or within the MHP. On February 15, 2018, the MHP (and its contract agencies) in partnership with the California Association of Mental Health Peer Run Organizations (CAMHPRO) will be hosting The Solano Regional Peer Support Forum. Over 150 peers are currently registered to attend. With a focus upon peer support services, several panels will address such topics as: the origins of peer providers, evidence-based support for the use of peers, advocacy for the establishment of peer certification, and action planning.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
The MHP has three wellness centers operated through contract providers: Circle of Friends in Fairfield and Vacaville, and Caminar in Vallejo. All centers are peer-run and operated. While Fairfield and Vallejo centers are well-established and open five-six days per week, the Vacaville center is smaller, currently serving clients two days per week. All centers offer curriculum and support services consistent with wellness and recovery principles, including such activities as Wellness and Recovery Action Planning (WRAP) support groups, leadership training, life skills, exercise classes, and social events.		
3G	Measures clinical and/or functional outcomes of consumers served	M
Wellness and Recovery is one of the goals incorporated within the FY17-18 Quality Assessment and Performance Work Plan. WRAP is utilized throughout the system. DBT, an evidence-based practice with outcomes, is provided to consumers CANS and ANSA are utilized to measure individual consumer outcomes across the SOC.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
The newly developed Reasons for Discharge system allows the MHP to track ethnicity and completion of goals at the time of discharge or when a step-down in services occurs.		
3H	Utilizes information from Consumer Satisfaction Surveys	PM
The MHP administers the semi-annual consumer survey required by DHCS. They engaged in a detailed analysis of the results returned by the state. Although staff and contractors are responsible for conducting and collecting the surveys from consumers, the results are not shared as an overview of the system way in a systematic fashion. Staff and contractors would like to be informed as to how results are used, and if they are used to affect system changes.		

Key Components Findings—Impact and Implications

Access to Care

- The Open Access initiative at the Fairfield and Vallejo clinics is a promising approach to improving access to services and engagement with treatment.
- Providing services in a beneficiary's preferred language remains a challenge. The MHP reports difficulty identifying and attracting qualified candidates with the needed language and cultural competency despite competitive salaries.
- The MHP reports doing the best job they can with limited available resources, and moving current resources closer to beneficiaries to address linguistic and cultural needs. While they have not been able to meet demand due to capacity, they have succeeded in closing the gap between need and capacity.
- The MHP has assigned hospital liaisons to facilitate appropriate transitions in care, but they can succeed only when there is appropriate level of treatment available.
- While the MHP made progress by filling all available items, stakeholders report that the MHP may not have enough child psychiatry availability.
- The MHP continues to work with community organizations and resources to improve access to care. They have established several recent programs such as the CSU, and have mentored organizations including Solano Pride in order to provide services to the LGBTQ community.

Timeliness of Services

- The MHP tracks most timeliness indicators, but does not track time for children and youth beneficiaries from first contact to first psychiatric appointment. The MHP reports that this is because children are not routinely prescribed medication early in their care. A better measure in that circumstance would be from identification of need to first psychiatric appointment, but that measure is not yet in place.

- The MHP only tracks no-show rates for MHP psychiatrists serving adults. This needs to be expanded to non-psychiatric clinicians and to services delivered by CBOs in order to reflect an accurate account of no-shows throughout the system, and reveal opportunities for increasing capacity.

Quality of Care

- The MHP prioritized communication to stakeholders and feedback in meetings, indicating an improvement over the past year. In an organization of the size and complexity of this MHP, there are always opportunities to improve communication, so this will continue to be a work in progress. Stakeholders appreciate what has been accomplished, but those furthest away from MHP management reported that messages did not always reach them.

- Field-based crisis services are the first opportunity to de-escalate a tense situation, possibly avoid hospitalization or arrest, and productively engage someone who may need mental health services to avoid future crises. Having no mobile crisis response is a barrier to this opportunity. The MHP was preparing an RFP for Mobile Crisis services in collaboration with law enforcement, with an anticipated launch in early 2018. However, this has been placed on hold due to fiscal concerns.

- Lack of affordable housing, though not a mental health service issue, exacerbates the problems of the homeless and can lead to mental health crises.

- Consumer run programs do exist within the MHP and there are consumer employees in Solano County positions, although a very small number, and within the CBOs. The Solano MHP is working on finding a way to establish paid peer positions within the County.

Consumer Outcomes

- The MHP uses CANS and ANSA to measure beneficiary outcomes, but they recognize some limitations in their utility to measure broad program effectiveness.

- The MHP developed a revised set of reasons for discharges which will be put into production in the near future. The revised set of reasons for discharge include if the client completed treatment goals, vacated treatment or was stepped down or up in level of care. They anticipate that this data will provide more useful information about beneficiary movement within and out of mental health 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 two focus groups 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 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 8-10 parent/caregivers of child/youth beneficiaries including both high and low utilizers of MHP services, who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group was comprised of a combination of foster parents and parents. The participants were all female and included five disparate ethnicities. The focus group was held on January 31, 2018 at 675 Texas St., 6th Floor, Room 6003, Fairfield, CA, 94533.

Number of participants: 6

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

- Information on services available came from a variety of sources, including a foster care agency, hospital, and CWS.
- Initial wait times were approximately a month or more to receive an initial assessment.
- After the initial assessment, time to first therapy appointment averaged a month or more, with a notable exception of a child being hospitalized and receiving an almost immediate appointment post discharge.
- Services received were satisfactory and participants reported being included in treatment planning for their child.
- Wait times and distance to services were reported as barriers to access.

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

- All participants see a therapist on a regular basis, with varying frequency of twice weekly, weekly and every other week as needed. Therapists often serve as case managers for their clients.
- Some participants were offered and participated in group or family therapy.
- Nearly all the participants' children were seeing a psychiatrist. Several participants voiced concern over the frequent change in psychiatrists and the treatment issues of starting with someone new.
- Conversely, when the consumer wishes to change therapists or psychiatrists, all report there is no difficulty in the process to achieve that.
- All participants endorsed knowing how to contact the appropriate person/program for an urgent situation. Some had a contact number and some had text numbers for the therapists involved.
- Information about what is happening in the MHP, including services available, are received from therapists, psychiatrists, parent partners and the County website.
- All participants report they are asked to fill out service satisfaction surveys every six months. Many are involved in classes that ask for feedback on services on a routine basis.

Recommendations for improving care included the following:

- Parents/caregivers do not have legal support. Children in foster care can accuse the foster parent, and the adults need legal support when this happens.
- The benefits gained from the six-week support group for parents/caretakers were significant. An ongoing monthly group would be beneficial. Specifically, a support group around dealing with an out of control child would be very helpful.
- Availability of rehab for adolescents is needed (it was unclear if this was for mental health and/or substance use issues).

Interpreter used for focus group 1: Yes Language: Spanish

Consumer/Family Member Focus Group 2

CalEQRO requested a culturally diverse group of 8 – 10 adult beneficiaries including both high and low utilizers of MHP services who are mostly new clients who have initiated/utilized services within the past 12 months. The focus group was comprised of adult and older adult consumers, both male and female of three disparate ethnicities. The focus group was held on January 31, 2018 at 1119 East Monte Vista Avenue, Vacaville, CA, 95688.

Number of participants: 5

There were no participants who entered services within the past year.

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

- All participants see a therapist, some receive therapy services through managed care and some county outpatient services. Frequency of visits vary according to need from weekly to monthly.
- All participants see a psychiatrist either through the MHP, a contractor or through managed care. Generally, appointments are every six to eight weeks, depending on the need.
- Case management is available for consumers, and they reported it was useful in resolving placement, claims and billing, and transportation issues.
- All participants endorsed knowing how to contact the appropriate person/program for an urgent situation. They were also knowledgeable on Exodus (CSU) procedures for crisis stabilization.
- Information about what is going on in the MHP is mostly obtained through the DBT group facilitator and/or the individual therapists. None of the participants were familiar with the County website.
- All participants report they are asked to fill out a service satisfaction survey every few months, reporting on how they liked their doctors and the treatment process.
- No one in the group could remember being asked to participate in any committees within the MHP.
- All participants agreed that their cultural and linguistic needs are being met. The cultural/linguistic composition in the focus group agreed that they felt represented in the staffing of the MHP.
- The participants unanimously reported that they felt the services they receive improve their recovery and that the staff create a wellness and recovery environment that encourages independence of the consumers.

Recommendations for improving care included the following:

- Consumers would like more and varied groups, especially after the DBT group ends.
- Several participants would like the option to participate in the DBT group for more than the two cycles presently allowed.
- WRAP needs to be expanded and have more instructors.

Interpreter used for focus group 2: No

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Access to initial assessments and clinical services was less timely than the parent/caretaker focus group interviewed thought was sufficient.
- The adult consumer group found access to be timely and appreciated the Open Access system in two of the outpatient clinics (Fairfield and Vallejo).
- Transportation is noted as an issue for access to services. This is ameliorated by paratransit services, drivers for certain services in Fairfield and drivers in other areas for services as available. More is needed to ensure ability to access services.

Timeliness of Services

- Adult consumers reported that timeliness to psychiatric services have improved since the new psychiatrist team has been on board. They report that timeliness to see non-psychiatric clinicians has improved, however there is still a shortage that makes scheduling somewhat difficult.
- Parents/caregivers of child/youth beneficiaries who began treatment in the last 12 months reported that initial assessment took approximately one month (unless emergency or post discharge from hospital) and first therapy appointment one month after that.

Quality of Care

- Consumer group participants reported that frequent changes in clinicians, to include psychiatrists, was disruptive to services. These changes are most likely due to capacity issues of insufficient staff for the number of beneficiaries requesting services.
- Most consumers report that they receive culturally and linguistically competent services. There were no consumers in the focus groups that reported this as a problem or a barrier to services.
- Adult focus group participants spoke highly of the psychiatrists they see, and note that consumers are included in discussions of medication and treatment.
- Adult and children's crisis services continue to be mixed in experiences reported. Issues with referral post discharge from the CSU continue to be problematic.

Consumer Outcomes

- Consumers agreed that the services they received facilitated their wellness and recovery, and that they are involved in their treatment planning and changes.
- Wellness center information is made available to consumers from psychiatrists, therapists, group facilitators and at intake. Consumers report the wellness center is useful and many participate on a frequent basis.
- Consumers report that support groups are enjoyable and helpful to their recovery, however they report that there is a need for more of them and more variety in the topics.

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	43%
Contract providers	56%
Network providers	1%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): 3%

The budget determination process for information system operations is:

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

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 5

Identify primary reason(s) for using telepsychiatry as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☐ To serve outlying areas within the county
- ☐ To serve consumers temporarily residing outside the county
- ☐ Reduce travel time for healthcare professional staff
- ☐ Reduce travel time for consumers

- Telepsychiatry services are available with English and Spanish-speaking practitioners (not including the use of interpreters or language line).
- Approximately 1,950 telepsychiatry sessions were conducted in English and Spanish.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
3	1	0	0

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
0.5	0	0.5	0

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

- MHP has more resources involved in data analytics than the 0.5 FTEs shown in Table 11, including trained managers and supervisors.

Current Operations

- The MHP completed a reclassification of IT positions and salaries, and they are now more appropriate and competitive.
- The MHP moved to Netsmart hosting services for its myAvatar; implemented August 2017. This has taken some of the workload pressure off the small IT resource pool at the MHP.
- Both myAvatar system performance and reliability were consistently reported to be satisfactory across a range of users.
- A current project is cleaning up Client Service Information (CSI) reporting and catching up with reporting that is behind schedule. The need for this project appears to be at least partly resource-related.
- A current project is implementing MHSA data into myAvatar. This is a project that might have been anticipated years ago and it too raises the question of resource constraints in IT.
- The MHP added automation to the service authorization process within myAvatar. This was previously a paper/fax protocol.

Table 12 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 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Avatar	Practice Management, Clinical Workstation, Managed Services	Netsmart	4	Netsmart
Order Connect	Prescriptions, Labs	Netsmart	4	Netsmart
Data Warehouse	Offline access to current and legacy data	County IS	6	MHP

Priorities for the Coming Year

- Implement Scanning/Document Imaging
- Implement Data Analytics/KPI Dashboards
- Enhance Avatar Data Warehouse (improved connectivity to data sources)
- Clean up CSI Data
- Implement MHSA Data Collection in Avatar
- Health Information Exchange

Major Changes Since Prior Year

- Migrated to vendor hosted system
- Implemented eLab Orders and Results – all sites
- Implemented ePrescribing of Controlled Substances
- IS Staff certified in Avatar forms modeling; IS Staff certified in Avatar reporting/widgets

Other Significant Issues

- Data analysis resources remains an area of need. The MHP currently has one dedicated report writer, but no dedicated data analysts. The MHP is using data effectively to support decision making, and what they have done is quite useful, but they are constrained by resource limitations. With additional resources, they could get more actionable information from the data they have. Trained (busy) managers are no substitute for data analysis professionals.
- Three FTEs perhaps is adequate to reliably maintain current operations, especially with a vendor-hosted system, but that is scarcely adequate resources for go-forward initiatives in an organization the size and complexity of Solano County, using a system as complex as myAvatar. HIEs, integration with CBO systems, care coordination, and implementing the Personal Health Record will all require a depth of resources beyond current levels.
- The MHP is not using the Accredited Standards Committee X12 (ASC X12) 270/271 eligibility transaction, apparently because of a problem with their instance of myAvatar. Other counties using myAvatar are using the transaction successfully.
- The Personal Health Record (PHR) is not among the MHP's planned initiatives. The PHR is rapidly becoming a baseline expectation of any health services provider organization and eventually this will need to be addressed.

- Referrals are managed using paper/fax. This limits data available for analysis on this critical first step in accessing MHP services.
- Among the clinical record documents still held in paper format, the MHP listed "Outcomes." That may be adequate for assessing the progress of an individual beneficiary, but it is not helpful or adequate to determine the impact of the MHP on community well-being.
- Data integration with CBOs is not part of current myAvatar plans. This places a continuing drain on CBO resources, who are already challenged, that does not contribute to improved service delivery and outcomes.
- The Clean Up CSI Data project is not a project that moves the organization forward, however it needs to be done. It will only bring the organization into compliance with long established data reporting rules.

Plans for Information Systems Change

- The MHP has a new system in place, with no plans to change the system.
- Despite resource constraints, the MHP is working with Solano County Public Health, a primary care provider, to implement a local Health Information Exchange using Mirth Connect software. This is a promising initiative that, once established, could provide a platform for electronic data exchange with contract providers. This would streamline the workflow for CBOs and potentially ease the user support burden on MHP IT resources.
- The implementation of document scanning and electronic document storage in myAvatar using Perceptive software is an important step towards having a complete on-line health record for MHP beneficiaries. Currently hospital release documents and crisis assessments are maintained as paper documents. Having these incorporated into the on-line record will give clinicians simpler and perhaps quicker access to complete beneficiary clinical information.
- Electronic data integration with CBOs is not an immediate priority in an MHP where not all CBOs are doing batch file uploads of service/claim data to myAvatar.

Current Electronic Health Record Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				X	
Assessments	myAvatar	X			
Care Coordination				X	
Document imaging/storage				X	
Electronic signature—consumer	myAvatar	X			
Laboratory results (eLab)	myAvatar	X			
Level of Care/Level of Service	myAvatar	X			
Outcomes	myAvatar	X			
Prescriptions (eRx)	myAvatar	X			
Progress notes	myAvatar	X			
Referral Management				X	
Treatment plans	myAvatar	X			
Summary Totals for EHR Functionality:		**8**		**4**	

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

- No significant enhancements to EHR functionality were noted since prior CalEQRO review.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☐ Within the next year
☐ Within the next two years	☒ Longer than 2 years

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimension Reports

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Solano MHP Summary of CY16 Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
93,958	$29,886,833	5,214	$1,419,442	4.75%	$28,467,391	$1,698,642	$26,768,749

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017
The statewide average denial rate for CY2016 was 4.48 percent.
Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Solano MHP Summary of CY16 Top Three Reasons for Claim Denial

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	1,642	$555,279	39%
Other coverage must be billed prior to submission of this claim	890	$292,712	21%
Service Facility Location provider NPI not eligible	1,572	$250,679	18%
Total Denied Claims	5,214	$1,419,442	100%

- Regarding claim denials due to the Service Facility Location provider not being eligible for a National Provider Identifier (NPI), these claims are generally re-billable within the State claim resubmission guidelines.

Information Systems Review Findings—Implications

Quality of Care

- The MHP reported a denied claims rate of seven percent for network providers. In a discussion of this topic it was learned that the majority of NPs had a denied claims rate around three percent, but there were a few outliers that had issues with other health coverage that drove the overall rate higher.

- A comment from one of the EQRO sessions: "I can't imagine how a manager could function without these reports. It is helpful to show staff the data and it does often lead to changes."

- The MHP is launching the KPI Dashboard business intelligence tool shortly after the EQRO review. Managers and others interested in data previously needed to manipulate raw data sets. Currently there are many more canned reports that are useful, and the KPI Dashboard will deliver focused information to user's desktops that allows them to drill down to details without writing code. The MHP is already a data-driven organization and they continue to make progress in this area (within the limits of their resources).

Consumer Outcomes

- The implementation of controlled substances prescribing, and lab orders and results provides more complete and timely clinical information in myAvatar to support clinical decision making.

- The pending implementation of document scanning and storage using myAvatar with Perceptive software will make for a more complete clinical record in myAvatar, as documents previously only available in hardcopy will be incorporated into the record.

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 or conditions that significantly affected CalEQRO's ability to prepare for and/or conduct this review.

CONCLUSIONS

During the FY17-18 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 made progress toward improved staffing, and tools for data analysis and reporting. Data is routinely and appropriately used to guide decision making.
- Recent staffing adjustments that placed staff with needed language skills where they were most needed was a crucial first step towards addressing linguistic and cultural disparities.
- The MHP is working to develop compliance with the Presumptive Transfer rule to ensure appropriate services are delivered to their out-of-county transfers. Staff are trained to understand AB 1299 procedures and waivers.

Opportunities:

- Clinical staff for the Adult System of Care is enriched by moving some of the Children's System of Care providers into that system, however more recruitment of clinicians for adult services is needed.
- While progress has been made with staffing and tools for data analysis and reporting, and IT generally, the current level was described in one onsite session as "getting by." That assessment was confirmed in other sessions. The MHP can get more out of its systems and data with a more robust level of data analytical and information technology staffing.
- Mobile Crisis Services is a significant gap in the continuum of care in the Solano MHP. Mobile Crisis Services have proven a cost-effective means to reduce hospital emergency department overcrowding and keep people whose primary problem is mental illness out of the jails. It is a way to engage people in treatment before hospitalization or incarceration.

- The Crisis Stabilization Unit is sometimes used as a place to discharge people coming out of inpatient care for lack of another more suitable placement. The volume of mental health cases going to the local hospital emergency departments is reported to be growing, and reported also is that the people are coming in more acutely ill. This is a problem that is not going away and the MHP needs to establish adequate placement resources for people coming out of the hospital, but not ready to go home.

- Low contract rates paid to the CBOs are a constraint on the system's capacity and beneficiary's access to care. The CBOs have high staff turnover; this means CBO leadership is always involved in recruitment and training. Organizations do not get the same level of productivity and expertise from newly graduated/trained employees that they get from experienced professionals. Vacancies mean a reduction in capacity to deliver services; as do inexperienced employees. The MHP is very much a two-tiered system with the CBOs in the disadvantaged position. And just as the low CBO contract rates affect access to care, they impact both timeliness and quality of services. When impacting access, timeliness, and quality, it inevitably negatively affects consumer outcomes. It may be that higher CBO rates were in place, it would lead to improved access, timeliness, quality, and outcomes, as well as result in reduced costs elsewhere in the system of care.

Timeliness of Services

Strengths:

- The Open Access initiative in Fairfield and Vallejo has proven to be an important advancement in expediting access to services.

- The centralized assessment team for children's programs continues to provide an increase in timely access to services.

Opportunities:

- Post-acute programs are implemented through CBOs in the Solano MHP. There is an MHP assigned Hospital Liaison at selected hospitals to help facilitate beneficiary engagement in outpatient treatment post hospitalization. Meeting the standard of seven days or less to first outpatient appointment is difficult when a high percentage of the population is homeless and has no phone. This results in difficulty locating them in order to engage them in outpatient follow-up treatment. When they can be located, the Hospital Liaison will take homeless beneficiaries to outpatient appointments. The homeless problem is growing and the County is short of shelters. Affordable housing is a chronic and urgent need.

- Timely appointments with a child psychiatrist was a repeated issue mentioned during the review. With all psychiatry items currently filled, this would suggest that there may

not be enough child psychiatrist capacity in the MHP. This warrants consideration and investigation.

- The standard for psychiatric no-shows is 19 percent, which is high for a service of this importance and expense.
- A common issue with timeliness was the availability of clinicians with specific language or cultural skills. The MHP made progress in this area and continues to make it a focus of recruitment. However, it may be necessary to consider innovative approaches to draw in the number of people needed by the MHP.
- The MHP does not currently have comprehensive information about no-show rates for psychiatrists and non-psychiatric clinicians that includes both MHP directly-operated sites and CBO sites.

Quality of Care

Strengths:

- The MHP uses data routinely to assess the care delivered, and adjusts when the data suggests a need.
- The MHP created Reports 359 and 360 to assist program leaders in monitoring the overall LOC provided to clients.
- Program supervisors and managers are trained to run routine reports in Avatar, use pivot tables for more detailed level information and export to Excel for further analyses. This allows supervisors and managers to know the data better and supports the need for IT resources.
- Supervisors have a weekly care transition meeting. They assess quality of services delivered and whether a LOC change is warranted.
- Modeled after the Adult Transitions in Care (TIC) process implemented two years ago to manage the care of adults with high end service needs, a Youth TIC was implemented in Spring 2017. The MHP has improved collaboration across systems to ensure that children and youth are receiving the appropriate level of care.
- The MHP worked with the County geographic information system (GIS) mapping team to create GIS maps showing service array through Solano's MHP, including demonstrating compliance with new Network Adequacy Standards.
- Two PIPs were submitted as complete during the onsite EQRO review.
- The MHP instituted town hall all staff meetings to facilitate bi-directional communication between management and staff.

Opportunities:

- Vendor hosting of myAvatar saves substantial time for the small MHP IT staff. If hiring additional FTEs continues to be a challenge, the MHP might consider asking for additional services from Netsmart or other vendors.
- While the use of supervisors and managers to run routine Avatar reports is useful, it takes time away from clinical work that is essential to quality of service delivery.
- Steps to reduce the turnover rate in CBOs could have a significant impact on the quality of care given.
- Town hall meetings do not include contractors.
- In interviews of diverse levels of staff and areas of service, it was noted that communication and transparency diminish as you move away from the executive administration staff.
- The lack of mobile crisis as a first line of response/LOC is a barrier in the consumer receiving emergency services that might de-escalate a situation thereby preventing hospitalization or arrest.
- The MHP currently has no active PIPs (clinical and non-clinical). TA is available from EQRO.

Consumer Outcomes

Strengths:

- The MHP devoted $1.4million in MHSA funding to housing for the homeless, and they are using other funding for housing to prevent people remaining in the FSP level of care longer than necessary or appropriate.
- The new set of Discharge Reasons soon to be launched may provide improved information about how beneficiaries flow through the system of care and their status as they leave care or transition to a new level of care.

Opportunities:

- Develop reporting based on the new Discharge Reasons to begin to determine if they are as informative as intended regarding beneficiary flow through the system and their status as they leave care or transition to a new level of care.

Recommendations

- The MHP is not using the Accredited Standards Committee X12 270/271 eligibility transactions, apparently because of a problem with their instance of myAvatar. This is a

baseline requirement for any modern EHR system. Develop and implement a plan to correct this issue.

- To resolve issues of access and timeliness to psychiatry services:
    - Complete the work started to gather psychiatrist and non-psychiatrist outpatient appointment no-show rates for children and adults across the entire service delivery network.
    - Reconsider the 19 percent no-show standard for adult psychiatric appointments as being an ineffective baseline standard. Implement an effective standard for best practice.
    - Evaluate whether the MHP needs additional child psychiatrists to meet the needs of MHP beneficiaries in a timely manner.
    - Implement a mechanism in the MHP's information system to accurately measure timeliness for child psychiatry. If wait times do not meet appropriate clinical standards, implement adjustments to reduce wait times.
- Evaluate the effect of current CBO service contract rates, and the associated high staff turnover, on access, timeliness, quality, and outcomes.
- QI focused data analyst staff continue to be insufficient to engage in system-wide clinical data analyses, much of this work is performed by upper mid-level managers and the executive team. While competency of these staff is improving, it is not a substitute for data analytically oriented staff. Data analysis and IT staffing characterized by staff as "getting by" will be inadequate to support MHP priorities and goals, and to effectively support the electronic health record 24/7 environment.
    - Develop a plan to grow data analysis capability.
    - Explore the possibility of further increasing IT staffing.
- Develop and implement a pilot Mobile Crisis team to capture data and identify lessons-learned to assess both diversion and collaboration effectiveness with law enforcement, hospital emergency room services, and CSU placements.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions - Solano MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Groups
Contract Provider Group Interview – Administration and Operations
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Wellness Center Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.

Attachment B—Review Participants

CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT, Lead Quality Reviewer
Lenore Tate, PhD, Cultural Competency Quality Reviewer
Robert Greenless, PhD, Information Systems Reviewer
Deb Strong, Consumer/Family Member Consultant

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

DHCS Observer

Alice Connors, DHCS, MHSD-PPQA
(Katie A. session only)

Sites of MHP Review

MHP Sites

Solano County Health and Social Services Department
Behavioral Health Division
675 West Texas Street
Fairfield, CA 94533

Vacaville ICC Outpatient Clinic
1119 East Monte Vista Avenue
Vacaville, CA 95688

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Abrams	Michael	Clinical Director	Child Haven
Banks	Karen	Circle of Friends	Solano County Mental Health
Barnes	Penny	Office Assistant II	Solano County Mental Health
Bird-Marinucci	Meredith	Clinical Supervisor	Solano County Mental Health
Blair	Berry	Peer Counselor	Caminar, Inc.
Campbell	Kristie	Social Services Manager	Solano County Child Welfare Services
Coleman	Denise	Peer/Family Staff	Caminar, Inc.
Cook	Melanie	Outpatient Manager	Solano County Mental Health
Cowan	Emery	BH Administrator	Solano County Behavioral Health
Davis	Amanda	QI Clinical Supervisor (QI)	Solano County Mental Health
Davis	Kimberly	MH Specialist II (Fairfield Adult)	Solano County Behavioral Health
De Guia Samuels	Roanne	MH Clinician (Licensed)	Solano County Mental Health
De La Cruz-Salas	Leticia	BH Administrator	Solano County Behavioral Health
Delmendo	Nina	Staff Analyst	HSS Admin
Droke	Jenelle	Clinical Director	Sierra Schools
Durrah	Eugene	MH Clinician (Children's Assessment Team)	Solano County Mental Health
Epstein	Robert	Clinical Supervisor	Solano County Mental Health
Esters	Cheryl	Deputy Compliance Manager	HSS Admin

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Ferrell	Shiloh	MH Clinician (Institutional Care Services)	Solano County Mental Health
Ford	Freddy	Clinical Supervisor	Solano County Mental Health
Ford	Rachel	Consumer Affairs Liaison	Solano County Mental Health
French	Alison		Beacon
George	Rob	QI Sr. Manager (QI)	Solano County Mental Health
Greco-Gregory	Judeth	Clinical Supervisor (QI Audits)	Solano County Mental Health
Guevara	Maggie	Prevocational Circle of Friends	Solano County Mental Health
Halpin	Danielle	Clinical Supervisor (Foster Care)	Solano County Mental Health
Harris	Janine	Sr. Staff Analyst	HSS Admin
Huerta	Nazlin	Sr. Health Services Manager	Solano County Public Health
Johnson	Jane	Executive Director	Child Haven
Kellum	Katherine	Manager (Youth Specialty Care)	Solano County Mental Health
Kisliuk	Margaret	Behavioral Health Administrator	Partnership HealthPlan of California
Kitzes	Michael	Sr. Manager (Adult & Youth Outpatient)	Solano County Mental Health
Kughn	Chris	Caminar Executive Director – Solano Region	Caminar, Inc.
Kutz	Jody	Family Member Representative	
Lacey	Tracy	Sr. Manager (MHSA)	Solano County Mental Health
Leon Sammartino	Mara	MH Clinician (HOLA Outreach)	Solano County Mental Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Looy	Susan	Business Systems Analyst	Department of Technology
Mall	Anushua	MH Clinician (Vallejo Youth)	Solano County Mental Health
McDonald	Gail	Campus Administrator Crestwood Solano	Crestwood Behavioral Health, Inc.
Miller	Lindsey	Assistant Director	Seneca Family of Agencies
Milliren	Shelby	Accounting Technician	HSS Admin
Moore	Tiffany	None given	None given
Namin	Armenda	None given	Partnership HealthPlan of California
Neal	Kristin	Policy & Financial Manager	HSS Admin
Northcutt	Cherise	Clinical Director	A Better Way
Palomo	Charlene	Staff Analyst	HSS Admin
Perswain	Lorena	MH Clinician (Family Advocate)	Solano County Mental Health
Pierce	Sarah Marie	Program Manager	Caminar, Inc.
Pimentel	Jennifer	Office Assistant II	Solano County Mental Health
Powell	Threasa	Peer Volunteer Circle of Friends	Solano County Mental Health
Ramirez	Miranda	Clinical Supervisor (Institutional Care Services)	Solano County Mental Health
Rapacon	Rita	MH Specialist II (Vallejo Youth)	Solano County Mental Health
Ray	Megan	MH Clinician (Contract Agency)	Aldea Counseling
Rios-Klein	Cristina	Interim Clinical Supervisor (Vacaville Adult)	Solano County Mental Health

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Salassi	Anne	MH Clinician (QI/Presumptive Care)	Solano County Mental Health
San Nicolas Tagliaboschi	Laura	Sr. Systems Analyst	Department of Technology
Sheets	Eric	Clinical Supervisor (Fairfield Youth)	Solano County Mental Health
Sinz	Sandra	BH Deputy Director	Solano County Behavioral Health
Spars	Jonathan	Clinical Supervisor (Hospital Liaison)	Solano County Mental Health
Stimmann	Christina	Clinical Supervisor (Fairfield Adult)	Solano County Mental Health
Tolentino	Diana	Clinical Supervisor (Access/CAT)	Solano County Mental Health
Tyler	Niccore	Health Services Manager	Solano County Health Services
Valencia	Melissa	Circle of Friends	Solano County Mental Health
Verder-Aliga	Rozzana	Sr. Manager (Adult & Youth Outpatient)	Solano County Mental Health
Vicondoa	Maria	Clinical Associate Director	Uplift Family Services
Webb	Meredith	Clinical Supervisor (MHSA)	Solano County Mental Health
Weber	Patricia	Peer Support Specialist	
Werblin	Alan	Physician	Solano County Medical Services
Wilson	Eleanor	Sr. Info Tech Specialist	Department of Technology
Wong	Donovan	BH Medical Director	Solano County Behavioral Health
Woodhall	Cathy	Office Coordinator (QI)	Solano County Mental Health

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Solano MHP CY16 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	3,674,069	141,926	3.86%	$611,752,899	$4,310
Medium	527,196	19,252	3.65%	$86,808,902	$4,509
Solano	33,581	1,222	3.64%	$4,771,105	$3,904

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

Table C2: Solano MHP CY16 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
< $20K	4,696	93.19%	94.05%	$17,068,490	$3,635	$3,612	57.97%	59.13%
>$20K - $30K	162	3.21%	2.83%	$3,921,653	$24,208	$24,282	13.32%	11.98%
>$30K	181	3.59%	3.12%	$8,455,005	$46,713	$53,215	28.71%	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Solano	
PIP Title: Engagement after CSU visit	
Start Date (MM/DD/YY): January 2017 **Completion Date** (MM/DD/YY): January 2018 **Projected Study Period** (#of Months): 15-18 **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 01/30-31/18 **Name of Reviewer**: Lynda Hutchens	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): This topic was selected as an extension of successful strategies in the previous clinical PIP focused on inpatient re-admissions and timely follow-up from inpatient discharge. The goal is to assure timely follow-up post CSU discharge to prevent unnecessary re-admissions to either hospital or CSU. Consistent referrals from CSU at discharge will facilitate engagement in outpatient services as well as reduce the number of clients with frequent CSU admissions.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Although the MHP recognized the need for representation from CSU and consumers, as well as the children's provider representative, these were not present in the study.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP was partially a development from other PIPs and attempts to address another avenue for follow-up from inpatient discharge.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions	*Non-clinical:* ☐ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is based upon the learnings from the prior clinical PIP which focused on inpatient re-admissions and timely follow-up after discharge. The CSU serves all who come; after collecting two years of admissions data, the MHP discovered that 10% of all clients served had private insurance. 69.6% of all clients served were referred to a mental health clinic. From this the MHP inferred that 90% are referred to the County as there are few other local resources for the Medi-Cal/Medicare population – this high-end target goal is 63% of CSU visits.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP will include all clients who receive a service at the CSU.

	Totals	**4** Met **0** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Can we work with the CSU to create more consistent referrals and pathways for engagement in outpatient services after a CSU service? Can this also reduce the number of clients with frequent CSU admissions?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study questions need to be focused on the improvement for clients. The second question is closer to a PIP study question. Something like "Will consistent referrals and pathways for engagement following CSU reduce the number of clients with frequent CSU admissions?"
	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All Medi-Cal consumers who receive services at the CSU.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Adults with psychiatrist service within 30 days 2. Adults with outpatient service within 30 days 3. Children with outpatient (MD or therapy) service within 30 days 4. Number of adults with 2 CSU visits 5. Number of youth with 2 CSU visits 6. Number of adults with 3 CSU visits 7. Number of children with 3+ CSU visits 8. Number of adults with 4+ CSU visits	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Need information on where the goals of the indicators come from. It would be useful to tally number of days to psych service not just within 30 days but who gets in faster who takes longer. This would help in how to identify barriers to follow up post discharge.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators attempt to note who does not readmit within 30 days to CSU and how that is juxtaposed with those that do/do not receive follow up service within 30 days.
Totals		**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0 N**ot Met **3** NA **0** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CSU admissions, status at discharge, date of follow-up services, date of service just prior to CSU admit, number of admits for each client.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☒ Other: Service data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A new report was created in Avatar – report 397 – which shows all CSU admissions, status at discharge (collected from admissions open/close) and date of follow-up services (based upon next services billed by type). Pivot tables are used to calculate the number of clients for each indicator. Recently added date of service just prior to CSU admit. This allows MHP to know who utilizes the CSU that was not previously established with an outpatient clinic.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	There is no additional tracking necessary for this project as it can all be analyzed through service data.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Service data, pivot tables,	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The count of CSU visits as a post-intervention measure is only truly comparable to the baseline until a full year has ended. The previous year's data used in the baseline was a full year, which means that there are still a few months left for people to have another CSU visit. The percent improvement noted above is an interim measure. As a potential remedy to this, the MHP added additional indicators of repeat CSU visits within 30 days of CSU discharge. This analysis is pending at this time. The first 3 measures can detect improvement quarter by quarter if run a little over 30 days after the end of the quarter to allow for the 30-day service plus time for service entry. The MHP notes that even running the data at this time, it is a low representation ongoing because some contract providers enter their services into the system 4-6 weeks after the service was delivered. Therefore, the Q1 data included in this analysis is refreshed and would be considered a complete data set for the time frame. The Q2 data was run 60 days after the quarter ended and is likely almost a full data set, with potentially a few outlier delays in service entry. Each quarter the MHP will refresh the prior quarter data.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP had difficulty in bringing on participation by CSU discharge staff. A surprising finding was that the BACS aftercare program was not represented in the data. Possibly they are seeing post-acute clients, but are not the first service after discharge. This needs further inquiry for clarification.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Sandra Sinz, LCSW Title: BH Director Role: Project co-leader Name: Christina Stimmann, LCSW Title: Clinical Supervisor Fairfield ICC Role: Project co-leader Name: Jonathan Spar, LCSW Title: Clinical Supervisor Hospital Liaison Role: Project co-leader *Other team members:* Names: 4. Kate Grammy, PsyD, MH Manager, Adult Specialty Services 5. Larry Miller, MH Specialist, Hospital Liaison 6. Kimberly Davis, MH Specialist, Adult ICC Clinic	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data may be pulled in the form of a report by all supervisors within the system. All can review and interpret the data. The data is presented to the team of ICC leaders by the Adult Administrator (now Deputy Director) or Clinical Analyst. IT staff provide support in creating or amending Crystal Reports to pull data from the Avatar EHR.
	Totals	**5** Met **1** Partially Met **0** Not Met **0** UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *1.* Re-establish consistent weekly meetings with Exodus CSU provider. Establish monthly meetings with BACS provider; a vendor likely to be referred CSU clients and would do follow-up visits *2.* Adult ICC MH Specialist reviews CSU census and informs existing providers if their clients were seen at the CSU (there was some degree of inconsistency due to medical leave) *3.* Adult ICC MH specialist to do outreach to CSU clients who are eligible for clinic services *4.* Require adult clinics to allow post-CSU clients to by-pass orientation *5.* Initiate focused engagement of repeat users	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Without CSU and consumer input, there are gaps in ability to assess improvement strategies.

	Totals	**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Analysis tables and graphs were provided in the PIP submission. These were not well explained in narrative.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: ___1/1/17, Q1 1-3/17, Q2 4-6/17_____ Indicate the statistical analysis used: unknown Indicate the statistical significance level or confidence level if available/known: Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Need to analyze by quarter.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* BACs not represented in data. Need more inquiry. *Conclusions regarding the success of the interpretation:* So far adult clinics have shown improvement but children's clinics showed decrease in performance. Mixed results so far. *Recommendations for follow-up:*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Need to analyze by quarter. This PIP shows mixed results so far. Adult programs showed great increase in engagement after a CSU visit, though still not to the extent desired. Children's programs showed a decrease in engagement. This is being considered and discussed with the children's programs. In addition, there is a need to examine why BACS PEP program is not on the radar post-CSU discharge. This is one of the main purposes of the PIP so this is a surprising finding. The MHP will examine whether they are seeing CSU clients but perhaps they are not seeing them first after discharge; this would also be a curious finding. It's unclear thus far whether the number of high users is going down. Pending an analysis which will be completed shortly using a different measure of re-admission to CSU within 30 days. This allows for a shorter time frame for an ongoing measure in addition to the annual number. In looking at these numbers, one notable thing is that many of the re-admissions occur within days of their previous CSU visit. This brings to question whether some of the discharges are premature or even required inpatient admission. The MHP is initiating a retrospective clinical review on cases where there were multiple admissions and discharges, both with and without hospital admission.
	Totals	**1** Met **3** Partially Met **0** Not Met **0** NA **0** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Results were mixed and incomplete.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☒ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP notes the need to tighten up some of the interventions as well as gain buy-in from Exodus to participate in this project. They have not done so yet because there are many improvement efforts active with the CSU and they report that they do not want to overwhelm them further now. The other issues are basic with contractual compliance. Simultaneously they are also working on an improvement initiative regarding the workflow between the CSU and hospital emergency departments. All four EDs are involved in this project.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☒ Weak ☐ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	This PIP shows mixed results so far. Adult programs showed great increase in engagement after a CSU visit, though still not to the extent that was hoped. Children's programs showed a decrease in engagement. This is being further explored and discussed with the children's programs. In addition, the MHP needs to examine why BACS PEP program is showing up post-CSU discharge. This is one of the main purposes of the program so this is a surprising finding. The MHP plans to examine whether BACS are seeing CSU clients but perhaps not seeing them first after discharge; this would also be a curious finding. It's unclear thus far whether the number of high users is going down. This is pending an analysis which will be completed shortly using a different measure of re-admission to CSU within 30 days. This allows for a shorter time frame for an ongoing measure in addition to the annual number. In looking at these numbers, one notable thing is that many of the re-admissions occur within days of their previous CSU visit. This brings to question whether some of the discharges are premature or even required inpatient admission. The MHP is initiating retrospective clinical review on cases where there were multiple admissions and discharges, both with and without hospital admission.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals		**1** Met **1** Partially Met **1** Not Met **<#>** NA **2** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**

Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: The study lacked participation by CSU staff and any consumers. The MHP has decided to end this PIP due to the fact that the CSU provider contract ends this spring and the plan is to bring in a new vendor.		
Recommendations: The MHP needs a Clinical PIP in place and active this year in a timely manner. TA is offered by EQRO. Information gathered with this PIP could be useful in creating protocols for the new CSU vendor later this year.		
Check one:	☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Confidence in PIP results cannot be determined at this time	☒ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Solano	
PIP Title: Adult Timeliness Project	
Start Date (MM/DD/YY): July 2016 **Completion Date** (MM/DD/YY): **Projected Study Period** (#of Months): 18-24 months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review** (MM/DD/YY): 01/30-31/18 **Name of Reviewer**: Lynda Hutchens	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The goal of this PIP is to increase timeliness and engagement of adult consumers to services. Solano County has a history of sporadic performance with timeliness to service delivery for adults. Timely service delivery is a value that the entire adult service system has determined is an important characteristic of quality service delivery. The clinic staff are committed to providing clinical service that is both timely and clinically meaningful. The challenge is that the children's system is more richly resourced, in which each children's clinic has roughly the same number of clinical staff as all three adult clinics combined. Timely adult intake has been complicated by referral to an orientation prior to intake assessment.	

Referral to an orientation prior to intake assessment was implemented a few years ago as a PIP intervention, primarily to reduce the impact of no-shows for assessment. No-shows negatively impact the efficiency of the work operation because a clinician's schedule is held for at least two hours for the intake appointment. By scheduling group orientations instead, the negative impact of no-shows on clinician time and resources may be reduced. Data showed that clients who attend orientation have an 85% chance they will also attend the intake assessment. Therefore, the MHP hypothesized that clients who were unlikely to attend an intake assessment would instead not attend orientation. 30% of clients referred did not attend orientation. However, the MHP had not determined whether the orientation became a barrier to service – either because the "two-step" process was overly burdensome, or clients may have chosen to not attend orientation if they understood that it was not a clinical assessment.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The team members were MFTs or LCSWs who are leaders within the adult ICC clinics, each with extensive knowledge and experience in Adult Mental Health and the service delivery system within Solano County. When queried, the MHP said that no consumers or stakeholder representatives were interested due to fact that this study is incorporated into an existing meeting.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The selection of the topic did not include where the timeliness numbers need to be and where they are now. However, timeliness data reviewed showed an issue with time to adult first service.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☒ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All adult Medi-Cal consumers requesting outpatient services.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**2** Met **2** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* How can we provide more timely service delivery to adults? Will implementing open access improve timely service delivery and a higher rate of engagement?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The first sentence is a question, but not a study question that is measurable. The second sentence is more of a study question, however there is no discussion of engagement as an issue in why this is a question. The PIP narrative needs to define what is meant by "timely service delivery" in order that it can be measured. What are those rates now and how much do they hope to improve through this PIP?
Totals		**0** Met **1** Partially Met **0** Not Met **0** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Study population includes: All adults 18 and older requesting MH services (routine and urgent) through the centralized Access line.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The Access line is the initial point of contact for Solano County residents to obtain mental health services. Adults may be referred by self or family, their primary care physician, or other referring parties, and are then referred for orientation and then assessment. The PIP submission states "Spanish-speaking clients/families contacting the Access line are assessed by a clinician with the assistance of a scheduled interpreter." It is assumed that this includes other non-English speaking consumers. Within the adult system, contract providers receive referrals after they are assessed at a County ICC clinic, if the client is determined to meet the medical necessity criteria for the given program. Most adults are served entirely at the ICC, primarily through medication management. This is a high-volume issue in that service requests are placed for over 1300 adults per year.
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. % meeting timeliness standard – Routine 2. % meeting timelines standard – Urgent 3. Average Offered Wait Time – Routine (Assessment) 4. Average Actual Wait Time – Routine (Assessment) 5. Average Offered Wait Time – Urgent (Assessment) 6. Average Actual Wait Time – Urgent (Assessment) 7. Average wait to Psychiatry – Routine 8. Average wait to Psychiatry – Urgent 9. Assessment Engagement – Routine 10. Assessment Engagement – Urgent 11. Psychiatry Engagement – Routine 12. Psychiatry Engagement – Urgent	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	These are all outcomes. Indicators are also needed for assessments conducted by telephone, orientation attendee rates, and other indicators that could point to systemic breakdown. At the time for request for services, it is determined to urgent or routine.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☐ Yes ☒ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators had baseline and goals. It was unclear where the goals came from (i.e. literature, research, etc.)
	Totals	**0** Met **2** Partially Met **0** Not Met **0** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0** Not Met **3** N/A **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1. Date of call to Access line: this is the initial request for service and starts the clock for the measuring of timeliness – also includes demographic data regarding the client, source of referral, language, or other special needs (entered into Access Screening Tree by Access Clinician) 2. All adult initiating services require an assessment for services and are referred to their clinic orientation. (Clients who call Access but already have an open case are referred to their clinic directly.) 3. Date of offered intake appointment (occurs at orientation) – Only 65% of adult clients requesting services receive an appointment (takes into account no-shows). Note that the "offered wait" is a subset of the entire population. 4. Date intake assessment actually occurs (billed service in myAvatar). 5. Date of first service after assessment (non-assessment/planning service billed in myAvatar).
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Avatar	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1. When a consumer calls the Access line the Care Manager completes a screening and enters clinical and demographic information into myAvatar. 2. The clinical provider who does the orientation enters the date of the first offered appointment. (There are concerns about data integrity as it the offered appointment may not always be entered or be appropriate.) 3. The Hospital Liaison refers clients directly to assessment – this is an absence of data in the project (remedied Sept 2017). 4. Reports are run monthly to track timeliness within the ICC leadership group, and quarterly reports are reviewed at the QIC meeting. QIC evaluates the data and may make recommendations to improve the process.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Access Screening Tree, Avatar; Billed service, Avatar; non-assessment/planning service billed in Avatar	☒ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	Data may be pulled in the form of a report by all supervisors within the system. All can review and interpret the data. The data is presented to the team of ICC leaders by the Adult Administrator (now Deputy Director) or Clinical Analyst. IT staff provide support in creating or amending Crystal Reports to pull data from the Avatar EHR.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	• Download Report 333 into Excel and review for any missing elements or potential data integrity issues. Resolve by chart review when needed. • Select Access calls where "Integrated Care Clinic" is the "Disposition" of the call. (This disposition populates a Clinical Referral Report for the receiving supervisor.) • Review for duplicate entries due to more than one call to Access. The data for Assessment and/or MD visit may show on one or both of the client entries – this is consolidated and duplicate entry removed. • Sometimes the "offered appointment" is not entered but the person received an assessment. In these situations, the date of the assessment is recorded as the "offered" date. It's possible that this a high-end estimate, as the true offered date may have been sooner. • Lack of completion of the assessment documentation can affect the validity of the data (e.g., an assessment has been conducted but does not show on the report because the Assessment form was not completed). This requires manual review for assessment notations in progress notes, followed by notification to the clinician and supervisor that an assessment has not been completed. • When we note that when the Med Visit field in the report is empty – it is possible that appointments have been scheduled but no service provided, or is currently calendared but has not occurred yet. Or the client was not referred for psychiatry (there is no method currently to capture this data), or the client has declined psychiatry. • Calculate average time frames for assessment and service initiation – urgent and routine – for each clinic/program for each quarter. • Determine the percentage of services meeting timeliness standards. Percentages are based upon a denominator of total calls to Access. • Compare indicators across programs and over time – display in a chart (comparing programs) or graphs (showing data over time). Review changes over time and differences across programs. • Determine whether apparent improvements appear to be the result of the identified interventions.

6.6 Were qualified staff and personnel used to collect the data? Project leader: Name: Sandra Sinz, LCSW Title: BH Director Role: Project Leader Other team members: Names: 1. Anne Salassi, Clinician/Analyst 2. Melanie Cook, MH Manager, Fairfield ICC 3. Christina Stimmann, Clinical Supervisor, Fairfield ICC 4. Rozzana Verder-Aliga, MH Manager, Vallejo ICC 5. Robert Epstein, Clinical Supervisor, Vallejo ICC 6. Michael Kitzes, MH Manager, Vacaville ICC 7. Joy Castrejon, Clinical Supervisor, Vacaville ICC	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Unclear individual roles of data collection.
Totals		**4** Met **1** Partially Met **0** Not Met **0** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? Describe Interventions: Initiate Open Access in the Fairfield Adult ICC clinic - fully implemented in July 2016– The Fairfield clinic was selected to pilot this because its leaders were most ready to try a process vastly different than the current one. Further, the Fairfield clinic, when fully staffed, has four clinicians – a reasonable set of staff to accommodate walk-in demand. A fourth clinician was added to Fairfield in Spring 2016. Barriers addressed: orientation process is not very welcoming (this is validated by consumer input the Consumer Family Advisory Committee). Given that resources in the adult clinics are slim, no-shows for two-hour intake slots is wasteful use of a resource – this will allow clients to come to the clinic when they are willing and able. Measure: Impact on timely assessment. Measure: Impact on % receiving assessment. Hospital Liaison conducting non-billable assessment while client is inpatient to promote engagement. Barriers addressed: Inpatient clients can go directly to psychiatrist if they get assessed while in the hospital (if they are new to the system or have an inactive case). Measure: Impact on % receiving assessment. Measure: Impact on % receiving psychiatry service. 3. Direct pathway for clients who are post-CSU or post-inpatient to Vallejo and Vacaville – February 2017 – Barriers addressed: reduce engagement barriers to clients in crisis. Give clinics experience bringing in clients without orientation. Measure: Impact on timely assessment. Measure: Impact on % receiving assessment. 4. Create direct pathway for Whole Person Care clients – February 2017 – Refer directly to clinic for assessment appointment; skip orientation. Barriers addressed: reduce engagement barriers to clients in crisis. Give clinics experience bringing in clients without orientation. Measure: Impact on timely assessment. 5. Completion of baseline assessment project – March 2017 – Now can focus on assessments of new clients. 6. Follow up and outreach to Urgent clients who do not show for orientation/assessment – September 2017 – Barriers addressed: orientation process is not very welcoming (this is validated by consumer input at the Consumer Family Advisory Committee) 7. Initiate Open Access in Vallejo ICC based upon lessons learned in Fairfield implementation – October 2017. – Eliminate orientation and see clients when they come in. Barriers addressed: reduce engagement barriers to clients in crisis. Give clinics experience bringing in clients without orientation. Measure: Impact on timely assessment. Measure: Impact on % receiving assessment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

	Totals	**1** Met **0** Partially Met **0** Not Met **0** NA **0** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	There was no Section 8 in the PIP submission. There were charts and tables indicating the analysis was perform according to the data analysis plan.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: FY17Q1, FY17Q2, FY17Q3, FY17Q4 Indicate the statistical analysis used: n/a Indicate the statistical significance level or confidence level if available/known: Unable to determine.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Several charts and tables were presented in the PIP submission. More narrative analysis as well as future plans for the study were needed.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* The only measure with negligible improvement was urgent assessment engagement. This is being reviewed. *Conclusions regarding the success of the interpretation:* Overall there is improvement in all measures. Wait times improved 18% to 73% across the various measures. Wait times for assessment are decreased across all clinics and the average meets the 10-day goal. *Recommendations for follow-up:* EQRO recommended that the MHP ensure that the same steps to access (with or without orientation, open access or by appointment) be implemented in all outpatient clinics to create a level playing field for measurement.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	Met Partially Met Not Met NA UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Provided in PIP submission and in additional attachments.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

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

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	• Overall there is improvement in all measures. Wait times improved 18% to 73% across the various measures. Wait times for assessment are decreased across all clinics and the average meets the 10-day goal. • The only measure with negligible improvement is urgent assessment engagement. The MHP just added an intervention for more careful oversight and follow-up of urgent referrals. This is despite a marked improvement in the wait times for urgent services. This is a particularly important measure given that these are determined at screening to be higher risk. The average offered wait at baseline was over 9 days and this was improved significantly to less than 3 days. The urgent psychiatry wait was also decreased by half. More attention will be paid to this population. • Much of the improvement is driven by the Fairfield clinic, which initiated the open access model. The other clinics showed improvement over the baseline, just not nearly as much as the Fairfield clinic. The findings interested the Vallejo clinic leadership in initiating open access in the next month. Overall wait times are longer and engagement is lower in the Vallejo clinic. • These results may encourage access improvements across the system. • Fairfield clinic shows higher rates of engagement across all measures. With routine requests, 26% more clients are assessed in Fairfield than Vallejo which has the lowest assessment and psychiatric service rates. The Vacaville clinic performance falls in between the two. Performance in Fairfield is similar for urgent and routine clients, which is consistent with the notion that all clients are referred to the clinic the day they call or the next day (if they call in the afternoon). • There are some outliers in psychiatry wait times, most notably urgent clients showed an increase in wait time in the last quarter. Staffing was stable in that quarter, so reasons for this increase in wait for this small population (n=21) is unclear.
	Totals	Met Partially Met Not Met NA UTD

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

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

Conclusions:

The PIP was successful in increasing timeliness in different percentages at distinct locations and for different services. It also pointed out some issues to resolve, to include orientation versus open appointments. More analyzation of the charts and tables presented in the narrative would have been useful.

Recommendations:

EQRO recommends that the MHP follow up on the unexpected results in different clinics that was encountered.

It was noted that consumer input would have made the PIP stronger.

Check one:

☐ High confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results

☐ Confidence in PIP results cannot be determined at this time

☐ Low confidence in reported Plan PIP results

☐ Reported Plan PIP results not credible