



April 3, 2017

Bill Carter
Mental Health Director
Napa County Mental Health Plan
2751 Valley Corporate Dr.
Napa, CA 94558

Dear Director Carter:

Enclosed is the Final Report completed by Behavioral Health Concepts, Inc., California's External Quality Organization (BHC) for the review of the Medi-Cal Specialty Mental Health Services Waiver Program, reflecting the findings and recommendations from the FY16-17 External Quality Review of the Napa MHP.

This review was conducted in accordance with the Centers for Medicare and Medicaid Services (CMS) Managed Care regulations. These CMS regulations mandate that the California Department of Health Care Services (DHCS) provide an annual external quality review of the quality, outcomes, timeliness of care, and access to care provided by California Mental Health Plans (MHPs). BHC customized each FY16-17 review based upon the issues and recommendations outlined in the prior year's EQRO report.

BHC performed the following activities to meet the requirements for the External Quality Review as related to MHPs:

1. Validating Performance Improvement Projects (PIPs) – BHC reviewed and validated two MHP submitted PIPs, one clinical and one non-clinical.
2. Information Systems Capability Assessment (ISCA) – BHC utilized a California-specific ISCA protocol to review the integrity of the MHP's information system(s) and the completeness and accuracy of the data produced by those systems.
3. Validating Performance Measures (PMs) – BHC conducted a performance measurement analysis based upon variables identified through discussion with DHCS.
4. Technical Assistance and Training – BHC has provided technical assistance and training as part of the on-site review, webinar PIP Clinics, and remains available to respond to any MHP questions.

Please contact Ewurama Shaw-Taylor (ewurama.shawtaylor@bhceqro.com) if you have any questions about the final report or to request technical assistance between reviews.

BHC appreciates the MHP's participation in the review. We hope that the recommendations and technical assistance provided are helpful in sustaining quality processes and in improving the overall quality of the MHP's program.

Sincerely,



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FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Napa

Conducted on
December 09, 2016

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NAPA MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—1,298
- MHP Threshold Language(s)—Spanish
- MHP Size—Small
- MHP Region—Bay Area
- MHP Location—Napa
- MHP County Seat—Napa

Introduction

The Napa County Mental Health Plan (MHP) is categorized as a Small, Bay Area MHP. The MHP is part of the county's Health and Human Services Agency (HHSA); its official name is Napa County Mental Health. The MHP has one location, in the city of Napa, which serves as both the administrative offices and service site. In addition to adult and children's system of care, the MHP provides residential services to consumers.

During the FY16-17 review, CalEQRO found the following overall significant changes, efforts and opportunities related to Access, Timeliness, Quality and Outcomes of MHP and its contract provider services. Further details and findings from EQRO mandated activities are provided in the rest of the report.

Access

The MHP relocated to a larger facility outside of the city center. The new location also houses nine other divisions that comprise the HHSA. While this new location enables coordination of services for shared consumers (e.g., with Child Welfare Services), it has posed access challenges for consumers and staff alike. The MHP has promoted place-based services as another way to reach consumers. The MHP states that place-based services is their approach to provide services in areas that are adversely affected by social determinants of health. Place-based services adds demands on staff time and the MHP may wish to examine further the impact of this on consumer access.

Timeliness

The MHP tracks and publishes various measures of timeliness and hours of service utilization. These data are captured in a Mental Health Data Dashboard, which the MHP has revised and expanded. While the MHP provides granular information for most of the timeliness measures, their tracking for timeliness to urgent conditions is broad and does not permit the MHP to provide even average times to response to urgent conditions.

Quality

During the previous year, the MHP initiated a comprehensive system planning initiative to examine their capacity to serve consumers. The MHP has a Quality Improvement (QI) Committee, a Utilization Review Steering Committee, and a few other subcommittees that together attend to quality management and review. In an effort to better serve monolingual Spanish and Spanish-prefering consumers, the MHP has assigned these consumers to bilingual (Spanish-speaking) staff; the perception is that this has created higher caseloads for bilingual staff members.

Outcomes

The MHP is making progress towards systemic utilization of outcomes instruments. The MHP has adopted use of Milestones of Recovery Scale (MORS) in the adult system of care by contract providers. The Youth Outcome Questionnaire (YOQ) is used by some mental health staff, but the MHP has yet to mandate the use of this instrument in the children's system of care.

INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the FY16-17 findings of an EQR of the Napa MHP by the California EQRO (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES¹

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (\$30,000 or higher)

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS²

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES³

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

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

Key Recommendations from FY15-16

- Recommendation #1: Where there exists limited numbers of bilingual staff, the MHP should consider consolidating caseloads and creating specialized linguistic caseloads to meet the needs of monolingual Spanish speakers.

Fully addressed Partially addressed Not addressed

- The MHP hired three bilingual (Spanish) clinicians, and a total of 20 bilingual clinicians and case managers, representing 20% of their staff.
- The MHP reported that it has adjusted caseloads such that the Spanish-speaking staff have more of the monolingual Spanish or Spanish-preferring consumers. The perception among staff is that caseloads of Spanish-speaking staff were much higher than non-Spanish-speaking staff.
- Consumer/family member focus group participants did not report any concerns with provision of services in their preferred language.
- The MHP's Hispanic penetration rate declined at a greater rate than the Small MHP and statewide Hispanic rates.

- As the MHP is attempting to meet the linguistic needs of consumers, the MHP should consider hiring bicultural staff, in addition to bilingual. Stakeholders reported the need for bicultural clinicians, particularly in the children's system of care.
- Recommendation #2: The MHP should continue its efforts to develop and operate Clinical and Non-Clinical PIPs which have clear focus and impact on the health of its consumers, obtaining consultation and support throughout the process.
 - Fully addressed Partially addressed Not addressed
 - The MHP presented two PIPs for review; however, only one was considered active.
 - The MHP's Non-Clinical PIP was considered Active. The PIP has a clear focus; it is intended to affect access to care for consumers through appropriate referrals from and care coordination with one of their federally qualified health centers. The PIP has measurable outcomes and has been appropriately implemented.
 - The MHP's Clinical PIP was rated *Concept Only*. The PIP was started only recently (in November 2016) and has one identified indicator and does not include interventions.
- Recommendation #3: The MHP should mandate its already selected outcomes suites (POMs & MORS) across its entire SOC including service partners. Where already operational, the MHP should begin use of these tools for Level of Service/Level of Care analysis to determine if consumers are getting well.
 - Fully addressed Partially addressed Not addressed
 - The MHP has chosen the MORS as the universal outcome tool for adults and the MORS is integrated in the (electronic health record) EHR.
 - The MHP has approved use of the California Institute of Behavioral Health Solution 2011 Children's Palette of Measures (POMs), which includes three universal outcome tools, including the YOQ, and nine diagnosis-specific tools.
 - The MHP has not implemented the YOQ or other POMS in their EHR; the MHP has opted to use the California Institute of Behavioral Health Solution's data dashboard, which is more practical for the MHP.
 - The MHP continues to work on utilization of these outcome measures as Level of Service/Level of Care tools.
- Recommendation #4: The MHP should finalize deployment of EHR resources to its service partners so that treatment and tracking resources are consistent across the MHP.
 - Fully addressed Partially addressed Not addressed

- The MHP implemented the Emergency Crisis Team (ERT)/Crisis Triage program in the EHR, which they have contracted to Progress Foundation with a subcontract to Mentis. However, all three adult system contractors – Buckelew, Progress Foundation, and Mentis – report that they cannot use the EHR for their other programs.
- The MHP has not yet implemented outcome tools or Mental Health Services Act (MHSA) reporting in the EHR, which impacts contractors.
- Recommendation #5: QI should begin to implement the use of national quality measures within its SOC to provide additional CQI data to executive team to improve consumer wellness and recovery and reduce harm.

Fully addressed Partially addressed Not addressed

- The MHP tracks an extensive suite of data metrics in their Mental Health Data Dashboard, formerly referred to as the Utilization Review Steering Committee (URSC) Dashboard. Consistent with national quality measures, the MHP is revising timeliness performance measures in the MHDD to calculate business days rather than calendar days to service.
- The MHP has adopted results-based accountability as a means to assess how consumers are improving, inclusive of wellness and recovery.

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

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

- Access to Care
 - The MHP moved to a new and larger campus that enables all of their programs to be located in one place. However, the new campus is farther from the town center. Stakeholders reported difficulty accessing the MHP now that it is farther away and further exacerbated by traffic in the new area. The MHP has attempted to mitigate the distance (i.e., through the provision of shuttle service).
 - A long-time psychiatrist left the MHP. This provider was Spanish-speaking, well-known to consumers, and adept at facilitating a treatment team coordinating care. Even though the MHP has filled the psychiatrist position, the absence of the previous psychiatrist, and the unique qualities of this person, has affected perceptions of access and quality.

- The MHP received an *Investment in Mental Health Wellness Act of 2013 (SB 82)* grant to establish the first Crisis Stabilization Unit (CSU) in Napa County which they hope to open in 2017.
- The HHSA received a Whole Person Care grant, which will improve housing access for persons with mental illness who experience homelessness.
- Timeliness of Services
 - The MHP has emphasized place-based services, wherein mental health staff meet consumer's at their homes, schools, and other suitable places where consumers access. Staff reported that this has increased the demand on their time (e.g., allocating time for travel and traffic) and consequently decreased the time that they have to meet with consumers.
- Quality of Care
 - The MHP has endorsed and implemented two evidenced-based practices in their system of care: Cognitive Behavioral Therapy for Psychosis and Child-Parent Psychotherapy. The MHP has more tools with which to support consumers and families dealing with psychosis and trauma, respectively.
 - In response to the capacity demands created by Medicaid Expansion, the MHP hired additional staff. The MHP is also conducting a system mapping and analysis to assess and balance their capacity.
 - The MHP selected a new contractor, On The Move, to run the MHP's Wellness Center, now called the Innovations Community Center.
- Consumer Outcomes
 - The MHP has completed their conversion to both DSM-V and ICD 10.
 - The MHP approved the Milestones of Recovery Scale (MORS) as the universal outcome tool for the adult system of care.
 - The MHP compiled results of the Fall 2014 and Spring 2015 Consumer Perception Survey (CPS), but has yet to analyze and disseminate the results to staff and contract providers.

PERFORMANCE MEASUREMENT

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of TBS Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries (\$30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Napa MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	6,824	27.6%	617	47.5%
Hispanic	14,892	60.2%	491	37.8%
African-American	435	1.8%	34	2.6%
Asian/Pacific Islander	1,165	4.7%	19	1.5%
Native American	42	0.2	4	0.3%
Other	1,363	5.5%	133	10.3
Total	24,719	100%	1,298	100%
<p><i>*The total is not a direct sum of the averages above it. The averages are calculated separately. The actual counts are suppressed for cells containing n ≤ 11.</i></p>				

5% of elig.

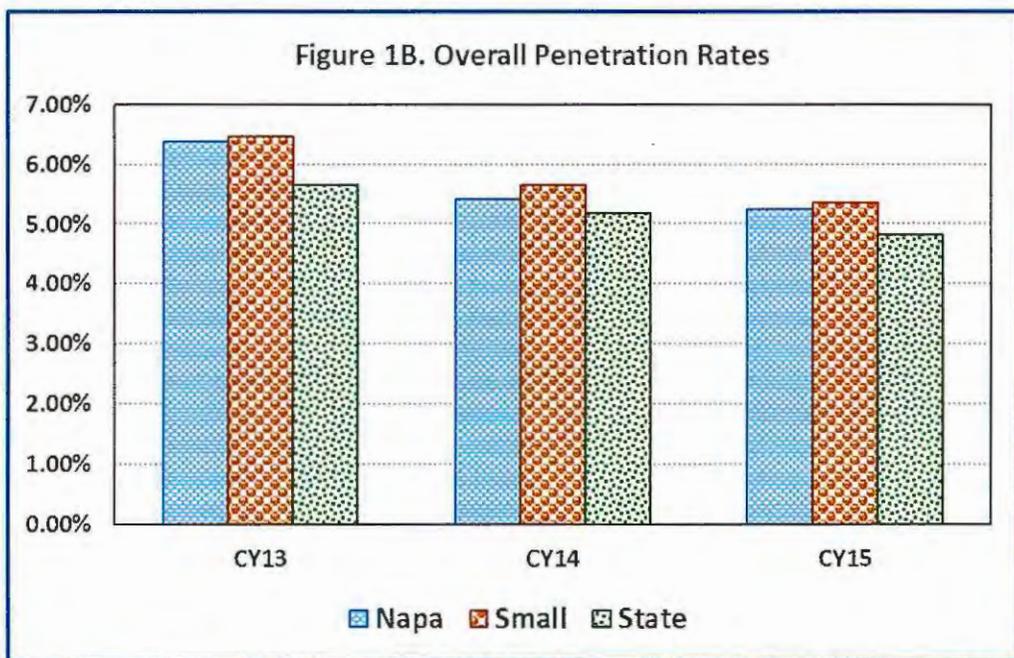
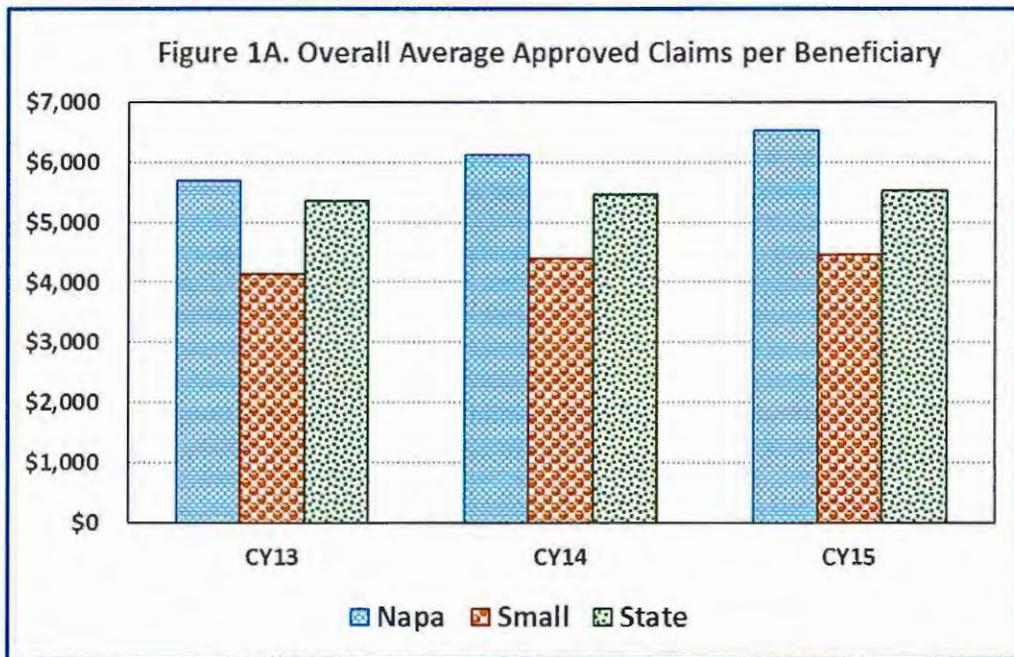
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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.

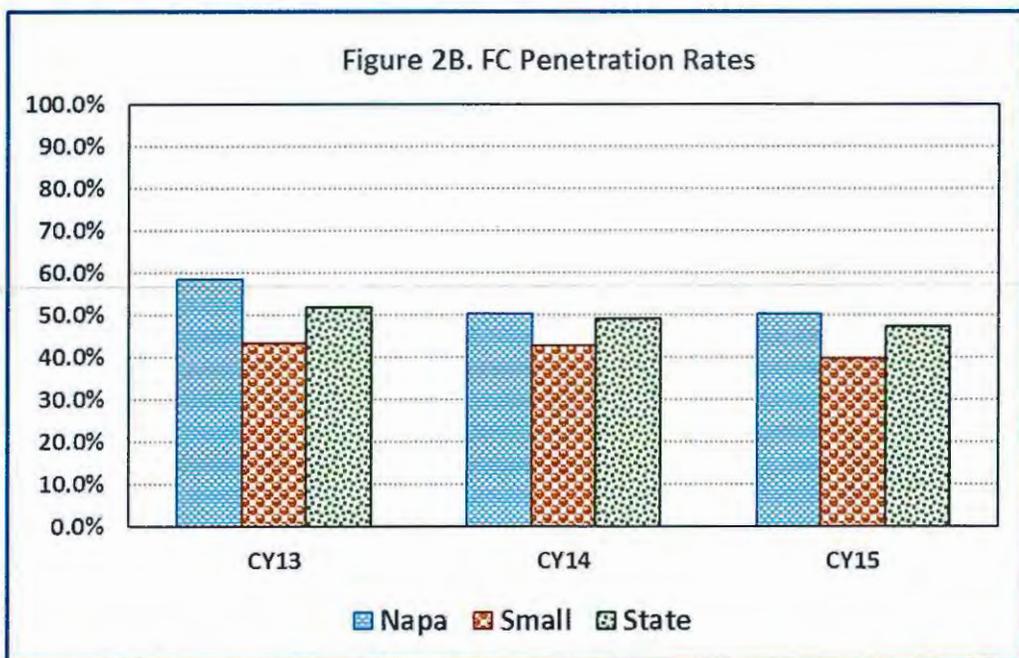
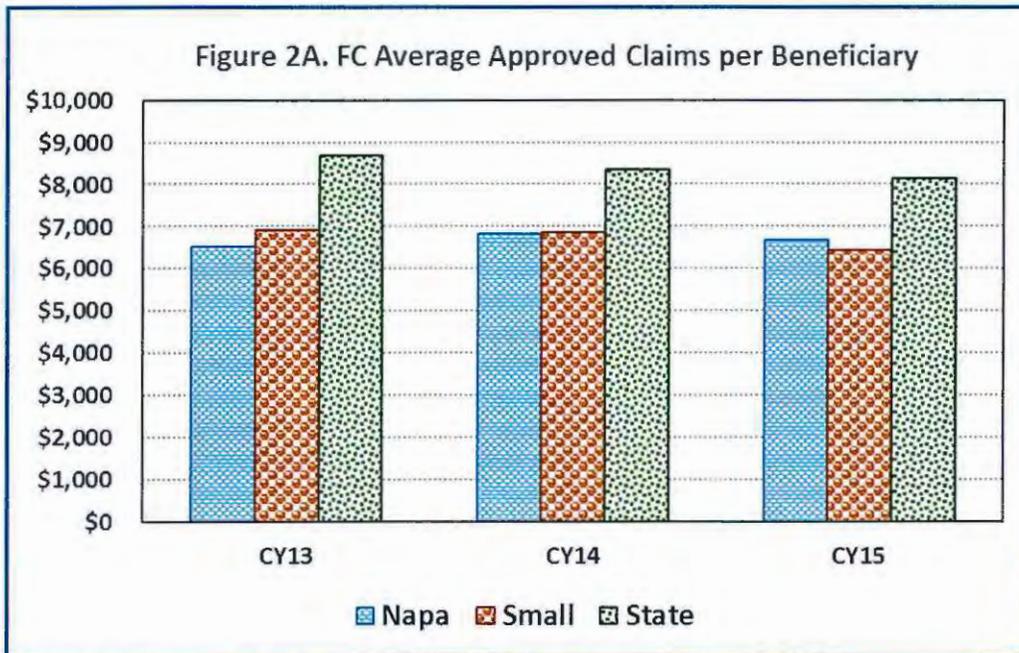
Regarding calculation of penetration rates, the Napa MHP:

- Uses the same method as used by the EQRO. The MHP uses CalEQRO penetration rate data for a number of Mental Health Data Dashboard (MHDD) performance measures.
- Uses a different method: The MHP analyzes data from the Cerner Community Behavioral Health Unduplicated Client Services report and County level Medi-Cal eligibility data to monitor on-going penetration rates.
- Does not calculate its penetration rate.

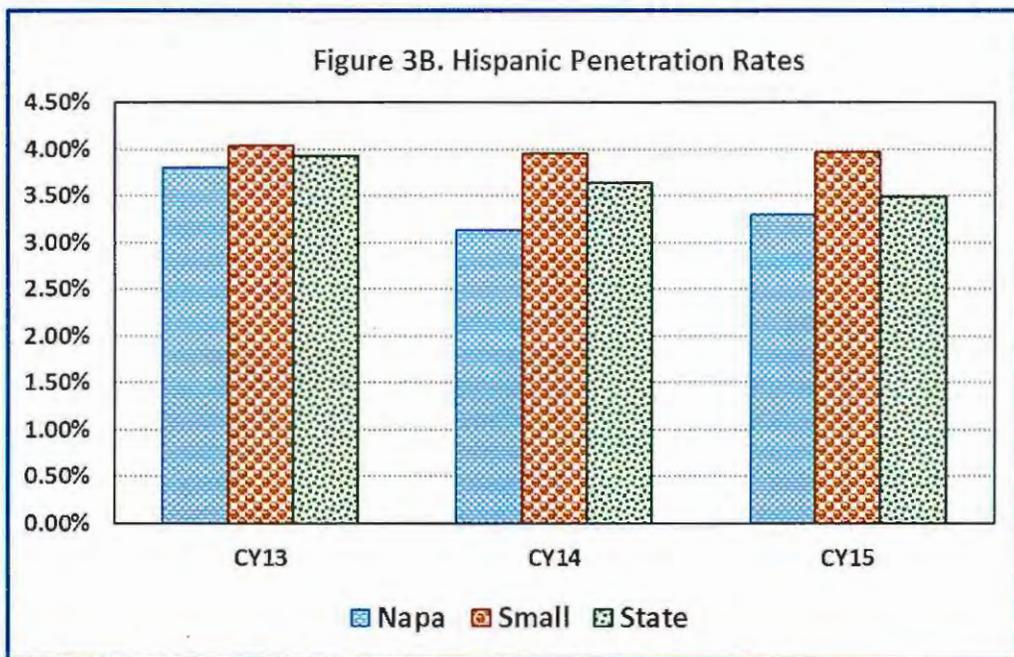
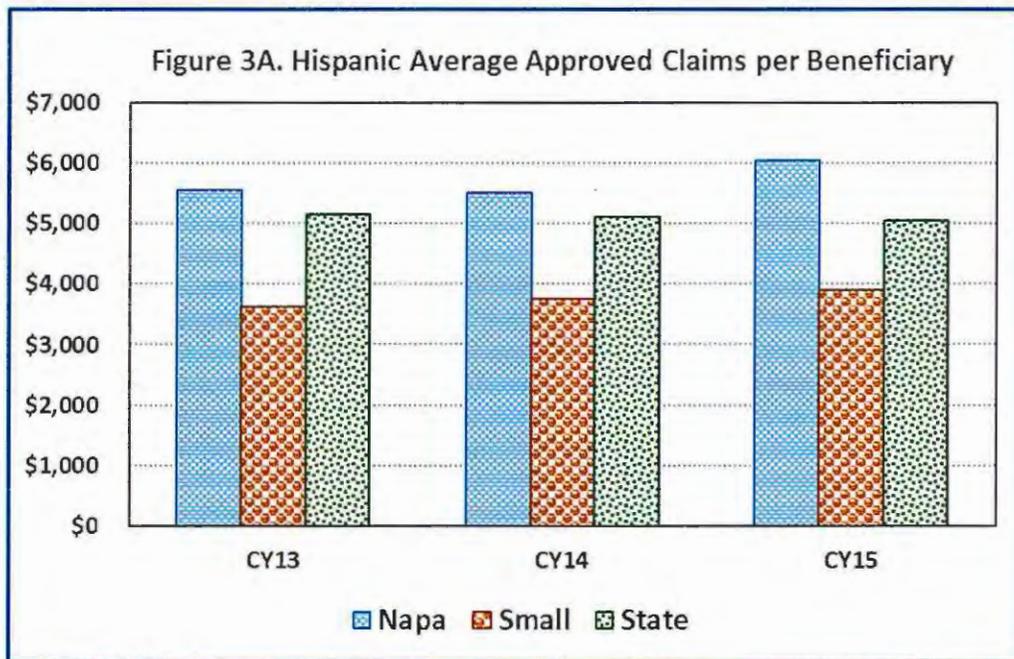
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



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



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



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

HIGH-COST BENEFICIARIES

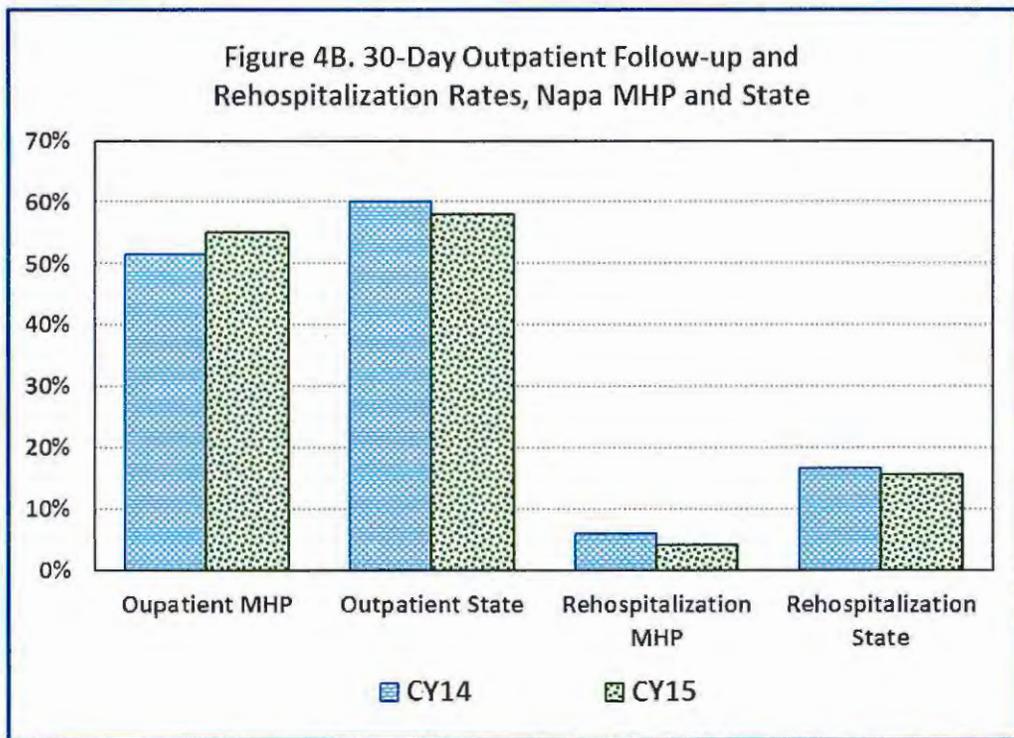
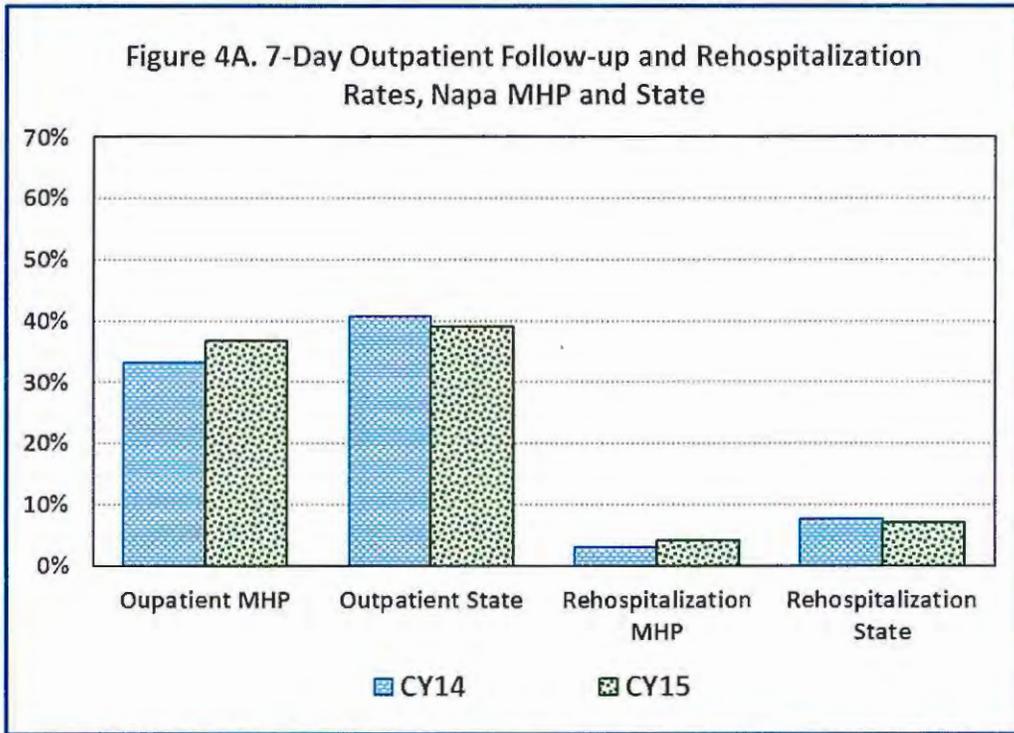
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than \$30,000 in a year.

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	\$51,635	\$715,196,184	26.96%
Napa	CY15	38	1,298	2.93%	\$43,283	\$1,644,772	19.45%
	CY14	28	1,295	2.16%	\$41,662	\$1,166,538	15.16%
	CY13	24	1,293	1.86%	\$48,532	\$1,164,757	15.84%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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



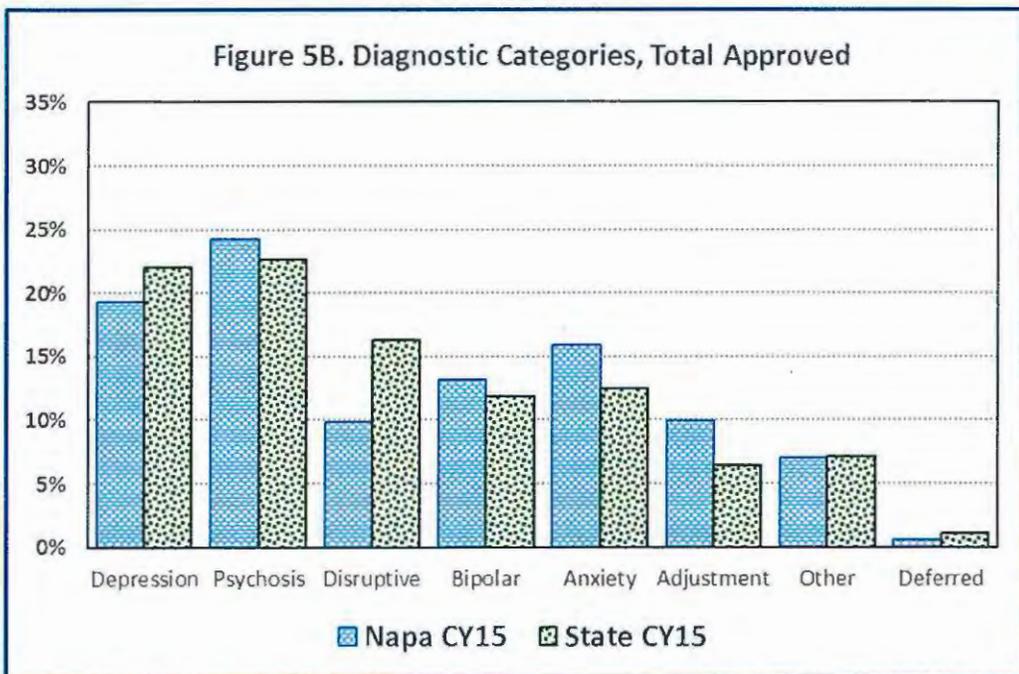
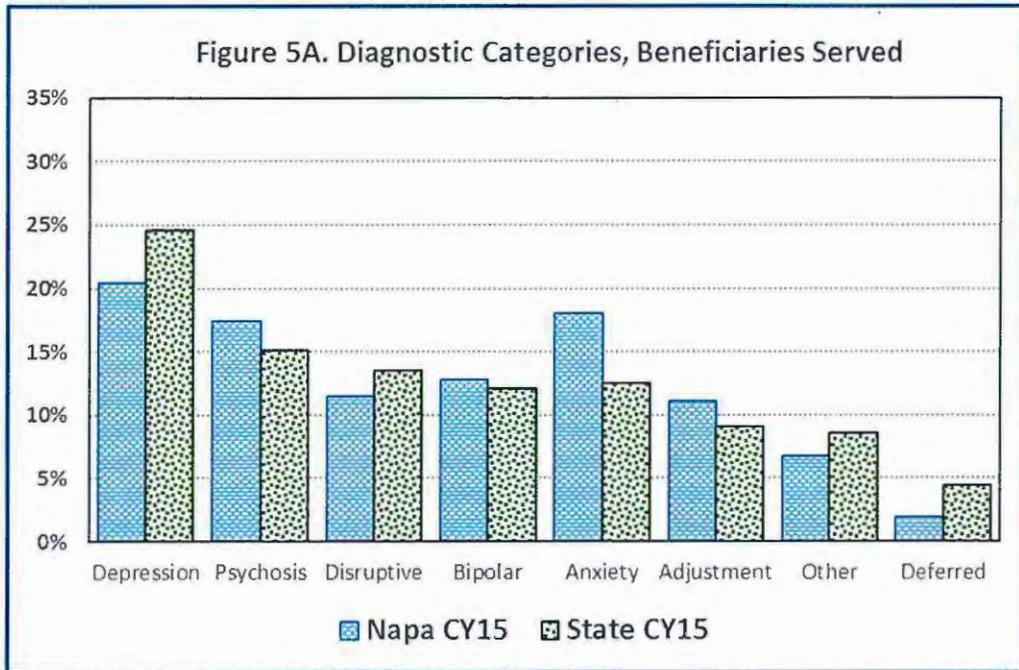
DIAGNOSTIC CATEGORIES

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

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

16%

National prevalence estimates of co-occurring substance use disorders in low-income mental health populations are approximately 35%



PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - While the MHP's traditional Medi-Cal eligibles increased from 24,074 in CY14 to 24,719 in CY15, the number of beneficiaries served decreased from 1,303 to 1,298 during this period. This correlates to a decrease in penetration rate from 5.41% in CY14 to 5.25% in CY15, both of which are still higher than the CY15 statewide rate of 4.82%.
 - The MHP's number of ACA eligibles for CY15 was 7,503 and the beneficiaries served was 303, for a penetration rate of 4.04% for this sub-group (see Table C1 of Appendix C).
 - Combining the Medi-Cal and ACA data, the MHP's CY15 total eligibles was 32,222 while beneficiaries served total was 1,601, giving the MHP a CY15 overall combined penetration rate of 4.97%.
 - The MHP's Overall penetration rate (i.e.: for traditional non-ACA Medi-Cal enrollees) remains slightly lower than the Small MHP rate and higher than the statewide rate. For CYs 12 – 15, penetration rates have equally decreased for the MHP, Small MHPs and statewide.
 - The MHP's FC penetration rate remains higher than the Small MHP rate and similar to the statewide rate.
 - The MHP's Hispanic penetration rate trails the Small MHP rate by approximately 0.70% and the statewide rate by approximately 0.20%, about equal to the disparity in CY14. CY12 showed the MHP equal, and CY13 nearly equal, to the Small MHP and statewide rates.
- Timeliness of Services
 - The MHP's 7-Day and 30-Day follow-up rates after hospital discharge for CY15 improved from CY14, and are just below the statewide rates.
- Quality of Care
 - The CY15 percentage of consumers who were HCBs is the highest in the last four years, slightly exceeding the statewide rate. The MHP's ACBs per HCB and percentage of total claims for HCBs is still below statewide averages.
 - The MHP's Overall and Hispanic ACBs have increased in each of the last four years (CY12 through CY15) and remain higher than statewide averages.
 - The MHP's FC ACB has remained relatively stable since 2013. In CY15, it is slightly higher than the Small MHP but below the statewide average.
 - The MHP's 7-Day rehospitalization rate is below and 30-Day rehospitalization rate well below the statewide rates.

- The MHP has somewhat lower percentages of consumers and total approved claims for depression than statewide averages. The MHP has somewhat higher percentages of consumers and total approved claims for Anxiety and Adjustment Disorders.
- Consumer Outcomes
 - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as “a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner.” The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2015.

NAPA 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—PIPs Submitted		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Adult Full Service Partners Social Engagement
Non-Clinical PIP	1	OLE Health to Mental Health Access Referral

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item	Item Rating*		
			Clinical PIP	Non-Clinical PIP	
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	M
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	M
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	M

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NA
		5.2	Valid sampling techniques that protected against bias were employed	NR	NA
		5.3	Sample contained sufficient number of enrollees	NR	NA
6	Data Collection Procedures	6.1	Clear specification of data	NR	M
		6.2	Clear specification of sources of data	NR	PM
		6.3	Systematic collection of reliable and valid data for the study population	NR	PM
		6.4	Plan for consistent and accurate data collection	NR	PM
		6.5	Prospective data analysis plan including contingencies	NR	PM
		6.6	Qualified data collection personnel	NR	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	PM
		8.2	PIP results and findings presented clearly and accurately	NR	PM
		8.3	Threats to comparability, internal and external validity	NR	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NA

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	NR	NA
		9.4	Statistical evidence of true improvement	NR	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NA

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

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met		11
Number Partially Met		7
Number Not Met		0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)		18
Overall PIP Rating $((\#Met*2)+(\#Partially\ Met))/(\#AP*2)$	%	80.56%

CLINICAL PIP—ADULT FULL SERVICE PARTNERS SOCIAL ENGAGEMENT

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

- “Will the implementation of interventions allow the number of adult full service partnership (FSP) consumers who report a lack of social engagement to decrease to 15%?”
- Date PIP began: November 2016
- Status of PIP:

- Active and ongoing
- Completed
- Inactive, developed in a prior year (*Not Rated*)
- Concept only, not yet active (*Not Rated*)
- Submission determined not to be a PIP (*Not Rated*)
- No PIP submitted (*Not Rated*)

The MHP found lower than accepted affirmative responses to questions related to social engagement on the CPS. The MHP's analysis of the CPS data showed that 25% of the adults who completed the survey reported that they disagreed, strongly disagreed or were neutral on four measures of engagement:

- I am happy with the friendships I have.
- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

Based on a literature search, many studies confirm the negative impact of social isolation on mental health. Therefore, the MHP has put forward a project to improve the social connectedness of its customers.

The MHP convened a workgroup, comprised primarily of staff. The MHP has since decided that they did not have enough consumer voice and they will convene four focus groups of consumers to identify barriers and eventually build a network of peer providers. The focus groups will also assist in the development of interventions and next steps in the PIP.

At the time of this review, the MHP only had one indicator, which was the percentage of adult FSP respondents who rated neutral, disagree or strongly disagree on the CPS items related to social engagement.

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 on and assistance with: rewriting the study question, making it measurable and achievable; discussing clinical interventions to be incorporated into the PIP; and, determining which survey to use and frequency of administration.

The MHP was encouraged to contact CalEQRO for further assistance as the project progressed.

NON-CLINICAL PIP—OLE HEALTH TO MENTAL HEALTH ACCESS REFERRAL

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

- “By completion of the project, will the percentage of individuals referred from OLE Health to MH Access who eventually receive MH services increase to 85%” and “Will the average number of days from referral to commencement of services decrease from 32 days to 28 days?”
- Date PIP began: April 2016
- Status of PIP:
 - Active and ongoing
 - Completed
 - Inactive, developed in a prior year (*Not Rated*)
 - Concept only, not yet active (*Not Rated*)
 - Submission determined not to be a PIP (*Not Rated*)
 - No PIP submitted (*Not Rated*)

The MHP receives referrals from OLE Health, a federally-qualified health center (FQHC) with two clinic sites in Napa. The MHP contends that they receive an unacceptably high number of referrals who do not meet criteria for mental health access services. The referral process requires the MHP to conduct a four-hour comprehensive assessment before they can be screened in or “accessed out” to a lower level of care. The high number of inappropriate referrals from OLE Health utilizes valuable clinician time and resources that could be used to actually deliver care. The goal of this PIP is to increase the percentage of individuals referred from OLE Health who eventually receive services to 85%. The secondary goal of the PIP is to decrease the latency for request for services to first appointment to 28 days; currently it takes an average of 32 days. The MHP believes that by improving the referral stream, the average days from referral to commencement of services will also decrease.

In order to facilitate these goals, the MHP has applied three interventions:

1. Notify the Care Coordinator at OLE Health at the time of the completion of the assessment that a referral to specialty services has been made.
2. Facilitate continued contact between the Care Coordinator and the referred consumer until services commence.
3. Utilize the new e-referral form and protocol to refer eligible individual to specialty mental health.

The MHP presented preliminary data, but it was only for a few months of data, and repeated measurements had not been conducted. The MHP has yet to conduct in-depth analysis of the average length of time from referral to assessment.

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 assistance to refine and improve their study question. CalEQRO also helped the MHP develop a second study question that contained measurable factors.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - By ensuring appropriate referrals to mental health from the FQHC, the MHP facilitates access for consumers that are most in need.
 - The Non-Clinical PIP will streamline the referral process and improves access through the use of e-referral forms.
- Timeliness of Services
 - By ensuring appropriate referrals from the FQHC, the MHP can provide more timely access to services for those in need.
- Quality of Care
 - The Non-Clinical PIP can improve the MHP's quality of care by ensuring that consumers receive services in the most appropriate setting.
 - The MHP will likely increase consumer engagement in treatment through the provision of a care coordinator who maintains contact with the referred individual while he/she awaits services.
- Consumer Outcomes
 - The MHP has missed another opportunity to conduct a Clinical PIP which affects consumer outcomes. The Clinical PIP on social connectedness which was rated *Concept Only* has the potential to improve outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 6, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP tracks penetration rates of enrollees by age and by ethnicity. The MHP’s penetration rates are comparable to other Small MHPs, for all ages and certain ethnicities. The MHP is part of the HHSA’s multilingual task force, which addresses issues related to staff multiculturalism and language competency. There was little evidence of the MHP evaluating the impact or continued need for events that they have facilitated. The evaluation plan from 2015 reflected activities from 2014. The MHP did not present an update to their Cultural Competency Plan from FY11-12. The MHP presented their Racial Equity Action Plan as a template for the plan.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP implements strategies to meet the needs of consumers (e.g., providing mental health training to law enforcement who are point of entry to mental health services for some consumers). The MHP collects and shares data on service utilization. MHP’s recent implementation of a system planning project demonstrates a focus on utilizing data to assess the types and numbers of practitioners and services to meet needs of consumers. The MHP’s one and only clinic is in the City of Napa and serves the majority (79%) of consumers. Some of the MHP’s partners serve the outlying areas/communities, but other areas are not directly served. The MHP has lower utilization of Case Management compared to Small MHPs and statewide. The MHP may consider increased use of case managers to extend their geographical reach and service to consumers.
1C	Integration and/or	FC	The MHP collaborates with a number of community

Table 6—Access to Care		
Component	Compliant (FC/PC/NC)*	Comments
collaboration with community based services to improve access		providers and has co-located staff (e.g., at Child Welfare Services, with law enforcement agencies, with schools). The MHP has meetings with contract and community providers. Though, not always routine (as reported by stakeholders), there are means/opportunities to collaborate with the MHP on how to better serve consumers. The MHP is in the preliminary stages of developing a Health Information Exchange with community providers.

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

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. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 7—Timeliness of Services		
Component	Compliant (FC/PC/NC)*	Comments
2A	FC	The MHP defines initial contact as the time from the access call to intake assessment and tracks this manually. The MHP’s standard is 10 business days. The MHP averages 9 days for adults and 19 days for children. Both increased from FY15-16 averages of 7 and 15 days. The MHP achieved services in 14 days 62% of the time for all services, compared to 80.57% in FY15-16.
2B	FC	The MHP’s standard for time to first psychiatry appointment is 21 days. The MHP achieved their standard 46% of the time. The MHP averages 27 days for adults and 29 days for children, which is an improvement from the previous year’s timeliness of 40 days 30 days for adults and children, respectively. The MHP investigates and addresses times in excess of the standard.
2C	NC	The MHP did not include this data in their FY16-17 Self-Assessment (nor previously in their FY15-16). The MHP states they calculate this measure from the time the consumer requests an urgent service to the time they are first contacted by the Emergency Response Team. The MHP presented general data that all urgent

Table 7—Timeliness of Services		
Component	Compliant (FC/PC/NC)*	Comments
		conditions are responded to within 24 hours. Otherwise, the MHP does not appear to track actual times to urgent response. When questioned, staff could not provide even estimates of their times to respond. Further, stakeholders reported that one hospital contends that the MHP could respond faster to urgent/crisis calls, indicating that this is an area that the MHP should track in more detail—and that 24 hours may not be an appropriate metric for urgent/crisis conditions.
2D	PC	The MHP tracks the time from hospital discharge to any contact from mental health services, including phone call, face-to-face appointment, and return to previous mental health placement. The MHP averages 4.06 days for adults and 5.71 days for children. The MHP’s standard is 7 days. Despite having a dedicated position for coordinating hospital discharge and follow-up appointments after hospitalization, the MHP achieves 67% overall compliance with this standard. This suggests the need for closer monitoring and evaluation of this measure and its tracking.
2E	FC	The MHP tracks and monitors 30-day rehospitalizations. The MHP did not report a standard, but maintains an overall rate of 10%, 10.50% for adults and 8.70% for children.
2F	PC	The MHP monitors and reviews No Shows. The MHP reported an overall No Show rate for non-psychiatrists at 12% and for psychiatrists at 22%. The No Show rate for psychiatrists exceeded the MHP’s standard of 12%. QI meeting minutes document an attempt to broach elevated No Show rate for psychiatry that was subsequently tabled when it was presented that the no show rate was below industry standard (of 25%).

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

Quality of Care

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

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	PC	The MHP performs the functions of quality management through the QI committee and the URSC. The review of services and related data extraction and review (e.g., the Mental Health Data Dashboard) appears to occur primarily in the URSC, while the QI committee is akin to a community forum. The QI Plan does not appear to guide or be well integrated with the activities of either committee (e.g., goals were not aligned to what the MHP is actually doing or intends to do). The MHP’s QI plan for the current fiscal year will be available in Spring 2017 and similarly the evaluation will be available in early Spring 2017, both of which are six months beyond or into the years to which they relate.
3B	Data are used to inform management and guide decisions	FC	The MHP collects and tracks several data that relate to service utilization and quality, many of which are captured in the Mental Health Data Dashboard (e.g., consumers by zip code, penetration rates by ethnicity, by age group, timeliness, etc.). The QI department makes regular use of Plan-Do-Study-Act cycle, to identify, address, and resolve issues, and stakeholder surveys. The MHP would do well to better indicate how the data are used to guide decisions.
3C	Evidence of effective communication from MHP administration	PC	Communication with the MHP was perceived positively by line staff, supervisors, and contract providers. These stakeholders felt that leadership made an effort to keep stakeholders informed. Conversely, consumers reported little communication with/from MHP administration, only from their case managers.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Only supervisory staff appeared to be involved in meetings and forums for system planning and decision-making. Contract providers indicated recent efforts by the MHP to involve them more (e.g., through MHP advisory committee), but communication is presently unidirectional. Line staff were unaware of the MHP’s system planning initiative that occurred over the past year. Consumers sited use of surveys and questions to provide feedback to the MHP.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	In addition to broad partnerships with community groups and providers (e.g., schools, law enforcement, hospitals, primary care providers), the HHSA was awarded a Whole Person Care grant. This positions the MHP to further integrate or strengthen relationships with other agencies to facilitate coordinated care for shared consumers.
3F	Evidence of a systematic clinical Continuum of Care	FC	The MHP has a continuum of care approach, which was further evidenced by the move to the new location

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			where services can be integrated with other HHSAs agencies that consumers access. The MHP uses evidenced-based practices and has universally adopted a measure to track outcomes for adult consumers. The MHP is working on use of the existing outcomes instruments as Level of Care/Level of Service tools.
3G	Evidence of individualized, client-driven treatment and recovery	FC	Consumers and family members indicated that they were actively involved in treatment planning. The wellness center, the Innovation Community Center, provided another opportunity for education and access to supports and education, with a focus on wellness and recovery.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The MHP has designated positions for peers at the Innovations Community Center as well as two peer positions within the MHP. The positions did not appear to have a career ladder or opportunities for advancement. The positions were neither supervisory nor reportable to executive members of the MHP.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The MHP has consumer run and driven-programs at the Innovations Community Center. Peers run all the groups and consumers can give their input during regularly scheduled groups. The center's hours complement those of the MHP.
3J	Measures clinical and/or functional outcomes of consumers served	PC	The MHP uses MORS for adults and YOQ for children. The measures are being integrated into clinical practice, but stakeholders reported that they are not at the point of using the measures for level of care decision-making.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP participates in the annual consumer survey. The MHP prepares a report on survey findings, but the report does not include any evaluation of areas for improvement, change, or modifications. The survey results are also not compared to prior surveys. The MHP does not disseminate results to line staff or contract providers

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP attempts to meet the needs and promote access to services for consumers with diverse cultural, ethnic, racial, and linguistic needs, through

- collaboration with community and contract providers, hiring of bilingual staff, and outreach to underserved populations.
- The Multi-Lingual Task Force reported on activities to facilitate access, but other activities by the MHP (e.g., to increase access by women and teens) were not reported.
- Stakeholders indicated that the MHP would benefit from bicultural staff in addition to bilingual staff.
- **Timeliness of Services**
 - Overall, the MHP has clear methodologies for tracking timeliness to services, as reported on their Mental Health Data Dashboard and also the EQRO self-assessment of timely access.
 - The MHP's timeliness to first psychiatry appointment has improved from last year, though it still exceeds the MHP's 21-day standard.
 - The MHP's tracking of urgent conditions is not granular. It does not provide the MHP with enough detail to know exactly how timely they respond and if there are issues that need addressing.
 - The MHP's rates for follow-up appointments after hospitalization and psychiatry No Shows indicate below minimum performance.
- **Quality of Care**
 - The MHP's Mental Health Data Dashboard includes many performance measurements and trending on utilization. However, the MHP publishes neither the analyses nor the recommendations based on the review of these performance measures.
 - The MHP's QI Work Plan and evaluation of previous year's QI Work Plan indicate a fiscal year cycle, but ostensibly follow a calendar year schedule.
 - The MHP's communication with and involvement of stakeholders in system planning is variable. Supervisory staff and contract providers were more involved than line staff, consumers/peers, and family members.
- **Consumer Outcomes**
 - The MHP uses outcome tools, but not systemically, and, as of yet, not to inform level of care/level of service decisions. Stakeholders reported use of the outcome measures as required to send to MHP administration, or as needed in their clinical practice.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one 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 adult beneficiaries, parents/caregivers of child/youth beneficiaries, and transitional age youth, that includes Latinos and a mix of existing and new clients who have initiated and utilized services within the past 12 months. The focus group was held onsite at the MHP.

Number of participants – 10

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

- Helpful and that the process of scheduling appointments was mindful of their time as a working parent.

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

- The relocation of the MHP, away from the town center, now presents new barriers that consumers must consider/accommodate when scheduling appointments.
- The MHP provides services in their preferred language (Spanish) without issue.

Recommendations for improving care included the following:

- Increase the number of psychiatric providers in the children's system of care.
- Establish a satellite office near the old location, such that consumers do not have to deal with the distance and the traffic.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
 - Consumers use a variety of services that the MHP provides, including individual therapy, groups, medication management, and case management.
 - Focus group participants are still adjusting to the relocation of the MHP. One consumer changed providers because of the relocation.
 - Some participants reported difficulty in accessing crisis and having to wait three days before services were rendered. One participant opted to have law enforcement intervene rather than waiting for the MHP to respond.
- Timeliness of Services
 - Participants reported long wait times for children in crisis to see a psychiatrist. Participants recommended adding one more psychiatrist for children and better turnaround time for access for children.
- Quality of Care
 - Participants felt that they have a say in their treatment. They reported that for parents/caregivers, staff consult them to complete the treatment plan for their child.
 - Participants were not familiar with and did not frequent the wellness center. But, some consumers reported that they receive services that promote independence and education support through their therapists.
- Consumer Outcomes
 - Participants did not provide information related to consumer outcomes.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 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	60%
Contract providers	35%
Network providers	5%
Total	100%

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

1%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:

Yes
 In Testing/Pilot Phase
 No

- MHP currently provides services to consumers using a telepsychiatry application:

Yes
 In Testing/Pilot Phase
 No

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

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
3	0	0	0

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

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
3	0	0	0

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

- IS and data analyst staffing remained stable during the year.
- The MHP anticipates that in 2017 the proposed new CSU contractor, Exodus, will implement telepsychiatry.

CURRENT OPERATIONS

- The MHP continues to use the Cerner Community Behavioral Health system (CCBH) as its primary EHR. The MHP is beginning to consider the need to procure a new EHR as Cerner support for the Cerner Anasazi system sunsets in 2020.
- The EHR is maintained by the county HHSA and MHP IT collaboratively.
- The MHP continues to conduct modest levels of health information exchange (HIE) via DIRECT secure messaging with the Clinic Ole FQHC in Napa. The MHP has one staff person co-located in a non-FQHC behavioral health setting at South Napa Shelter, which also houses an Ole Health Clinic. The FQHC has two locations, one of which is a satellite office at the County Campus. The MHP does not have this capacity with the Clinic OLE FQHCs in St. Helena and Calistoga, the St. Helena Community Health Clinic, nor St. Helena and Queen of the Valley Hospitals or emergency departments.
- The percentage of services provided by contractors increased almost 6% from last year.

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 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
Cerner Community Behavior Health (CCBH) Client Database	Practice Management	Cerner Corporation	9	MHP
CCBH Clinicians Homepage	Clinical Management	Cerner Corporation	9	MHP
CCBH - Managed Care	Managed Care	Cerner Corporation	9	MHP
CCHB Doctors Homepage	Medical Management	Cerner Corporation	5	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP is considering a new system.
- This consideration is because of the projected ending of Cerner Corporation support for the current Cerner Anasazi product in 2020.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH	X			
Assessments	CCBH	X			
Document imaging/storage	CCBH	X			
Electronic signature—consumer	CCBH	X			
Laboratory results (eLab)				X	

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Level of Care/Level of Service				X	
Outcomes				X	
Prescriptions (eRx)	CCBH	X			
Progress notes	CCBH	X			
Treatment plans	CCBH	X			
Summary Totals for EHR Functionality		7		3	

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

- The MHP did not implement any new functions over the review year.
- Implementation of the ERT Community Connection Network services in the EHR; and the move of the MHP to its new campus took precedence.
- During the coming year (i.e., Calendar Year 2017), implementing the new CSU with telepsychiatry may take precedence over adding greater functionality.
- Consumer’s Chart of Record for county-operated programs (self-reported by MHP):

Paper Electronic Combination

NOTE: Though the MHP’s self-reported Chart of Record is electronic, the MHP has not yet implemented e-Lab or Level of Care/Level of Service functionality in the EHR. (The MHP does use MORS scores for individual FSP consumers to make level of care decisions).

Table 14 - Napa Summary of CY15 Processed SDMC Claims							
Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
29,045	\$8,085,834	\$64,402	0.80%	248	\$8,021,432	\$136,266	\$7,885,166

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

MAJOR CHANGES SINCE LAST YEAR

- Implementation of ERT Community Connection Network/Crisis Triage services into the EHR.

- Move of the MHP to its new campus.
- Procured Ultra-Sensitive Exchange (USX).
- Server Refresh – installed new servers to handle new demands of USX.
- Implemented standardized new employee training on EHR. Created a dedicated training facility at Agency’s new campus location.

PRIORITIES FOR THE COMING YEAR

- Integrate the remaining contract providers into CCBH (most notably the new CSU contractor).
- Implement electronic prescribing of controlled substances.
- Enhance existing employee EHR training program.
- Implementation of new Progress Note functionality.
- Implementation of e-labs.

OTHER SIGNIFICANT ISSUES

- Implementing Ultra-Sensitive Exchange, including the adult MHP contractors (Progress Foundation, Mentis and Buckelew) in the EHR, enhancing existing technical training in the EHR for program staff, and implementing electronically prescribed controlled substances – were all “*Priorities for the Coming Year*” in last year’s Fiscal Year 2015 – 2016 (FY15-16) CalEQRO Report which were not completed during the current review period.
- Preparing for implementation of MHSA entry, tracking, and online upload from CCBH was a “*Priority for the Coming Year*” in last year’s FY15-16 CalEQRO Report which is not listed/continued as a priority this year. Contract providers are concerned about this lack of MHSA access. The MHP stated it was too difficult for Cerner Corporation or too costly for the MHP to include MHSA in the EHR.
- The MHP anticipates that the proposed contractor for the new CSU will implement telepsychiatry.
- Implementation of Ultra-Sensitive exchange as well as additional “*Priorities*” not currently listed will be necessary for the MHP to implement full HIE with Clinic OLE, other community health centers Queen of the Valley and St. Helena Hospitals and emergency departments, or other primary care providers in the county (such as the

Calistoga, St. Helena and Napa Migrant Farmworker Health and Housing Centers) through HIO Redwood MedNet.

- The MHP may also be ill-prepared to actively participate in the Whole Person Care Pilot without more robust interoperability or full HIE.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:
 - Monthly More than 1x month Weekly More than 1x weekly
- MHP performs end-to-end (837/835) claim transaction reconciliations:
 - Yes No

If yes, product or application:

Local SQL Database, supported by MHP/Health/County staff

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

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
 - Though contractors provide services outside the City of Napa, the county itself has no satellite clinics nor other capacity to provide services outside of Napa.
 - The MHP currently does not provide telepsychiatry or telemental health.
- Timeliness of Services
 - The Central Access and Authorization, 24/7 Line, ERT, and Medication Request for Services Logs are separate from the MHP’s EHR. The MHP states that it is either too difficult, too costly, and/or the MHP does not have a high enough priority with Cerner Corporation to have their Access logs included in the EHR.

Calculating timeliness from initial requests is labor intensive and requires ongoing review of these logs by staff.

- The MHP allows “open access” in which consumers can initially request outpatient services directly from contractors. Contractors may forward these initial service requests to the MHP Access Unit for incorporation in the MHP Access Log. However, the contractors do not have direct access to the MHP Access Logs or other EHR functionality to enter initial service requests themselves.
- Quality of Care
 - The MHP has not implemented the POMS outcome tools in the EHR.
 - It is unclear if training is currently being given on the MORS or any of the 12 POMS and whether or not the MHP has the means to determine fidelity in use of these tools.
 -
 - Among the MHP’s three adult contractors – Mentis uses the MHP’s EHR for its Medi-Cal programs, Progress House uses it for one program, and Buckelew does not use it. The MHP’s children’s contractor, Aldea, uses a Cerner Anasazi EHR that is separate from the MHP’s.
 - Alcohol and Drug Services is a separate department in HHSa from the MHP. The MHP continues to calculate low co-occurring disorders rates for consumers.
 - Further implementation of the HIE is pending due to other priorities.
 - The MHP has not yet implemented e-Lab.
- Consumer Outcomes
 - None noted.

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 to the site review.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
 - The MHP hires bilingual (Spanish) staff to facilitate access by Latino consumers. The MHP has approximately 20 bilingual clinicians and case managers.
 - The MHP prepared for and mitigated some of the impact of the relocation of the center by providing shuttle service from the city center and also promoted provision of place-based services.
- Opportunities:
 - In spite of these actions to reduce barriers to getting to the new MHP location, there are other factors to consider to further mitigate distance and traffic that stakeholders must contend with to access the MHP at its new location.
 - The MHP may benefit from better understanding of the needs of the communities in which Hispanic consumers reside and analyze the availability of after-hours/weekend appointments, transportation, and/or child care as a means to address low Hispanic penetration rate but very high Hispanic Medi-Cal enrollment.
 - The MHP should consider ways to increase capacity to serve consumers located remotely, especially in Up Valley and in American Canyon.

Timeliness of Services

- Strengths:
 - The MHP publishes clear definitions and methodologies for its timeliness measures.
- Opportunities:
 - The MHP should provide more detail for the time to response to urgent conditions, as they provide for other timeliness indicators.

- There is a need for evaluation and implementation of improvement activities for timeliness to routine appointments, rate of follow-up appointments after hospitalization, and rate of psychiatry no-shows, which have either declined or did not meet MHP's own standards.
- The MHP should examine the impact of place-based services on clinician's time and the number of consumers that staff can serve with the place-based approach versus onsite.
- The MHP should consider integrating Adult and Children's Central Access and Authorization Team, 24/7 After-Hours, Crisis Triage, and Medication Clinic Authorization Logs into CCBH EHR to facilitate facile tracking of timeliness, which currently is labor intensive.

Quality of Care

- Strengths:
 - The MHP is conducting an analysis of their service capacity.
 - Through the Whole Person Pilot, the MHP is positioned to better coordinate care and address the social determinants of health (e.g., housing) that contribute to high utilization by consumers.
 - The MHP invests in approaches that promote positive mental health and wellness. The MHP's Clinical PIP, once implemented, addresses social engagement as a tool.
 - The MHP completed their Certified Behavioral Health Clinic application to CMS which, if approved, may allow the MHP to convert its outpatient mental health system to one or more licensed community behavioral health clinics.
 - The MHP maintains a robust Mental Health Data Dashboard.
- Opportunities:
 - The MHP should review and reduce the caseloads of Spanish-speaking staff so that their caseloads are comparable to those for staff serving English-speaking consumers. The MHP should continue to explore other ways to serve Spanish-preferring consumers, for example through the use of more skilled interpreters.
 - The MHP should maintain progress on the Clinical PIP, ensuring that they are able to develop and implement a viable Clinical PIP.
 - The MHP needs to develop strategies to reliably determine co-occurring disorders in MHP consumers.
 - The MHP needs to incorporate the QI Plan into either the URSC or the QIC, such that the plan and its evaluation guide QI activities for the MHP for the entire year in question.
 - Participation in the WPC Pilot and implementing CBHCs will require robust HIE and electronic data system interoperability.

- Implement ultrasensitive exchange functionality and move towards robust implementation of HIE.

Consumer Outcomes

- Strengths:
 - The MHP seeks to use and incorporate outcome instruments to provide a standard measure to assess outcomes. The MHP has successfully done so with MORS in the adult system of care.
- Opportunities:
 - The MHP should provide training on all outcome instruments that are currently in use to ensure reliability and fidelity.
 - The MHP should analyze CPS data by program and consumer demographics and distribute findings to line staff, the public, and contract providers.

RECOMMENDATIONS

- Increase access and participation in services by monolingual/bilingual Spanish-speaking beneficiaries and ensure that this increased access does not place additional burden on the caseload of Spanish-speaking staff.
- Track and provide more detail on the time to response to urgent conditions within 24 hours.
- Incorporate the Quality Improvement (QI) Plan into the Utilization Review Steering Committee, such that the Plan guides QI activities for the entire year, and accordingly, the Plan and its evaluation are completed and rolled out in a timely manner so as to precede actual implementation of the activities therein.
- Develop strategies to accurately determine the full prevalence of co-occurring mental health and substance use disorders among all seriously mentally ill consumers served by the MHP.
- Initiate a Clinical Performance Improvement Project that is considered active and ongoing, with measurable clinical outcomes.
- Implement regular and mandatory use of the Milestones of Recovery Scale and at least one children's universal Palette of Measures outcome tool by all county and contract providers at regular intervals and begin analyzing these outcome results.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Table A1—EQRO Review Sessions - Napa 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
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Family Member Focus Group
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview –Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Wellness Center Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Ewurama Shaw - Taylor, PhD, Quality Reviewer
 Richard Hildebrand, Information Systems Reviewer
 Amy McCurry Schwartz, Esq., MHSA - EQRO Consultant
 Walter Shwe, Consumer/Family Member Consultant

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

SITES OF MHP REVIEW

MHP SITES

Napa County Mental Health
 Building A
 2751 Napa Valley Corporate Drive
 Napa, CA 94558

CONTRACT PROVIDER SITES

On The Move, 3281 Solano Avenue, Napa, CA 94558

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
William Carter	Mental Health Director	Napa County Health and Human Services - Mental Health (NC-HHS-MH)
Doug Hawker	Mental Health Manager	NC HHS-MH
Jim Diel	Mental Health Clinical Director	NC HHS-MH
Joel Mostow, MD	Psychiatric Medical Director	NC HHS-MH
Harry Collamore	Mental Health Quality Coordinator	NC HHS-MH
Courtney Vallejo	Utilization Review Coordinator	NC HHS-MH
Sandra Schmidt	Staff Services Analyst	NC HHS-MH
Felix Bedolla	MHSA Project /Ethnic Services Manager	NC HHS-MH

Name	Position	Agency
Rocio Canchola	MHSA Staff Services Analyst	NC HHS-MH
Kimberly Danner	Deputy Chief Fiscal Officer	HHS Administration
Carolina Harry	Staff Services Manager	HHS Administration
Lisa Murphy	Senior Systems Support Analyst	HHS Administration
Carolina Mariposa	Supervisor, Children and Family Behavioral Health	NC HHS-MH
Sarah O'Malley	Supervisor, Mental Health Access	NC HHS-MH
Karl Porter	Deputy Director, Quality Management/ Compliance Officer	HHS Administration
Lisa Storment	Assistant Manager, Quality Management	HHS Administration
Adriana Navarro	Supervisor, Child FSP Team	NC HHS-MH
Robin Merrill-Payne	Supervisor, Forensic Mental Health	NC HHS-MH
Amanda Jones	Supervisor, Adult FSP Team	NC HHS-MH
Vicky Huezo	Supervisor, Adult Therapy Services and Grad Student Program	NC HHS-MH
Chelsea Stoner	Assistant Deputy Director	NC HHS-CWS
Brenda Flores	Social Worker Supervisor II	NC HHS-CWS
Marti Palmer	Clinical Director	Mentis
Farrah Khabagnote	Program Director	Aldea
Bob Brown	Director, Community Support Services	Buckelew Programs
Paula Castaneda	Housing Program Manager	Mentis
Burt Hutton	Program Director, Progress Place	Progress Foundation
Barbara Reynolds	Supervisor, CFBH	NC HHS-MH
Luke Roundy	Mental Health Counselor	NC HHS-MH
Martha Alamillo	Mental Health Counselor	NC HHS-MH
Gwendolyn Dean	Mental Health Counselor	NC HHS-MH
Christina Tobie	Mental Health Counselor	NC HHS-MH
Linda Ibitz	Mental Health Counselor	NC HHS-MH
Blanca Mihedji	Mental Health Counselor	NC HHS-MH
Kevin Powers	Auditor, Quality Management	NC HHS-MH
Lola Espinoza	Mental Health Worker II	NC HHS-MH
Colleen Paul	Supervising Mental Health Counselor II	NC HHS-MH, Pathways to Wellbeing
Lorrie Weeks	Program Director	Progress Foundation

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing $n \leq 11$.

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

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	\$533,318,886	\$4,060
Small	146,642	6,478	4.42%	\$21,306,066	\$3,289
Napa	7,503	303	4.04%	\$1,510,477	\$4,985

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

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
\$0K - \$20K	1,211	93.30%	94.46%	\$5,657,210	\$4,672	\$3,553	66.88%	61.20%
>\$20K - \$30K	49	3.78%	2.67%	\$1,156,201	\$23,596	\$24,306	13.67%	11.85%
>\$30K	38	2.93%	2.86%	\$1,644,772	\$43,283	\$51,635	19.45%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

CLINICAL PIP

GENERAL INFORMATION

MHP: Napa

PIP Title: Adult Full Service Partners Social Engagement PIP

Start Date (MM/DD/YY): 11/2/16

Completion Date (MM/DD/YY): N/A

Projected Study Period (#of Months):

Completed: Yes No

Date(s) of On-Site Review (MM/DD/YY): 12/09/16

Name of Reviewer: Amy McCurry Schwartz

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): Based on a literature search, many studies confirm the negative impact of social isolation on mental health. Napa County found through analysis of their Consumer Perception Survey (CPS) that 25% of the adults who completed the survey reported that they disagreed, strongly disagreed or were neutral on four measures of engagement:

- I am happy with the friendships I have.

- I have people with whom I can do enjoyable things.
- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.

Therefore, Napa County has put forward a project with the aim of improving the social connectedness of its customers.

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?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Napa County convened a group to work on November 2, 2016 to begin this project. The initial stakeholder group consisted of only paid staff. They have since decided they did not have enough "consumer voice" and they will be convening four focus groups of consumers to identify barriers and hopefully eventually build up a network of peer providers.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	A literature review and analysis of the survey responses regarding social engagement was done, information about the use of a network of peer providers was not provided to CalEQRO.
Select the category for each PIP: Clinical: <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		Non-Clinical: <input type="checkbox"/> 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? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The causal link between social engagement and improved health outcomes could be described in more detail.

<p>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)?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>All Adult FSP patients would be included.</p>
Totals		<p>1 Met 2 Partially Met 1 Not Met 0 UTD</p>

STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> "Will the implementation of interventions, allow the number of Adult FSP consumers who report a lack of social engagement to decrease to 15%?"</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>During the on-site review, CalEQRO helped the MHP to refine the study question.</p>
Totals		1 Met 0 Partially Met 0# Not Met 0 UTD
STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	
Totals		0 Met 0 Partially Met 0 Not Met 2 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators? <i>List indicators:</i> Text</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	<p>At the time of the site visit, Napa County only had one indicator identified for this project and that is the "Percentage of Adult FSP respondents who score neutral disagree or strongly disagree on the CPS items related to social engagement." They will be working with the consumer focus groups to identify barriers, interventions and next steps in the process of this PIP.</p>

<p>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.</p> <p><input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine</p>	
Totals		<p>0 Met 0 Partially Met 0 Not Met 2 UTD</p>
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> Text</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
Totals		<p>0 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider</p> <p><input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
<p>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?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other: Text if checked</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Text Title: Text Role: Text <i>Other team members:</i> Names: Text</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Data collection for the study population and indicators was not included in the narrative provided by the MHP. The MHP cited that "data modeling for this has not yet been accomplished due to the initial unavailability of the MHSA Analyst for the kick-off meeting.</p>
Totals		<p>0 Met 0 Partially Met 6 Not Met 0 UTD</p>
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> Text</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>No further information was provided by the MHP for this PIP.</p>
Totals		<p>Met Partially Met Not Met NA UTD</p>
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	

<p>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?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>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?</p> <p><i>Limitations described:</i> Text</p> <p><i>Conclusions regarding the success of the interpretation:</i> Text</p> <p><i>Recommendations for follow-up:</i> Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		Met Partially Met Not Met NA UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>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?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		<p>Met Partially Met Not Met NA UTD</p>

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
<i>Conclusions:</i> Text	
<i>Recommendations:</i> Text	
Check one:	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible <input type="checkbox"/> Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 **NON- CLINICAL PIP**

GENERAL INFORMATION	
MHP: Napa	
PIP Title: OLE Health to Mental Health Access Referral Performance Improvement Project	
Start Date (MM/DD/YY): 4/15/16 Completion Date (MM/DD/YY): Projected Study Period (#of Months): Ongoing Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review (MM/DD/YY): 12/09/16 Name of Reviewer: Amy McCurry Schwartz	Status of PIP (Only Active and ongoing, and completed PIPs are rated): Rated <input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR) Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only. <input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP <input type="checkbox"/> No Non-Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): OLE Health (a Federally Qualified Health Center) in Napa County, located on the same campus as Napa County Mental Health, has been referring an unacceptably high number of individuals to the MHP who do not meet the criteria for receiving Mental Health Access services. Each of these referrals must be accessed through a comprehensive assessment before they can be accessed in to Mental Health Access services or "accessed out" to a lower level of care. The high number of inappropriate referrals from Ole Health is utilizing valuable clinician time and resources that could be better focused on delivering care to those who need Mental Health Access services. The goal of this PIP is to increase the percentage of individuals referred from Ole Health to MH Access who eventually receive MH services will increase to 85%. Additionally, the MHP contends that by improving the referral "stream", the average days from referral to commencement of services can decrease.	

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?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Although the MHP utilized front-line staff and those stakeholders that were involved in the day to day operation of the MHP and its partner in the PIP (Ole Health) there is no indication that consumer involvement was requested.	
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine		
Select the category for each PIP: <i>Clinical:</i> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<i>Non-Clinical:</i> <input checked="" type="checkbox"/> 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? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Although the PIP is designed to improve a process or delivery of care, the overall purpose of the PIP is to ensure that consumers receive care in the most appropriate setting possible.	
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)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP included all referrals to MH Access from Ole Health.	
Totals		3	Met 1 Partially Met 0 Not Met 0 UTD

STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> "By completion of the project, will the percentage of individuals referred from Ole Health to MH Access who eventually receive MH services increase to 85% and will the average number of days from referral to commencement of services decrease from 32 days to 28 days?"</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>During the site visit, CalEQRO worked with the MHP to refine and improve their study question. CalEQRO also helped the MHP develop a second study question that contained measurable factors.</p>
Totals		1 Met 0 Partially Met 0 Not Met 0 UTD
STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input checked="" type="checkbox"/> Other: Access Log</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Data is collected from an Excel spreadsheet Access log which is maintained by the MHP Access secretaries on a daily basis and updated in real time.</p>
Totals		2 Met 0 Partially Met 0 Not Met 0 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i> Text</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The study used a series of PDSA cycles to try to effectuate change.</p>

<p>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.</p> <p><input checked="" type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The indicators measured the process of care that referrals were made to the correct level of services and the time it took to receive those services.</p>
Totals		<p>2 Met 0 Partially Met 0 Not Met 0 UTD</p>
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> Text</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	
Totals		<p>0 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider</p> <p><input checked="" type="checkbox"/> Other: Access log (excel spreadsheet)</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The Access Log was the only data source, the use of the log was separate from the MHP's EHR and seemed wrought for human error</p>
<p>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?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The reliability of the data collection is subject to those completing the Access log.</p>
<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools</p> <p><input checked="" type="checkbox"/> Other: Access Log</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The reliability of the data collection is subject to those completing the Access log.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The first PDSA cycle was questioned by the PIP committee and the idea that workflow changes and staff changes may have influenced the results was tested after the fact.</p>

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Text Title: Text Role: Text <i>Other team members:</i> Names: Text</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	
Totals		2 Met 4 Partially Met 0 Not Met 0 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> 1: The Access Clinician will notify Ole Health Care Coordinator at the time of the completion of the assessment that a referral to specialty services has been made. 2: The Ole Health Care Coordinator with stay in contact with the referred individual to provide support until services commence. 3: Access Assessment Clinicians will utilize the new e-referral form and protocol to refer eligible individual to specialty mental health.</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The interventions measured the consumers' engagement in services and the time between referral and commencement of services.</p>
Totals		1 Met 0 Partially Met Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>1: The Access Clinician will notify Ole Health Care Coordinator at the time of the completion of the assessment that a referral to specialty services has been made. 2: The Ole Health Care Coordinator with stay in contact with the referred individual to provide support until services commence. 3: Access Assessment Clinicians will utilize the new e-referral form and protocol to refer eligible individual to specialty mental health.</p>

<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
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<p>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?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP is not far enough along for the remainder of the PIP Validation Tool. CalEQRO will expect to see these Steps completed fully during the next site visit</p>
<p>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?</p> <p><i>Limitations described:</i></p> <p>Text</p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p>Text</p> <p><i>Recommendations for follow-up:</i></p> <p>Text</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		<p>0 Met 2 Partially Met 0 Not Met 2 NA 0 UTD</p>
STEP 9: Assess Whether Improvement is "Real" Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>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?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		<p>0 Met 0 Partially Met 0 Not Met 5 NA 0 UTD</p>

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
<p><i>Conclusions:</i> This PIP has great potential, it needs more time to analyze results and determine if the interventions will truly make a difference.</p>	
<p><i>Recommendations:</i> The MHP should consider expanding the PIP to target other groups of referral sources who tend to refer inappropriately, other clinics, probation and parole.</p>	
<p>Check one:</p>	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Confidence in PIP results cannot be determined at this time
	<input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible

