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

NAPA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 12, 2018

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

INTRODUCTION

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

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Napa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Small

MHP Region — Bay Area

MHP Location — Napa

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 1,552

MHP Threshold Language — Spanish

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies for calculating PMs.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

Due to the Napa County Complex Fire, CalEQRO granted a four-month extension for the FY 2017-18 review which was subsequently held in April 2018. In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit held in December 2018, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY 2017-18

Recommendation 1: The MHP needs to have two active performance improvement projects (PIPs) that are ongoing or completed at the time of each EQR. The MHP is encouraged to seek technical assistance from CalEQRO early and often throughout the year to ensure that two active PIPs are in place.
(This recommendation is a carry-over for the past several years.)

Status: Partially Met

- The clinical PIP is considered complete as of December 2018, with minimal quantifiable results and validity. The MHP reported that numerous barriers were experienced during the implementation of this PIP including insufficient staff resources and conflicting priorities, natural disasters, and community partners dropping out and providing unpredictable and inconsistent services and data.
- The non-clinical PIP submission was determined not to be a PIP. The submission was incomplete because it did not include Step 6 (Data Analysis Plan). The write-up was a Plan-Do-Study-Act (PDSA) cycle.

Recommendation 2: System navigation improvements need to be implemented including clearer signage, maps, and beneficiary information in the form of pamphlets and verbal communication during reminder calls. The MHP should also assess the potential use of peer navigators/greeters to help beneficiaries navigate the new campus facilities.

Status: Partially Met

- Stakeholders, staff, and beneficiaries continue to report that it is difficult to navigate through the campus and access mental health and crisis services.
- While the MHP's efforts have been hampered by limitations on signage by the neighborhood association that manages the campus, the MHP has replaced confusing signage for the Crisis Stabilization Services Program (CSSP), and continues to work on additional signage in English and Spanish for the parking lots and other outpatient clinical service sites on campus.
- The MHP endorses a culture that asks all staff to provide navigation assistance on campus to anyone at all times.
- Inside the front entrance of the building, the MHP has placed a table staffed by a peer navigator to greet beneficiaries and guide them to clinical service venues. However, additional peer navigators are needed in this role.

Recommendation 3: After evaluating the percentage of claims greater than $30,000 per beneficiary and the High-Cost Beneficiaries (HCB) percentage of approved claims:

- Explain why this trend has steadily increased over the last three years; and
- Develop a plan to mitigate this increase and bring the MHP's data in line with State and large county averages.

Status: Partially Met

- The MHP has not analyzed their data on percentage of claims greater than $30,000 and HCB percentage of approved claims.
- Initial efforts are underway for analyses of cost per beneficiary served by individual county programs and contract providers, but no data are being analyzed in the aggregate.
- The new CSSP initially saw an increase in hospitalizations, which contributed to higher costs per beneficiary. However, the hospitalization rates are now trending downward, the data for which are being tracked in the data dashboard.
- The MHP reports that they are hiring a new analyst who will be responsible for analyzing this data. Also under consideration is the addition of this data on the Utilization Review Steering Committee data dashboard.

Recommendation 4: Complete installation of Cerner Community Behavioral Health (CCBH) Promotion version 224 to provide enhanced functionality with Ultra-Sensitive Exchange for ePrescribing Controlled Substances.

Status: Not Met

- The MHP is running the same version, 222.18, of the CCBH system that it was running during the prior year review.
- The MHP reported plans to implement version 229 in December 2018, which will provide a progress note enhancement.
- The MHP is still in discussion with Cerner Corporation to obtain a contract amendment for enhanced functionality with ultra-sensitive exchange for ePrescribing controlled substances.

Recommendation 5: Monitor systems performance as additional applications (e.g. Child and Adolescent Needs and Strengths [CANS]) are brought online; and measure impact of batch file uploads from contract providers to CCBH EHR system when they are initiated.

Status: Partially Met

- The MHP went live with an electronic version of CANS, as well as a paper version of the Pediatric Symptoms Checklist (PSC-35) in October 2018.
- While no system performance issues have been identified, the MHP is still in the process of determining the best way to obtain CANS and PSC-35 data from contract providers that do not have access to CCBH.

Recommendation 6: Provide contract providers with:

- Data entry and access to the CCBH EHR (for Buckelew, Progress Foundation and Ole Health).
- Formalized, prioritized meetings monthly or bimonthly, providing an open forum to collaborate and discuss centralized access, the new CSSP and emergency response, fluid access to a shared EHR, and aggregate data collection and usage, including outcomes.

Status: Partially Met

- The MHP will begin initial planning for the implementation of the Cerner Millennium EHR in March 2019. Given the time-consuming nature of bringing contract providers into the EHR, the MHP chose to cease adding additional providers into the current CCBH system.
- To support collaboration, a number of meetings are held routinely:

  - Quarterly round table meetings have been scheduled with contract providers for FY 2018-19.
  - The executive leadership of the MHP's five largest contract providers attend a meeting with the MHP every other month.
  - Various weekly meetings are held with contracted provider clinical and program staff to coordinate referrals, routine services, and crisis care.

- Contract providers state that communication with the MHP has improved in the past year.

PERFORMANCE MEASUREMENT

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

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a calendar year (CY).
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.

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[4] Public Information Links to SB 1291 Specific Data Requirements:
1. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx
2. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Napa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	9,849	29.8%	680	43.8%
Latino/Hispanic	19,012	57.6%	607	39.1%
African-American	587	1.8%	34	2.2%
Asian/Pacific Islander	1,687	5.1%	*	n/a
Native American	71	0.2%	*	n/a
Other	1,828	5.5%	200	12.9%
Total	**33,032**	**100%**	**1,552**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

All claims for December services were not yet available when CalEQRO downloaded CY 2017 data during April 2018. This represents approximately 3 to 5 percent of the total approved claims for Napa. Due to the Napa County Complex Fire, claims in October 2017 were approximately 21 percent less than the prior three-month average.

Penetration Rates and Approved Claims per Beneficiary

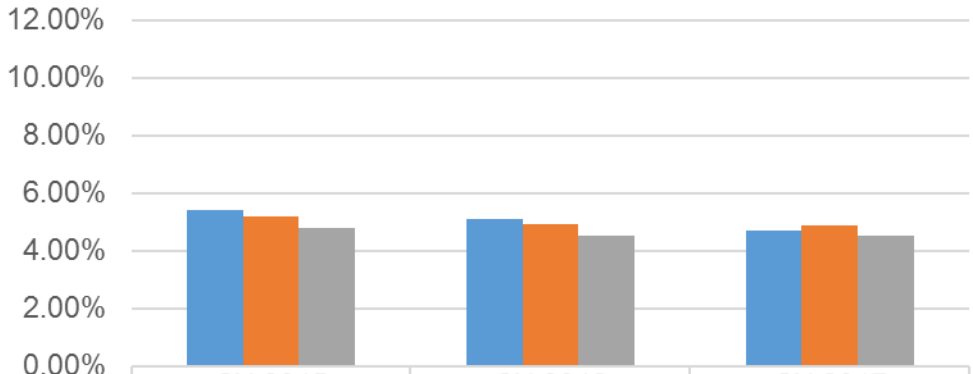
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

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

Regarding the calculation of penetration rates, the Napa MHP uses the same method used by CalEQRO.

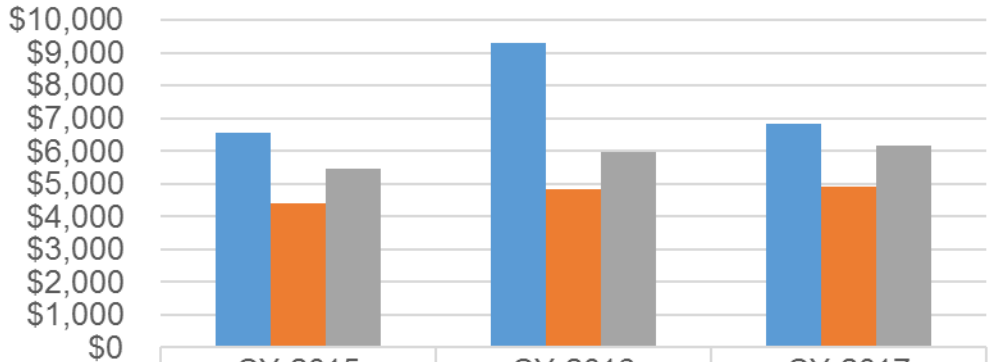
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs. CY 2017 results are incomplete as some claim transactions were not yet available when CalEQRO downloaded data files during April 2018.

Figure 1A. Overall Penetration Rates
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	5.40%	5.09%	4.70%
Small	5.19%	4.90%	4.87%
State	4.78%	4.53%	4.52%

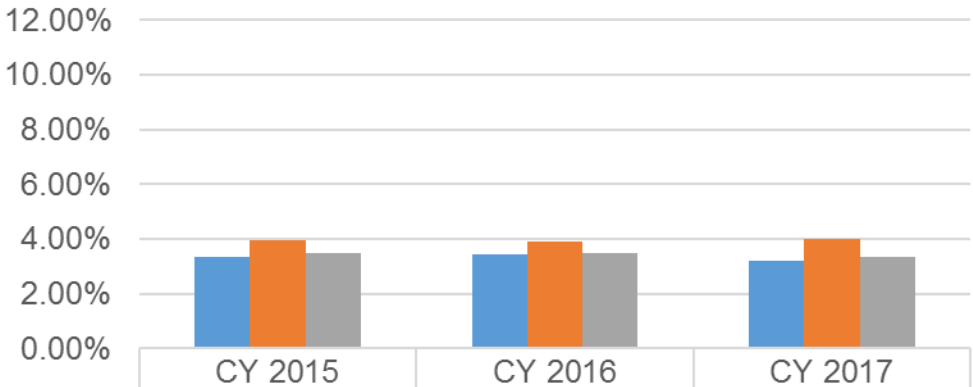
Figure 1B. Overall ACB
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	$6,551	$9,291	$6,845
Small	$4,417	$4,852	$4,895
State	$5,458	$5,978	$6,170

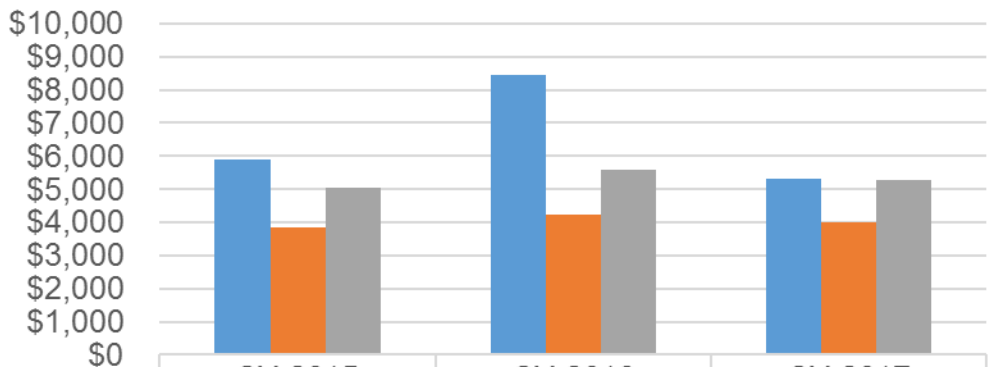
Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs. CY 2017 results are incomplete as some claim transactions were not yet available when CalEQRO downloaded data files during April 2018.

Figure 2A. Latino/Hispanic Penetration Rates
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	3.37%	3.44%	3.19%
Small	3.96%	3.92%	4.01%
State	3.50%	3.51%	3.35%

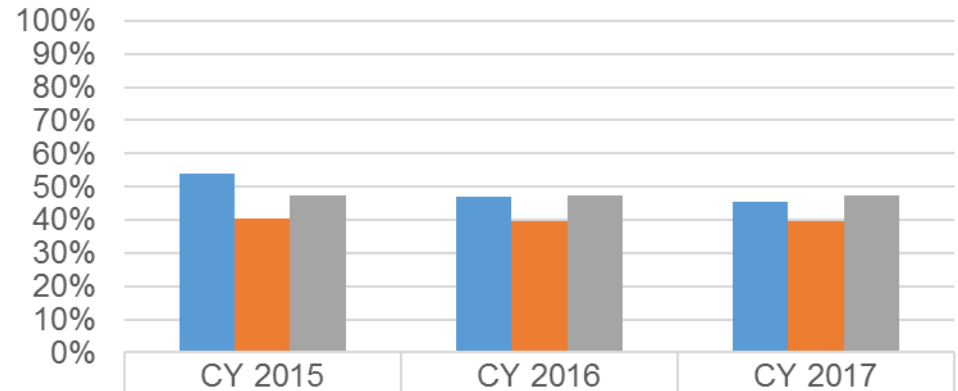
Figure 2B. Latino/Hispanic ACB
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	$5,910	$8,441	$5,308
Small	$3,857	$4,243	$3,993
State	$5,029	$5,588	$5,278

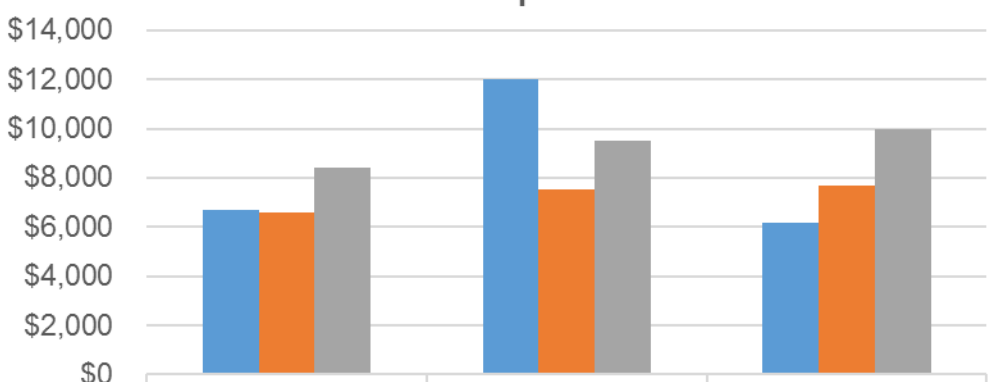
Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs. CY 2017 results are incomplete as some claim transactions were not yet available when CalEQRO downloaded data files during April 2018.

Figure 3A. FC Penetration Rates
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	54.12%	46.98%	45.45%
Small	40.42%	39.46%	39.64%
State	47.52%	47.48%	47.28%

Figure 3B. FC ACB
Napa MHP



	CY 2015	CY 2016	CY 2017
MHP	$6,685	$12,011	$6,179
Small	$6,569	$7,507	$7,671
State	$8,432	$9,521	$9,962

High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP's data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. CY 2017 results are incomplete as some claim transactions were not yet available when CalEQRO downloaded data files during April 2018.

Table 2. High-Cost Beneficiaries
Napa MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	$54,563	$1,174,305,701	31.11%
MHP	CY 2017	54	1,552	3.48%	$46,209	$2,495,291	23.49%
	CY 2016	125	1,696	7.37%	$51,624	$6,453,010	40.95%
	CY 2015	56	1,733	3.23%	$45,270	$2,535,097	22.33%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-2017) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

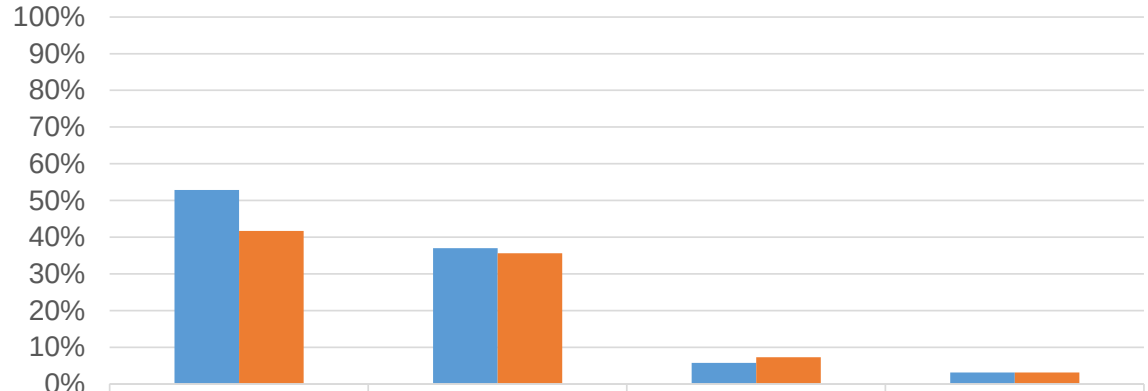
Table 3. Psychiatric Inpatient Utilization - Napa MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	102	185	7.48	$9,956	$1,015,489
CY 2016	109	179	9.24	$11,632	$1,267,883
CY 2015	99	167	7.59	$5,621	$556,521

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

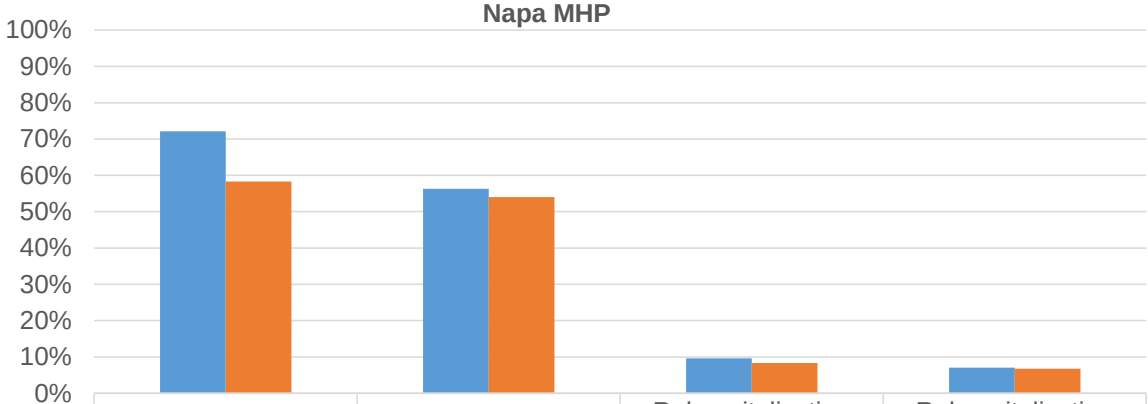
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Napa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	53%	37%	6%	3%
CY 2017	42%	36%	7%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Napa MHP



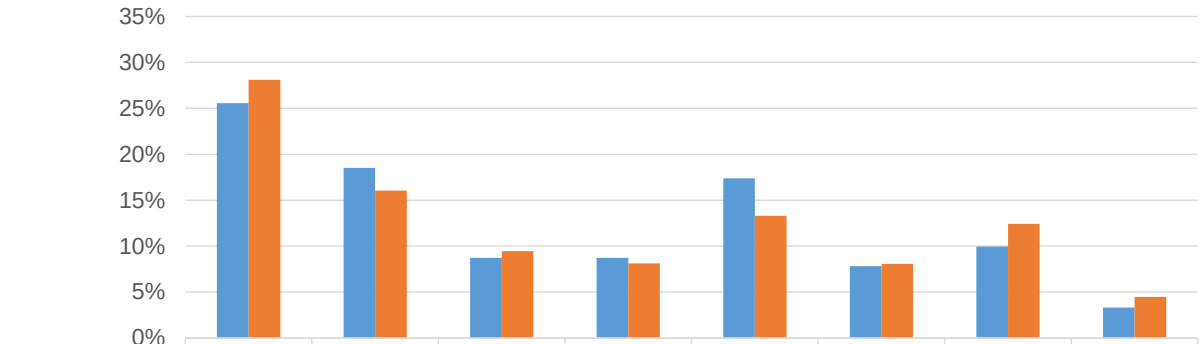
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2016	72%	56%	10%	7%
CY 2017	58%	54%	8%	7%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

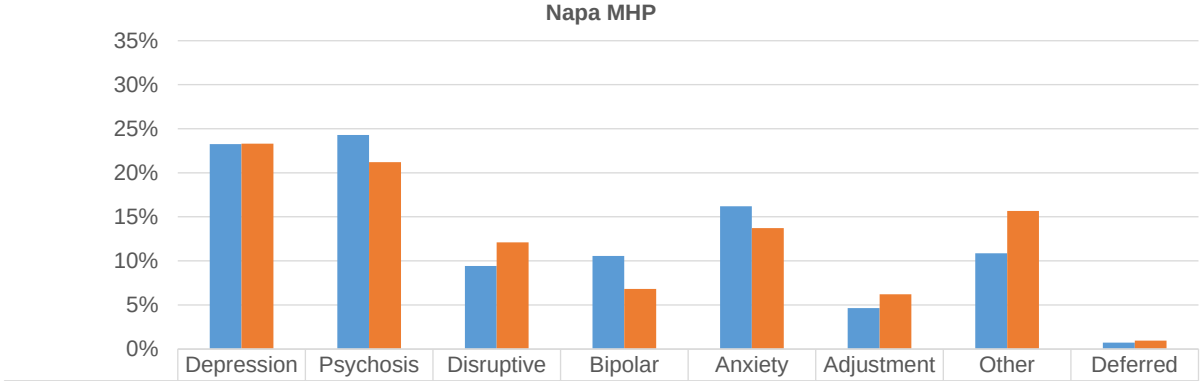
MHP self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 15n percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Napa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	26%	19%	9%	9%	17%	8%	10%	3%
State CY 2017	28%	16%	9%	8%	13%	8%	12%	4%

Figure 5B. Diagnostic Categories, Total Approved Claims
Napa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2017	23%	24%	9%	11%	16%	5%	11%	1%
State CY 2017	23%	21%	12%	7%	14%	6%	16%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Napa MHP PIPs Identified for Validation

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

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 4: PIPs Submitted by Napa MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Adult Social Engagement
Non-clinical PIP	1	Internal Referrals Timeliness

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

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

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

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

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	7	NR
Number Partially Met	12	NR
Number Not Met	7	NR
Unable to Determine	2	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	56	NR
Overall PIP Rating ((#M*2)+(#PM))/(AP*2)	**46.43%**	**0%**

Clinical PIP—Adult Social Engagement

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

"If Napa County Mental Health introduces a series of social engagement activities, particularly targeting the most isolated beneficiaries, will it increase the number of actively engaged individuals?"

Date PIP began: November 2016

End date: December 2018

Status of PIP: Completed

The goal of the clinical PIP is to align the responses of mental health beneficiaries with improved perception scores regarding their social engagement as measured by their Consumer Perception Survey (CPS) responses. This is the third year that the MHP submitted this PIP, with a slightly different write-up, which does not reflect the technical assistance (TA) and suggestions made by CalEQRO staff during the previous two onsite reviews. Last year this PIP was scored, and the previous year it was Concept Only.

Indicators and validity of future findings: During the previous review CalEQRO advised the MHP that the study methodology should have the power to detect the changes among the intended beneficiaries. Currently, the CPS methodology is generic and the sample reflects the overall adult beneficiaries. CalEQRO recommended that the MHP consider more frequent administration of CPS among the target beneficiaries; however, this was not done.

The MHP reported numerous barriers including insufficient staffing resources, natural disasters (e.g., wildfire, earthquake), and community partners dropping out and/or providing unpredictable and inconsistent services and data.

Suggestions to improve the PIP: This PIP is considered complete, with minimal quantifiable results and validity. Nevertheless, the MHP reports that the PIP has been effective in introducing the value of regular social engagement in improving the quality of life and social connectedness.

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

The TA provided to the MHP by CalEQRO consisted of a discussion on the interventions carried out and the numerous barriers experienced in implementing this PIP, as well as the suggestions made by CalEQRO in the two previous onsite reviews and the MHP's inaction in following through on them. The MHP is encouraged to initiate a new clinical PIP as soon as possible, and to seek technical assistance from CalEQRO early and often to ensure that the PIP meets the standards and requirements as per CMS Protocol 3. Potential new PIP topics discussed include improved coordination for co-occurring beneficiary referrals between mental health and substance use services and increasing the number of Katie A. non-subclass youth receiving Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) intensive services.

Non-clinical PIP—Internal Referrals Timeliness

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

"How much time does it take for people referred for services, both from access and internally, to receive an initial specialty mental health service?

- Will a new referral form and a better defined process allow us to better track the timeliness and accuracy of internal referrals?
- Will this process allow us to accurately track timeliness data and establish baselines from which we can generate goals?"

Date PIP began: August 2018

End date: N/A

Status of PIP: Submission determined not to be a PIP (not rated), and is not active.

No further information was provided on the PIP team beyond the select few staff members involved, and no peer involvement was evident. No literature search or research was reviewed in the PIP to justify the PIP topic, study question, and interventions. The PIP focused exclusively on timeliness of referrals for additional services for beneficiaries already engaged in services; however, no data were provided

to demonstrate that this is a problem. The initial referral process was never described, nor was a detailed description of the impact the referral problems were having on the child population being served (e.g., current timeliness metrics). The PIP lacks a description of the Children's Access and Referral Team, and how the team determines to which services a potential beneficiary will be referred. The initial phase of the PIP will include children and families served by the MHP, with the intention of expanding to all beneficiaries in later phases/years of the PIP. The study question as written is neither clear nor measurable, and the study question bullets do not answer the beneficiary-related initial study question. The study question does not differentiate between a PDSA cycle and a PIP. It is unclear whether sampling methods will be used for this PIP. Step 6 of the PIP was not completed; however, Step 4 does include some of the information needed for Step 6. Without a data analysis plan, the submission is determined not to be a PIP. The PIP includes only one intervention which is an assortment of steps. In addition to the PIP Development Outline, the MHP also submitted an Internal Referrals Workflow summary and diagram, a Program Referral Summary Template, and a Cycle One PDSA. However, no discussion of these documents or how they will be utilized was provided in the PIP write-up.

Suggestions to improve the PIP: A thorough description of the PIP team is needed, as is participation/input of stakeholders (e.g., beneficiaries) who are the target of the PIP outcomes. While the MHP states that no literature search or research is needed beyond the language in the MHP Contract and DHCS Information Notices (IN), the PIP does need to reflect evidence suggesting that a wait time of no more than 15 business days for new services is clinically indicated. Considerable amount of additional information and data are needed to fully describe the problem and to justify the PIP process for this topic. The study question needs to be clear and measureable. Step 6 needs to be fully completed, with a detailed data analysis plan included. Individual, specific interventions should be listed, with each able to be measured individually to determine its impact on the indicators and in terms of being able to answer the study question.

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

The TA provided to the MHP by CalEQRO consisted of a discussion on how to write a PIP and differentiate it from a PDSA cycle, as well as how to improve the current non-clinical PIP submission so it meets the requirements of a PIP. The MHP is encouraged to implement a non-clinical PIP as soon as possible and to seek TA from CalEQRO early and often to ensure that the PIP meets the standards and requirements as per CMS Protocol 3.

INFORMATION SYSTEMS REVIEW

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

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

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 2 percent.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	65%
Contract providers	35%
Network providers	0%
Total	**100%**

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Monthly
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Monthly
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
3	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2	0	0	1

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

- There has been no change in IT staffing in the past year.
- Data analytic staff includes two Staff Services Analysts. One additional Staff Services Analyst position is currently in recruitment.

Current Operations

- The MHP continues to utilize the CCBH system for practice management and EHR functionality.
- The MHP produces a data dashboard, which includes total served by age and gender. Crisis stabilization services are tracked by total served, unduplicated served, homeless, and co-occurring disorders.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
CCBH	EHR and Billing System	Cerner Corporation	11	MHP/Health and Human Services Agency
CCBH	Managed Care	Cerner Corporation	11	Cerner Corporation
CCBH	Doctors Home Page	Cerner Corporation	8	Cerner Corporation

The MHP's Priorities for the Coming Year

- Implement CCBH version 229 in December 2018. Go live with progress note refresh and complete staff training.
- Collaborate with Cerner Corporation to finalize CANS reports.
- Test CANS/PSC process with the State.
- Bring Client and Service Information (CSI) reporting current by January 2019. The last CSI file submitted was the August 2018 file. CSI files were held back while the CSI look-back expansion from 12 to 36 months was being tested and implemented.
- Continue discussions and technical analysis to permit contract provider, Aldea, to perform 837 uploads to CCBH to minimize back end data entry.
- Obtain an Electronic Prescribe of Controlled Substance (EPCS) CCBH contract amendment with Cerner Corporation.
- Develop the Implementation plan for Millennium and kick off project.
- Begin CCBH data clean up in preparation for Millennium implementation.

Major Changes Since Prior Year

- Established progress note refresh in CCBH and trained super-users.
- Signed a contract for procurement of Cerner Millennium in October 2018.
- Implemented a CSI enhancement to increase look back from 12 to 36 months.
- CANS functionality went live in CCBH in October 2018.
- Developed a new method to replicate the CCBH database environment, including creating a full backup.

- Updated notification functionality for the clinician Homepage.
- A CCBH interim service log was created for the CSSP.
- The client signature was updated on the Wellness and Recovery Plan (WRAP).

Other Areas for Improvement

- Aldea Children and Family Services, the largest children's contract provider in Napa, has their own CCBH system, which does not interface with the MHP's own CCBH system.
- Large contract providers, Progress Foundation and Buckelew, are still without access and do not have data entry capability to the CCBH system.
- Input PSC-35 outcome data into CCBH to comply with DHCS IN 18-048.
- MHP current staffing levels to support the electronic record remains inadequate. Core team leadership for Cerner Millennium project may include up to four distinct roles: the Executive Sponsor, Overall Project Director/Manager, Clinical Project Manager, and Technology Project Manager. Additional subject matter expertise to be identified and assigned as project implementation phases unfold.
- Develop a plan for contract provider organizations to be involved and informed as the Cerner Millennium project implementation begins.

Plans for Information Systems Change

- The MHP has a new system selected, but it is not yet in the implementation phase.
- Cerner Millennium was selected in October 2018. The MHP expects to go-live with Millennium by the fall of CY 2020.

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts	CCBH	X			
Assessments	CCBH	X			
Care Coordination				X	

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Document Imaging/ Storage	CCBH	X			
Electronic Signature—MHP Beneficiary	CCBH	X			
Laboratory results (eLab)				X	
Level of Care/Level of Service				X	
Outcomes	CCBH	X			
Prescriptions (eRx)	CCBH	X			
Progress Notes	CCBH	X			
Referral Management				X	
Treatment Plans	CCBH	X			
Summary Totals for EHR Functionality:		8	0	4	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0
FY 2017-18 Summary Totals for EHR Functionality:		8	0	4	0
FY 2016-17 Summary Totals for EHR Functionality:		7	0	3	0

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

- EHR functionality has remained unchanged over the past three fiscal years. The MHP has not yet achieved a fully functional EHR.
- The CANS assessment went live in CCBH in October 2018.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Local SQL database.

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 13 summarizes the MHP's SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims
Napa MHP

Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
27,093	$11,145,874	**171**	$67,170	0.60%	$11,078,704	$1,069,999	$10,008,705

Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2017 was **2.73 percent.**

- During December 2017, the MHP experienced claims submission delays that resulted in approximately 3 to 5 percent of claim transactions not being included in the below analysis for CY 2017 results.

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial Napa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed prior to submission of claim.	112	$47,836	71%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	34	$8,577	13%
Beneficiary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	17	$7,749	12%
TOTAL	171	$67,170	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with denial reason ‘description Medicare or other health coverage must be billed prior to submission of claim’ are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP

CalEQRO conducted one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 10 to 12 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift cards to thank the beneficiaries and family members for their participation.

Consumer/Family Member Focus Group One

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

The group was inconsistent with that requested by CalEQRO, as it consisted of 35 predominantly Caucasian participants, several of whom were incapable of participating due to severe mental disabilities. The focus group was held at Napa County Mental Health, 2751 Napa Valley Corporate Drive, Napa, CA 94558.

Number of participants: 35

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

- Initial access took one week to more than one month; initial therapy appointments occurred after two weeks to one month; and initial psychiatry appointments took one week to three months.
- The process of being referred from the MHP to a contract provider took a couple of months and was confusing.
- The medication clinic often cancels and reschedules appointments.
- Participants' perception was that the security guard outside of a clinical service location seems to block the entrance.
- Group therapy is required before accessing any individual therapy.
- Participants obtained information about mental health services from crisis services, family, and friends. All participants denied using the MHP's website to find information.

Participants' general comments regarding service delivery included the following:

- Routine therapy is available regularly and as needed; however, the wait time for a new case manager extended up to four months for several participants when their existing case manager resigned.
- Participants consistently reported knowing whom to call in case of urgent care needs, and had the phone number available.
- Nearly a third of participants reported having a WRAP and using it consistently.
- Participants generally felt that their cultural and language needs were met.
- Coordination between the CSSP and MHP psychiatrists is problematic, and continuity of care is experienced as a challenge. Coordination of care between psychiatrists and primary care providers was reportedly smoother.
- Staffing seems to change often, which feels unstable to participants, and makes it difficult to engage in a therapeutic alliance.
- Participants were in agreement that transportation is a significant issue, and the current county location is difficult to access since the shuttle was discontinued.
- More than half of the participants reported having completed a satisfaction survey.
- Participants commented that dairy and carbohydrates are frequently/mostly served at the peer-run café.

Participants' recommendations for improving care included the following:

- The medication support clinic needs more and consistent staffing.
- More and consistent psychiatrists are needed.
- Reinstate the shuttle to facilitate transportation to the MHP's mental health and crisis services.
- Provide more vegetable and protein options at the peer-run café. The café should accept food stamps.

Interpreter used for focus group one: Yes Language: Spanish

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 15: Access to Care Components

Component		Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	PM

The MHP newly completed a FY 2018-19 Cultural Competency Plan update that includes some current data as well as historical perspective; however, it would be helpful to provide quantifiable goals with measurable metrics, which are comparable year over year, consistent with the newly designed quality improvement (QI) work plan.

The Latino/Hispanic penetration rate has remained below statewide and small county averages for the third consecutive year.

Bilingual clinical staff reported that their skills were very helpful in serving beneficiaries and that their supervisors are very supportive. However, they also reported that there are too few of them, and that they are pulled in too many directions. At the same time, the bilingual staff are held accountable for their productivity. Staff finds it helpful to refer beneficiaries to other clinicians within the MHP as opposed to using an interpreter or the language line, which is not staffed by clinicians. American Sign Language capacity was added in the past year.

Stakeholders reported access to care challenges due to the U.S. Immigration and Customs Enforcement (ICE) Agency conducting raids in Napa County, initiated after the wildfires. The raids and threat of more raids have led to escalating rates of anxiety for beneficiaries and staff. As a result, more than 900 families (including children) dis-

Table 15: Access to Care Components		
Component		**Quality Rating**
enrolled from Medi-Cal. The MHP reported that some outreach sites, operated by contract providers, are requesting that the MHP cease activities due to these raids, making it difficult to serve the population.		
1B	Manages and adapts its capacity to meet consumer service needs	PM
Staff reported that the mass exodus of leadership, both within the MHP and the Health and Human Services Agency (HHSA), coupled with significant budget issues and hiring freeze, are anxiety-provoking and further impacting staff retention and capacity. Staff reported being informed that their positions were at-risk and their productivity was essential to ensure their continued employment, causing additional stress to the existing challenges. While the MHP currently has 5.5 filled FTE positions for prescribers, with the Medical Director position (recently vacated) seeing an addition 0.5 FTE, inadequate and continuously changing adult and children's psychiatry capacity was cited as an issue by staff, beneficiaries and contract providers. These stakeholders reported that the increased use of locum tenens has led to difficulty with communication, coordination of care, continuity of care, and building a therapeutic alliance with beneficiaries. The MHP added a new Clinical Manager position to support the Clinical Director. Staff reported increased clinical supervision compared to previous years. Contract provider staff and sub-contractors appreciated the increased amount of training to which the MHP invited them. Transportation to the MHP, for both existing and potential beneficiaries, was cited as a barrier to services. An MHP-provided shuttle from downtown Napa to the MHP was discontinued in October 2018 due to fiscal limitations. The MHP reports that the shuttle was intended to be a one-year service, but was extended for an additional year, which has now ended. The MHP is providing beneficiaries with bus passes and encouraging them to utilize the existing public transit system; however, beneficiaries report that public transportation does not provide ready access to MHP services. There are no Short-Term Residential Treatment Programs (STRTPs) in Napa County and FC youth are generally placed out-of-county.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP holds quarterly contract provider meetings. In addition, the executive leadership meets with the five largest contract providers every other month. A new		

Table 15: Access to Care Components	
Component	**Quality Rating**
request for proposals (RFP) for contract providers is moving towards competitive procurement, which includes clearly defined expectations. Napa County Mental Health participated in Sequential Intercept Mapping, embedded Forensic Mental Health resources in targeted partner co-locations (Public Defender, Probation, and Napa Police Department/Napa County Sheriff Office), and committed to the expansion of the embedded mental health staff at Napa County Detention Center (adding two FTEs, which will extend hours of on-site clinical staff until midnight seven days per week). The Mental Health Division, in response to unprecedented community critical incidents and disasters over the past four calendar years, has worked collaboratively with the Public Health Emergency Preparedness Department, California Office of Emergency Services (CalOES), the Department of Health Care Services (DHCS), and both local and regional stakeholders to develop updated disaster and critical incident response plans.	

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first offered appointment	M
The MHP has a standard of ten business days and meets this standard 100 percent of the time for both adults and children. To meet this standard the MHP maintains a walk-in clinic for initial assessments twice weekly from 8 a.m. to 1 p.m. Although this metric is tracked for the entire system of care (SOC), including both county-operated and contracted services, the MHP centralized authorization for initial access this past year.		

Table 16: Timeliness of Services Components		
Component		**Quality Rating**
The MHP tracks first kept appointment for county-operated services only, with a standard of ten business days, which was met 86.89 percent of the time for adults and 74.75 percent for children. The MHP met the standard for FC youth 60.47 percent of the time.		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
The MHP has a standard of 15 business days and met this standard 34.75 percent of the time for adults and 14.81 percent for children. This metric is tracked for county-operated services only, and therefore, does not represent the entire SOC.		
2C	Tracks and trends access data for timely appointments for urgent conditions	M
All urgent care calls received and all walk-ins to the MHP's Access Unit are transferred or walked over to the CSSP for immediate response. Call logs are used to track time (in minutes) and disposition of calls and walk-ins. Call log data from the Access Unit and the CSSP are reviewed and matched on a monthly basis. In addition, county-operated clinics provide urgent care appointments, prioritizing beneficiaries who are discharged from psychiatric hospitalizations and post-release from the Napa County Jail, where the MHP operates the Mental Health Unit.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	M
The MHP has a standard of seven business days and met the standard 83.23 percent of the time for adults and 82.76 percent of the time for children. The MHP met the standard for FC youth 75 percent of the time. This metric is tracked for the entire SOC, including both county-operated and contracted services. The Hospital Liaison follows up with beneficiaries pre- and post-discharge/release.		
2E	Tracks and trends data on rehospitalizations	M
The MHP has set a target readmission rate of less than/equal to 15 percent. The readmission rate for adults is 10.71 percent and for children is 3.13 percent.		
2F	Tracks and trends no-shows	PM

Table 16: Timeliness of Services Components	
Component	**Quality Rating**
The MHP demonstrated an improvement in the no-show rate for psychiatry appointments, at 16 percent compared to 20 percent last year and 25 percent the year before. While this metric has improved, the MHP is not yet meeting their standard. This metric is tracked for county-operated services only, and therefore does not represent the entire SOC. The MHP does not track no-show data for clinician appointments, as the majority of clinician services are place-based and not delivered in clinics during set appointments.	

Quality of Care

In Table 17, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 17: Quality of Care Components		
Component		**Quality Rating**
3A	Quality management and performance improvement are organizational priorities	PM
The MHP has an updated QI work plan developed for 2018 and an evaluation for the previous calendar year's work plan. The Quality Improvement Committee (QIC) meets monthly, has a standing agenda, and meeting minutes. In addition, a Utilization Review Steering Committee (URSC) meets monthly; however, both committees have inconsistent participation from stakeholders, including beneficiaries. The MHP does not consistently engage in a continuous quality improvement (CQI) process and QI is not integrated throughout the SOC. Rather, the QI Unit is		

predominantly focused on compliance requirements, reporting that staff resources do not allow them to do both.

The MHP had only one active PIP in the past 12 months. PIPs are not an integral part of QI; therefore, they are not linked directly to systematic improvements in clinical care and beneficiary outcomes.

3B	Data used to inform management and guide decisions	PM

Currently, the MHP has two Staff Analyst positions which are filled and a new Staff Analyst position which is vacant.

QI staff and clinical supervisors run reports to assess productivity, caseloads, date last seen for beneficiaries, final approved notes and assessments, access to services and timeliness of access, and treatment plan tracking. Additional data are needed; however, the MHP lacks analyst capacity to provide it on a regular basis.

Mentis provides quarterly reports, which reflect beneficiary outcomes, number of beneficiaries served, and their disposition. Two other adult contract providers (Progress Foundation and Buckelew) provide outcomes data. The children's contract provider, Aldea, submits quarterly reports.

Crisis stabilization services are tracked by total served, unduplicated served, homeless and dual diagnosis.

Staff reported they are spending more time completing their documentation, which takes them away from beneficiary care and services.

3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM

In the past year, the Mental Health Director, Administrative Manager, Clinical Manager and Psychiatric Medical Director positions have all been vacated. Stakeholders reported that the substantial changes in leadership are a barrier to consistency and achievement of MHP vision and goals.

Staff reported that the previous MHP Director was transparent and available. However, clinicians stated that advanced notice of program changes was not forthcoming and they did not feel they had input into the changes, which occurred frequently (e.g., weekly) without sufficient orientation and training, leading to confusion and, at times, clinically triggering beneficiaries. Staff reported that recent efforts to improve morale have been positive.

While contract provider leadership staff reported that communication has improved over the past year, overall they did not feel that they were a significant part of system planning and implementation. The relationship was akin to an employer-employee rather than a collaborative partnership. However, contract provider supervisor staff

reported a concerted effort to increase collaboration by the MHP, particularly around coordination of care.

3D	Evidence of a systematic clinical continuum of care	M

The MHP centralized authorization for initial access, removing contractor authority for new intakes and instead embedded MHP staff in contracted agencies, schools, clinics, and other sites to provide authorization. New intakes are now rerouted to the most appropriate level of care (LOC). Stakeholders recommended that staff be placed in the downtown area of Napa City to facilitate initial access for new beneficiaries.

Initial assessments are conducted by MHP clinicians on a walk-in basis and are tracked in an Excel spreadsheet. If beneficiaries are turned away twice, an appointment is provided for the third attempt to present for an initial assessment. Both beneficiaries and contract providers noted this process as a significant barrier to potential beneficiaries.

The CSSP, operated by Exodus Recovery, Inc., offers psychiatry 24/7 through telehealth as well as a medication clinic for refills. Stakeholders report that collaboration between the MHP and the CSSP continues to be challenging; that the medication clinic is difficult to use; and, the CSSP lacks space for clinicians to meet privately with beneficiaries.

Clinicians throughout the SOC reported that a feedback loop is missing to inform them of when their clients are hospitalized, making follow-up and continuity of care especially challenging.

The MHP maintains crisis residential services through Progress Place, an eight bed facility for (adult) hospital step-down and hospital diversion. The county does not have children's crisis residential.

For routine clinical appointments, stakeholders reported the need for evening and weekend scheduling for beneficiaries. Stakeholders reported that the SMI population served by the MHP is severely traumatized and periodically disruptive. While the adult SOC offers primarily group therapy, more individual therapy and focused groups are needed. Only very limited adult therapy is offered due to lack of adequate staffing and budget constraints; however, case managers provide one-on-one care. The children's SOC offers individual and family therapy.

The MHP has a referral process in place with their managed care organization (Partnership Health Plan who contracts with Beacon) and with primary care for beneficiaries to step-down to a lower LOC as needed.

Coordination and collaboration with substance use services remains challenging, as they are managed under the HHSA as a separate division from mental health. Mental health programs are needed for beneficiaries with co-occurring diagnoses.

Clinical use of evidence-based practices in various programs includes Dialectical Behavior Therapy, Strengths-based Case Management, Functional Family Therapy,

Trauma-focused Cognitive Behavioral Therapy, Child Parent Psychotherapy (CPP) and Cognitive Behavioral Therapy for Psychosis.

There are no STRTPs in Napa County and foster youth are generally placed out-of-county.

Napa County does not host mobile crisis services and there are no plans for mobile crisis due to budget constraints. However, professional staff including a dedicated Licensed Practitioner of the Healing Arts (LPHA) respond to community crises and as appropriate do ride-alongs with law enforcement.

Stakeholders report the need for more long-term lower levels of care within the county to step-down beneficiaries from more intensive services.

Stakeholders recommended that exit interviews be facilitated with beneficiaries at time of discharge.

3E	Evidence of peer employment in key roles throughout the system	M

The MHP has one FTE Peer Support Specialist position and a 0.5 FTE extra-help Family Partner position to assist with community outreach and engagement and the Full Service Partnership (FSP) program. However, the MHP does not provide a defined career ladder. Stakeholders reported that there are not enough Peer Support Specialists and those that exist are not adequately supported.

Innovations Community Center has a career ladder for peer staff who start as interns, then move to peer mentors, and eventually to floor staff and floor supervisors. The parent organization, On the Move, has peer positions to which beneficiaries can be promoted.

3F	Peer-run and/or peer-driven programs exist to enhance wellness and recovery	M

Innovations Community Center is open for drop-in Monday through Friday 8 a.m. to 4 p.m., and is well attended. Many different classes are available including art, yoga, mental health coping, and others. Classes are available in English and Spanish. Lunch is served daily.

Stakeholders recommended that specific, focused classes and times be made available for the acute SMI population, and that staff training be provided to better communicate with this group of beneficiaries who need socialization and more accessible, simplified activities.

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

The CANS went live in CCBH in October 2018; however, no reports are available to date, and the MHP reported that no decisions have been made as to how the data will be utilized.

The PSC-35 is being implemented in paper format and subsequently scanned into the EHR.

The Milestones of Recovery Scale (MORS) is utilized as an adult outcome tool; however, there is no policy stating the interval at which this tool should be administered. MORS data is entered into Anasazi, but the MHP lacks a data analyst to routinely aggregate and analyze it.

3H	Utilizes information from Beneficiary Satisfaction Surveys	M

The MHP implements the statewide CPS twice a year and analyzes the data as it is received. Data are shared in QIC meetings and with providers. The MHP set a target that 85 percent of survey questions will be ranked satisfied to very satisfied, and they met this target for most of the categories.

The MHP completed a PIP that utilized CPS data (perception of social connectedness domain) ranked at 76 percent in an attempt to improve overall scores.

Mental Health Services Act (MHSA) staff completed a three-year evaluation, including focus groups with contract providers, community members and other stakeholders. Issues raised included communities were not aware of the range and scope of services available and the need for housing. A full report is being drafted and will be shared with the public.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Napa MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Submission determined not to be a PIP (not rated)

Recommendations:

- As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. *(This recommendation is a carry-over from FY 2016-17 and FY 2017-18)*
- The MHP should seek technical assistance from CalEQRO early and often to ensure that the two new PIPs meet the standards and requirements as per CMS Protocol 3.

Access to Care

Changes within the past year:

- An MHP-provided shuttle from downtown Napa to the MHP was discontinued in October 2018 due to fiscal limitations.

Strengths:

- The MHP centralized authorization for initial access by removing contractor authority for new intakes and embedding MHP staff in contracted agencies, schools, clinics, and other sites to provide authorization. New intakes are now rerouted to the most appropriate level of care.
- Bilingual clinical staff reported that their skills were very helpful in serving beneficiaries, and that their supervisors are very supportive.

Opportunities for Improvement:

- Stakeholders, including staff and beneficiaries, continue to report that it is difficult to navigate through the campus and access mental health and crisis services. A recommendation for this issue can be found in the Carry-over and Follow-up Recommendations from FY2017-18 below.

- Transportation to the MHP, for both existing and potential beneficiaries, was cited as a barrier to services.
- The Hispanic penetration rate has remained below statewide and small county averages for the third consecutive year. However, due to the Napa County Complex Fire, claims in October 2017 were approximately 21 percent less than the prior three-month average.
- Initial assessments are conducted by MHP clinicians on a walk-in basis and are tracked in an Excel spreadsheet. If beneficiaries are turned away twice, an appointment is provided for the third attempt to present for an initial assessment.

Recommendations:

- To reduce the transportation barrier for both existing beneficiaries and those accessing initial assessments for service, examine all transportation options, including the discontinued shuttle service.
- Assess the potential for staff to be placed in the downtown area of Napa City to facilitate initial access for new beneficiaries.
- Evaluate whether the new centralized walk-in system for initial assessments is a barrier to access and develop and implement an improved strategy as needed.
- Address staff and provider capacity issues by expediting the filling of all vacancies.
- Assess and, if possible, implement evening and weekend scheduling for beneficiaries.
- Develop and implement an assessment tool to quantify beneficiaries with co-occurring diagnoses, and streamline the referral process between mental health and SUD services.

Timeliness of Services

Changes within the past year:

- None noted

Strengths:

- The Hospital Liaison follows up with beneficiaries pre- and post-discharge from a psychiatric hospitalization.
- The MHP has a standard of ten business days for timeliness of initial request to first offered appointment, and met this standard 100 percent of the time for both adults and children due to the new walk-in clinic for initial assessments.

- The MHP has a standard of seven business days for timely access to follow-up appointments after hospitalization and met the standard 83.23 percent of the time for adults and 82.76 percent of the time for children. This metric is tracked for the entire SOC, including both county-operated and contracted services.

Opportunities for Improvement:

- Three of the six timeliness metrics are tracked only for county-operated clinics/facilities and therefore do not reflect the entire SOC.
- The MHP tracks and trends access data from initial contact to first offered psychiatric appointment, with a standard of 15 business days and met this only 34.75 percent of the time for adults and 14.81 percent for children.

Recommendations:

- Expand tracking of timeliness metrics to consistently include all contracted services in order to reflect the entire SOC in the aggregate.
- Explore reasons for the low percent of adult and children's appointments that met the 15-day standard from initial request to first offered psychiatry appointment and implement intervention(s) to improve the timeliness of this metric.

Quality of Care

Changes within the past year:

- None noted.

Strengths:

- The MHP updated its Cultural Competency Plan for FY 2018-19.
- The MHP added a new Clinical Manager position to support the Clinical Director, and staff reported increased clinical supervision compared to previous years.
- The MHP added a Staff Analyst position, which is currently being filled.

Opportunities for Improvement:

- The MHP does not consistently engage in a CQI process, and QI is not integrated throughout the SOC. Rather, the QI Unit is predominantly focused on compliance requirements.
- PIPs are not an integral part of QI. PIPs are not linked directly to systematic improvements in clinical care and beneficiary outcomes.
- The newly completed FY 2018-19 Cultural Competency Plan would benefit from the inclusion of quantifiable goals with measurable metrics.

- Staff reported they are spending more time completing their documentation, which is taking them away from beneficiary care and services.
- Staff stated that advanced notice of program changes was not forthcoming, and that they did not feel that they had input into the changes, which occurred frequently and without sufficient orientation and training.
- Stakeholders report that collaboration between the MHP and the CSSP continues to be challenging; that the medication clinic is difficult to use; and, the CSSP lacks space for clinicians to meet privately with beneficiaries.
- Clinicians reported that a feedback loop is missing to inform them of when their clients are hospitalized, making follow-up and continuity of care especially challenging.

Recommendations:

- Engage in a CQI process, integrating QI and PIPs throughout the SOC.
- Examine the volume of documentation required by clinical staff and implement minimum necessary documentation standards that meet DHCS requirements.
- Facilitate staff input into system and program changes and provide advanced notice of, orientation to, and training for program changes.
- Assess the difficulties beneficiaries are experiencing with utilizing the medication clinic and develop and implement a plan to address these issues.
- Ensure that adequate private meeting space is available for clinicians to meet with beneficiaries in the CSSP facility, and that clinicians are aware of it.
- Ensure that provider staff are consistently using the feedback loop so clinicians are informed when their clients are hospitalized.

Beneficiary Outcomes

Changes within the past year:

- The MHP implemented the CANS and PSC-35 clinical outcomes measures in October 2018.

Strengths:

- Innovations Community Center has a career ladder for peer staff who start as interns and can be promoted upwards.

Opportunities for Improvement:

- Stakeholders reported that there are not enough Peer Support Specialists and those that exist are not adequately supported.

- Specific, focused classes and times need to be made available for the acute SMI population, and staff need training to better communicate with this group of beneficiaries who need socialization and more accessible, simplified activities.

Recommendations:

- Assess and, if possible, create and fill additional Peer Support Specialist positions within the MHP.

Foster Care

Changes:

- A Therapeutic Foster Care (TFC) RFP has been initiated with at least two interested children's SOC providers who appear to meet criteria for both history of providing ESPDT services and establishment as a Foster Family Agency (FFA). It is anticipated that one or more of these providers will have an established contract by early 2019.

Strengths:

- The MHP established a Continuum of Care Reform (CCR) inter-county meeting with all Bay Area counties. The group meets regularly to discuss and formalize processes and coordination efforts for presumptive transfers.
- The MHP received notification from DHCS that they can now begin claiming for TFC services.
- Both Child Welfare Services (CWS) and Probation staff explicitly stated that their working relationships with the MHP were very positive, with open communication and sharing of responsibilities so agencies can serve youth more effectively.
- Timeliness metrics for FC youth tracked by the MHP include initial access to first offered and first kept appointment, urgent appointments, seven-day follow-up post-hospitalization, rehospitalizations, and no-shows for psychiatry appointments.

Opportunities for Improvement:

- FC claiming data is decreasing steadily as there are no STRTPs in Napa County (the MHP stated that this was due to the fact that the cost of land and housing was prohibitive), and therefore foster youth are generally placed out-of-county. CWS is presumptively transferring many children out of Napa County for this reason.
- Napa County lacks crisis residential and in-patient hospitalization facilities for children.

- The MHP is aware of, but not yet systematically implementing and tracking medication and metabolic monitoring data for FC youth as per SB 1291 SDSS and HEDIS measures.

Recommendations:

- Systematically implement and track medication and metabolic monitoring data for FC youth as per SB 1291 SDSS and HEDIS measures.

Information Systems

Changes within the past year:

- While not yet in the implementation phase, the MHP selected a new EHR, Cerner Millennium.

Strengths:

- The CANS is now in the CCBH system.

Opportunities for Improvement:

- Contract provider access to CCBH is limited.
- CANS reports are not yet available.

Recommendations:

- Involve contract provider organizations in the implementation planning process for the implementation of Cerner Millennium, including a target date for contract provider access to Millennium.
- Continue collaboration with Cerner Corporation to create CANS reports.

Structure and Operations

Changes within the past year:

- Mental Health Division and HHSA Management changes:
    - Over the course of the past year the Mental Health Division experienced, and is still in the middle of a 100 percent turnover of its management team, including the Mental Health Director, Administrative Manager, Clinical Manager and Psychiatric Medical Director. One of the two Mental Health Analyst positions was vacated and subsequently filled, and recently a new Mental Health Analyst position has been created using state funds. The Mental Health Division made key staffing changes that included promoting the Quality Assurance/Utilization Review Clinician Counselor to the recently vacated Utilization Review Coordinator position, and a large number of staff reassignments related to budget constrictions.

  - Simultaneously, the HHSA lost its Director, Compliance Officer (who serves as the Mental Health Compliance Officer), Privacy Officer, Child Welfare Services Director, Quality Management Division Director, and many of the Quality Management staff.

- During the past 18 months, county leadership engaged with over 4,000 community members to develop the 2019-2022 DRAFT Strategic Plan.
- CSI look-back capability has been expanded from 12 to 36 months.
- The MHP has prepared for and is participating in several evaluations over a five-month span: 1) DHCS Triennial review in November 2018; 2) CalEQRO review in December 2018; 3) DHCS MHSA review in January 2019; 4) DMC-ODS CalEQRO review in March 2019. In addition, considerable resources have been spent on implementing requirements for the CMS Final Rule, and on emergency response to the wildfires in Northern California.

Strengths:

- The MHP's denied claims rate is lower than the statewide average.
- A new RFP for contract providers is moving towards competitive procurement, and it includes clearly defined expectations.

Opportunities for Improvement:

- As the MHP proceeds with the Cerner Millennium implementation, project sponsorship should be delegated to a senior executive level staff to support the implementation team and provide capacity for timely response for future contract amendments.
- Stakeholders reported that the substantial changes in leadership are a barrier to consistency and achievement of MHP vision and goals.
- Comply with DHCS IN 18-048 to implement processes and submit CANS and PSC-35 outcome data to DHCS as the system becomes available.

Recommendations:

- Work with Cerner Millennium to assure that the project core team includes an Executive Sponsor, Project Director/Manager, Clinical Project Manager, and Technology Project Manager. The Executive Sponsor role should be a senior executive level individual with authority to approve Millennium contract amendments to support business decisions as the project unfolds.
- Develop and implement workflow processes to submit CANS and PSC-35 data monthly to DHCS to comply with IN 18-048.

Summary of Recommendations

FY 2018-19 Recommendations:

- Seek technical assistance from CalEQRO early and often to ensure that the two new performance improvement projects (PIPs) meet the standards and requirements as per CMS Protocol 3.
- Examine all transportation options, including the discontinued shuttle service, to reduce the transportation barrier for both existing beneficiaries and those accessing initial assessments for service.
- Assess the potential for staff to be placed in the downtown area of Napa City to facilitate initial access for new beneficiaries.
- Evaluate whether the new centralized walk-in system for initial assessments is a barrier to access, and develop and implement an improved strategy as needed.
- Address staff and provider capacity issues by expediting the filling of all vacant positions.
- Assess and, if possible, implement evening and weekend scheduling for beneficiaries.
- Streamline the referral process between mental health and substance use disorders (SUD) services.
- Develop and implement an assessment tool to quantify beneficiaries with co-occurring diagnoses.
- Expand tracking of timeliness metrics to consistently include all contracted services in order to reflect the entire SOC in the aggregate.
- Explore reasons for the low percent of adult and children's appointments that met the 15-day standard from initial request to first offered psychiatry appointment and implement intervention(s) to improve the timeliness of this metric.
- Engage in a CQI process, integrating QI and PIPs throughout the SOC.
- Examine the volume of documentation required by clinical staff and implement minimum necessary documentation standards that meet DHCS requirements.
- Facilitate staff input into system and program changes and provide advanced notice of, orientation to, and training for program changes.
- Assess the difficulties beneficiaries are experiencing with utilizing the medication clinic and develop and implement a plan to address these issues.

- Ensure that adequate private meeting space is available for clinicians to meet with beneficiaries in the CSSP facility, and that clinicians are aware of it.
- Ensure that provider staff are consistently using the feedback loop so clinicians are informed when their clients are hospitalized.
- Assess and, if possible, create and fill additional Peer Support Specialist positions within the MHP.
- Involve contract provider organizations in the implementation planning process for Cerner Millennium including a target date for contract provider access to Millennium.
- Continue collaboration with Cerner Corporation to create Child and Adolescent Needs and Strengths assessment (CANS) reports.
- Work with Cerner Millennium to assure that the project core team includes an Executive Sponsor, Project Director/Manager, Clinical Project Manager, and Technology Project Manager. The Executive Sponsor role should be a senior executive level individual with authority to approve Millennium contract amendments to support business decisions as the project unfolds.

FY 2018-19 Foster Care Recommendations:

- The MHP should systematically implement and track medication and metabolic monitoring data for foster care youth as per SDSS and HEDIS measures.

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

- As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.
- Implement system navigation improvements including clearer signage, maps, and beneficiary information in the form of pamphlets and verbal communication during reminder calls. Additional Peer Support Specialists are needed to greet beneficiaries inside the front entrance of the MHP campus and guide them to clinical service venues.
- After evaluating the percentage of claims greater than $30,000 per beneficiary and the High Cost Beneficiaries (HCB) percentage of approved claims:
    - Explain why this trend has steadily increased over the last three years; and
    - Develop a plan to mitigate this increase and bring the MHPs data in line with State and large county averages.

- Obtain a contract amendment with Cerner Corporation and implement functionality for Ultra-Sensitive Exchange for ePrescribing Controlled Substances.
- Monitor systems performance as additional applications (e.g. CANS) are brought online; and measure impact of batch file uploads from contract providers to CCBH EHR system when they are initiated.
- Provide contract providers with data entry and access to the CCBH EHR (for Buckelew, Progress Foundation, and Ole Health).

SITE REVIEW PROCESS BARRIERS

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

- The consumer and family member focus group had 35 participants rather than the requested 10 to 12 participants, making it difficult to cover the necessary range and depth of topics.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions – 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
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Consumer Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Family Member Focus Group
Consumer Employee/Peer Employee/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Wellness Center Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Della Dash, Senior Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Laura Bemis, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

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

Contract Provider Site

Innovations Community Center
3281 Solano Avenue
Napa, CA, 94558

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Ahearn	Kerry	Chief Executive Officer	Aldea Children and Family Services
Bedolla	Felix	MHSA Coordinator/Ethnic Services Manager	Napa County Mental Health
Brown	Bob	Director, Mental Health Services	Buckelew Programs
Burch	Craig	Chief Deputy Probation Officer	Napa County Probation
Butler	Mary	Acting Director	Napa County Health and Human Services Agency
Cahill	Valerie	Supervising Mental Health Counselor II	Napa County Mental Health
Castaneda	Paula	Housing Program Manager	Mentis
Chang	Meena	Program Director	Exodus Crisis Support Services Program
Chase	Catherine	Assistant Director	Napa County Child Welfare Services
Coad	Steven	Peer Mentor, Janitor	Innovations Community Center
Collamore	Harry	Mental Health Quality Coordinator	Napa County Mental Health
Diel	Jim	Interim Mental Health Director	Napa County Mental Health
Esqueda	Liset	MHSA Staff Services Analyst	Napa County Mental Health
Geyer	Zachariah	Mental Health Worker Aide	Napa County Mental Health
Gibbons	Sadania	Mental Health Utilization Review Coordinator	Napa County Mental Health
Harry	Carolina	Assistant Manager	Napa Health and Human Services
Hernandez	Ana	Senior Director, Behavioral Health	Aldea Children and Family Services
Hernandez	Elizabeth	Director, Program Administration	Progress Foundation

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Huezo	Vicky	Supervising Mental Health Counselor II	Napa County Mental Health
Hutten	Burt	Program Director	Progress Foundation
Jones	Amanda	Supervising Mental Health Worker	Napa County Mental Health
Lawrence	Lynette	Provider Services Coordinator	Napa County Mental Health
Leiva-Gullord	Mirna	Bilingual Peer Support	Innovations Community Center
Lewis	Shauna	Peer Mentor, Floor Supervisor	Innovations Community Center
Mares	Claudia	Program Director	Buckelew Programs
Mariposa	Carolina	Supervising Mental Health Counselor II	Napa County Mental Health
Navarro	Adriana	Supervising Mental Health Counselor II	Napa County Mental Health
O'Malley	Sarah	Mental Health Clinical Manager	Napa County Mental Health
Powers	Kevin	Quality Management Utilization Review Coordinator	Napa County Health and Human Services
Salvatore	Theresa	Assistant Deputy Director	Napa County Alcohol and Drug Services
Schmidt	Sandra	Mental Health Staff Services Analyst	Napa County Mental Health
Tirado	Sara T.	Information Services Coordinator	Innovations Community Center
Vallejo	Courtney	Mental Health Administrative Manager	Napa County Mental Health
Weiss	Rob	Executive Director	Mentis
Zamora	Erin	Compliance Supervisor	Aldea Children and Family Services

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Napa MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	$703,932,487	$4,782
Small	175,611	7,175	4.09%	$27,856,376	$3,882
MHP	8,721	307	3.52%	$1,562,213	$5,089

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band
Napa MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	1,429	92.07%	93.38%	$6,454,869	$4,517	$3,746	60.76%	56.69%
>$20K - $30K	69	4.45%	3.10%	$1,673,812	$24,258	$24,287	15.76%	12.19%
>$30K	54	3.48%	3.52%	$2,495,291	$46,209	$54,563	23.49%	31.11%

Attachment D—List of Commonly Used Acronyms

Table D1 - List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1 - List of Commonly Used Acronyms	
IHBS	Intensive Home Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1 - List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Napa	
PIP Title: Adult Social Engagement	
Start Date: November 2016 **Completion Date**: December 2018 **Projected Study Period**: 25 Months **Completed**: Yes ☒ No ☐ **Date of On-Site Review**: December 12, 2018 **Name of Reviewer**: Della Dash	**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: The goal of this clinical PIP is to align the responses of mental health beneficiaries with improved perception scores regarding their social engagement as measured by their CPS responses. This is the third year the MHP submitted this PIP, with a slightly different write-up which does not reflect the technical assistance and suggestions made by CalEQRO staff during the previous two onsite reviews. Last year this PIP was scored, and the previous year it was Concept Only.	

Indicators and validity of future findings: During the previous review CalEQRO advised the MHP that the study methodology should have the power to detect the changes among the intended beneficiaries. Currently, the CPS methodology is generic and the sample reflects the overall adult beneficiaries. CalEQRO recommended that the MHP consider more frequent administration of CPS among the target beneficiaries; however, this was not done.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP lists the project team, and includes MHP staff, community partners, and peers. The MHP convened beneficiary focus groups to solicit ideas and guidance on how to proceed, including interventions, once the PIP topic was identified.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP found, through analysis of their CPS, that 25 percent 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. This PIP aims to reduce social isolation and improve social engagement among the adult beneficiaries receiving mental health services.

Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP only addresses the perception of social isolation and associated risks for severely mentally ill beneficiaries in general, but does not target those who are the focus of this PIP, as recommended by CalEQRO during the previous review.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other: Socially isolated adult FSP beneficiaries	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The focus during CY 2018 shifted to Adult FSP clients at the Fresh Start Housing Program in coordination with Community, Caring Compassion, Inc. (CCC), a non-contracted community partner that is peer led. Fresh Start was chosen as the focal point because the design of the program is to serve the highest acuity clients in the MHP who are known to be the most isolative and least socially engaged members of the community.
	Totals	**2 Met** **2 Partially Met** 0 Not Met 0 UTD

STEP 2: Review the Study Question		
2.1 Was the study question stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "If Napa County Mental Health introduces a series of social engagement activities, particularly targeting the most isolated beneficiaries, will it increase the number of actively engaged individuals?"	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question as written is not measurable and needs to include a quantifiable measure from x percent to y percent (e.g., from 30 percent to 50 percent).
	Totals	0 Met **1 Partially Met** 0 Not Met 0 UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other: Socially isolated adult FSP beneficiaries	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP included socially isolated adult FSP beneficiaries in the Fresh Start Housing Program, as described above. There is a very small number of participants (n=13) resulting in difficulty demonstrating statistical significance. The total number of socially isolated adult FSP beneficiaries was not identified. In addition, the CPS tool is not specific to the adult FSP population, but rather includes a sampling of all MHP beneficiaries, making the results difficult to apply to the study population.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Adult FSP beneficiaries in the Fresh Start Housing Program	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP did not identify all current adult beneficiaries who are socially isolated, but instead used the approximate number of adult enrollees in 2015-16. In addition, of the total enrollees (approximated at 750), only 13 were included in the study.
	Totals	0 Met **1 Partially Met** **1 Not Met** 0 UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. CPS social engagement aggregated score 2. Number of beneficiary focus groups 3. Number of attendees at social activity groups 4. Planned social activities that are attended 5. Number attendees at other social gatherings 6. Number of times the activity trailer is used 7. Number of attendees who participate in activity trailer	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP listed several process and impact indicators, several of which are proxies for reduction in social isolation. However, because of the lack of identification of those with social engagement challenges, the measures remain generic, and consequently, the MHP found it challenging to detect success among the intended target population.

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 beneficiary-focused. ☐ Health Status ☐ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	Only the CPS score changed across the sample who responded, regardless of whether the respondent was a recipient of the intervention. Therefore, there is no way to tell if the intervention was, in fact, causing the change in scores, if any occurred. Data collection should occur monthly with the ability to establish pre- and post-intervention findings.
	Totals	0 Met **1 Partially Met** **1 Not Met** 0 UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP provided the estimated sample size of the possible respondents to CPS, but not the sample size of the recipients of the interventions in relation to the population eligible for interventions.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP follows the state guidelines on the CPS, and the methodology may suffer from seasonal and self-selection biases. If CPS is the main indicator to measure beneficiary-level impact, the MHP should consider more frequent administration of the measure, and specifically for the target program sites such as the wellness center before and after intervention activities take place, and track monthly to detect continued impact.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP has not received the CPS data back that shows the post-intervention valid sample size of respondents. Based on past administration experience, the MHP estimates approximately 12 to 19 percent return rate. At the time of the review CalEQRO was unable to determine the sample size.
Totals	0 Met 0 Partially Met **3 Not Met** 0 NA 0 UTD	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Responses to the key four items on the Consumer Perception Survey will “Agree” or “Strongly Agree” at least an 85 percent aggregated score. In addition, the MHP is tracking intervention completion and participant attendance numbers as indicators for this PIP.
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☐ Met ☒ Partially Met	CPS data are collected and analyzed, and after clean-up and review by DHCS, the results are then made available to the MHP for further analysis.

☒ Member ☐ Claims ☐ Provider ☒ Other: CPS	☐ Not Met ☐ Unable to Determine	However, it is unclear why the MHP is relying solely on data which takes six to 12 months to be returned to the MHP. The MHP should have considered using instruments for which the data can be locally collected, analyzed and used regularly (see 5.2).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The CPS data applies to the entire study population, but not without validity issues (see 5.2). Data collection should occur monthly with the ability to establish pre- and post-intervention findings. For indicators capturing increasing numbers of participants in intervention activities, it is not clear how many in the study population do not get the intervention or choose not to engage.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☒ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: Participant counts in intervention activities	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While another organization ultimately stepped in to provide volunteer peer-run support, follow through was unpredictable and data was inconsistent.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP findings mostly consisted of the contingencies that took place, including natural disasters, certain failures in the PDSA cycles, and partner agencies dropping out and being inconsistent/unreliable.

6.6 Were qualified staff and personnel used to collect the data? Project Co- Leads: Harry Collamore, LMFT, MH Quality Coordinator and Sandra Schmidt, MH Staff Services Analyst Project Sponsor: Jim Diel, LMFT, MH Clinical Director Lynette Lawrence, Provider Services Coordinator Doug Hawker, MH Program Manager Denisse Madrigal, Innovations Community Center Program Coordinator Sara Tirado, Innovations Community Center Staff Yolanda Reyes-de-Nava, Peer Community Aide Willyum Smith-Watters, Caring, Community, Compassion Peer Services Director Amanda Jones, Adult FSP Supervisor Zacharia Geyer, Adult FSP Peer Provider Valerie Cahill, Adult Supervisor Gwendolyn Dean, Adult Case Manager Joseph Chow, Adult Case Manager Martha Alamillo, Adult FSP Therapist Rocio Canchola, MHSA Staff Services Analyst Susanne Snowden, Adult FSP Clinician, Fresh Start Housing Program Coordinator	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	CPS data are collected and analyzed by Sandra Schmidt, MH Staff Services Analyst Current participation data are collected and reported by Susanne Snowden, LMFT. Previous data for Innovations Community Center groups was collected by the facilitator, Sara Tirado. Overall data analysis is coordinated by Harry Collamore, LMFT, MH Quality Coordinator
	Totals	**2 Met** **4 Partially Met** Not Met UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Create and convene four beneficiary focus groups. 2. The number of attendees at the Innovations Community Center Programming Group meetings will increase. Planned social activities will be attended, particularly by individuals not currently participating in Innovations Community Center activities. 3. PDSA question: Will monthly community social gatherings encourage participation by our target group? 4. PDSA question: If we bring the hospitality trailer with coffee and snacks to Fresh Start and other locations where clients are living, will that encourage participation by our target group? 5. Provide social engagement activities at Fresh Start including, coffee, snacks and ice breaker activities on a bi-monthly basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The information listed in the PIP Development Outline is provided in more detail in the PDSA cycle attachments. The PIP stated that future interventions will be open to all beneficiaries, such as “Picnic in the Park” activities.
Totals		**1 Met** 0 Partially Met 0 Not Met 0 UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP aimed to encourage Innovations Community Center to improve and increase services for socially isolated beneficiaries with the goal of enhancing services and increasing beneficiary comfort in attending. Unfortunately, Innovations Community Center was unable to perform on this front, which was a significant obstacle during the launch of the PIP. Subsequently, they withdrew the availability of the van that had been used for the intervention, and then several months later withdrew from all participation in the PIP. While another organization ultimately stepped in to provide volunteer peer-run support, follow through was unpredictable and inconsistent.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Many of the activities did not occur as planned due to the MHP having conflicting priorities, and community partners dropping out/not being reliable.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described: See* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP reported onsite that while the PIP was not implemented in full, as planned, the PIP has been effective in introducing the value of regular social engagement activities in improving the quality of life and social connectedness through a community partner, Mentis, who has been introduced to the project when the MHP expected the next intervention cycle to include an expansion to housing complexes occupied by Supportive Living Program participants. Mentis experimented with adding regular social engagement activities to their services using an intern. They were so satisfied with the results that they proceeded to create and hire a half time position to continue this effort.

Totals	0 Met	**4 Partially Met**	0 Not Met	0 NA	0 UTD

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The data collected regarding participation in activities are comparable and accurate. It accurately and consistently measures beneficiary participation, and by inference, interest in social engagement activities. However, it does not measure changes in consumer perception of isolation vs. engagement and cannot inform the overall success of the PIP. The MHP determined that the N is too diluted and the data results too delayed for the CPS to be of value as an ongoing measurement. It was of value in identifying the topic need initially, but is ineffective as an outcome measure.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☒ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	

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

Totals	0 Met	**1 Partially Met**	**2 Not Met**	0 NA	**2 UTD**

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

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

Conclusions:

The MHP reports that the PIP has been active for two years. However, the first community partner withdrew from the PIP in 2017, and the subsequent community partner who stepped in during 2018 provided inconsistent and unreliable services and data. The MHP has now ended this PIP.

Recommendations made during the EQRO reviews of FY2016-17 and FY2017-18 were, for the most part, not incorporated into the PIP. During the onsite review in FY2018-19, the MHP reported that due to conflicting priorities, the PIP was not able to be completed as initially designed, and the interventions were minimally applied.

Number Met	**7**
Number Partially Met	12
Number Not Met	7
Unable to Determine	2
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	56
Overall PIP Rating ((#M*2)+(#PM))/(AP*2)	**46.43%**

Recommendations:

This PIP is considered complete; however, with minimal quantifiable results and validity. The MHP reports that the PIP has been effective in introducing the value of regular social engagement activities in improving the quality of life and social connectedness.

The MHP is encouraged to initiate a new clinical PIP as soon as possible, and to seek technical assistance from CalEQRO early and often to ensure that the PIP meets the standards and requirements as per CMS Protocol 3.

Check one:

☐ High confidence in reported Plan PIP results ☒ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Napa

PIP Title: Internal Referrals Timeliness

Start Date: TBD

Completion Date: TBD

Projected Study Period: 12-18 Months

Completed: Yes ☐ No ☒

Date of On-Site Review: December 12, 2018

Name of Reviewer: Della Dash

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☐ Active and ongoing (baseline established and interventions started)

☐ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☐ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☒ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP:

The goal of the non-clinical PIP is to track and improve the timeliness of internal referrals to additional adjunctive or replacement services for children ages 0-21 years who are already open to a service.

Future phases of the PIP will expand the population to include: 1) Internal adult beneficiaries; 2) New referrals from the MHP's Access Unit; and 3) Referrals from and to external organizational providers.

This submission is determined not to be a PIP, and is not active.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP states that initial stakeholders included all three Children's Services Supervisors, the Clinical Manager, Quality Coordinator and the Access Managed Care Secretary. No further information is provided on the PIP team, and no peer involvement is evident. No stakeholder input was reflected in the selection of the PIP topic.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP states that prior to the commencement of this project, internal referrals were occurring informally and haphazardly leading to inaccurate choices of additional services, delays for individuals in receiving new adjunct services, and caseload management challenges for supervisors and staff. Because of the ad hoc nature of the existing process, no baseline data existed. Further, no literature search or research is reviewed in the PIP, as the MHP states that none is needed beyond the language in the MHP Contract and DHCS Information Notices that suggest a wait time of no more than 15 business days for new services.

Select the category for each PIP: *Non-clinical:* ☒ Prevention of an acute or chronic condition ☒ Care for an acute or chronic condition ☒ Process of accessing or delivering care ☐ High volume services ☐ High risk conditions		
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP focuses exclusively on timeliness of referrals for additional services for beneficiaries already engaged in services. The initial referral process is never described, nor is a detailed description of the impact the referral problems are having on the child population being served (e.g., current timeliness metrics). The PIP lacks a full description of the Children's Access and Referral Team, and how it determines what services a potential referral will be referred to.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The initial phase of the project will include children and families served by the MHP. The PIP states that subsequent PDSA rounds are anticipated to expand the scope step by step and eventually include all beneficiaries of the MHP.
	Totals	

STEP 2: Review the Study Questions		
2.1 Was the study questions stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "How much time does it take for people referred for services, both from access and internally, to receive an initial specialty mental health service?" First PDSA cycle: 1. "Will a new referral form and a better defined process allow the MHP to better track the timeliness and accuracy of internal referrals?" 2. "Will this process allow the MHP to accurately track timeliness data and establish baselines from which goals can be generated?"	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question as written is neither clear nor measurable. The study question bullets do not answer the beneficiary-related initial study question. A PDSA cycle (or concurrent cycles) is not a PIP. The MHP needs to differentiate between the two, and provide a clear study question(s) that will improve processes leading to improved clinical beneficiary outcomes (e.g. improved health or functional status, and/or member satisfaction). To qualify as a PIP, the focus needs to be on beneficiary outcomes and not on MHP administrative processes as the end result.
Totals		
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The initial phase of the project will include children and families served by the MHP. The PIP states that subsequent PDSA rounds are anticipated to expand the scope step by step and eventually include all beneficiaries of the MHP.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The initial beneficiary population in the study will be children, 0-21, currently receiving any SMHS directly from the MHP internal staff who are referred for additional adjunctive or replacement services. However, no data are provided as to the number of youth currently receiving services, the number of youth who are routinely internally referred for additional services, or the numbers/types of additional services available. Future iterations will expand the population as PDSAs demonstrate success and data baselines are established, to include: 1) Internal adult beneficiaries; 2) New referrals from the MHP's Access Unit; and 3) Referrals from and to external organizational providers.
	Totals	
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Date of referral to the date of the first additional delivered service.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes only one indicator: The number of business days from the referral date to the date of commencement of services. The benchmark limit is 15 business days. The Children's Access and Referral Team determines what services a potential referral will be referred to.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The outcome is focused on the timeliness of the referral to first service, with implied improvements in health status.
	Totals	
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	It is unclear whether sampling methods will be used for this PIP.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals		
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Step 6 of the PIP was not completed.
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☐ Met ☐ Partially Met ☐ Not Met	Step 6 of the PIP was not completed. Section 4 includes the following information:

☐ Member ☐ Claims ☐ Provider ☐ Other:	☐ Unable to Determine	The data sources are twofold: A log is established and maintained by the PIP Team Leader. Key elements include: name, current service provider, date of referral, disposition, e.g. type of new service being referred to, or no service, and date of first new SMHS. The other data source is the EHR.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Step 6 of the PIP was not completed. Section 4 includes the following information: The methodology includes the data entered by the CART meeting facilitator during or immediately after the meeting. The date of the new service will be researched weekly by the Secretary by looking up each named client on the log in the EHR. Only specific types of services will be counted: any face to face SMHS or phone SMHS. Brokerage types of services will not be included.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Step 6 of the PIP was not completed.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Step 6 of the PIP was not completed. Without a data analysis plan, the submission is determined not to be a PIP.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Title: Role: *Other team members:* Names:	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Step 6 of the PIP was not completed.
	Totals	
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Using the recently created universal referral form and commencing with internal children's services only, we will beta test the processes, define practice and documentation guidelines and establish our data tracking methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP includes only one intervention. Individual, specific interventions should be listed, each able to be individually measured to determine their impact on the indicators, and in terms of being able to answer the study question. In addition to the PIP Development Outline, the MHP also submitted an Internal Referrals Workflow summary and diagram, a Program Referral Summary Template, and a Cycle One PDSA. However, no discussion of these documents was provided in the PIP write-up.

	Totals	
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable at this time. This PIP is determined not to be a PIP, and is not active.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals		

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Not applicable at this time. This PIP is determined not to be a PIP, and is not active.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

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

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

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

Conclusions:

This PIP is determined not to be a PIP, and is not active.

No further information is provided on the PIP team beyond the select few staff members involved, and no peer involvement is evident.

No literature search or research is reviewed in the PIP to justify the PIP topic, study question and interventions.

The PIP focuses exclusively on timeliness of referrals for additional services for beneficiaries already engaged in services; however no data is provided to demonstrate that this is a problem. The initial referral process is never described, nor is a detailed description of the impact the referral problems are having on the child population being served (e.g., current timeliness metrics). The PIP lacks a description of the Children's Access and Referral Team, and how the team determines what services a potential referral will be referred to.

The initial phase of the PIP will include children and families served by the MHP, with the intention of expanding to all beneficiaries in later phases/years of the PIP.

The study question as written is neither clear nor measurable, and the study question bullets do not answer the beneficiary-related initial study question. The study question does not differentiate between a PDSA cycle and a PIP.

It is unclear whether sampling methods will be used for this PIP.

Step 6 of the PIP was not completed. Without a data analysis plan, the submission is determined not to be a PIP. Step 4 does include some of the information needed for Step 6.

The PIP includes only one intervention which is a hodgepodge of steps.

In addition to the PIP Development Outline the MHP also submitted an Internal Referrals Workflow summary and diagram, a Program Referral Summary Template, and a Cycle One PDSA. However, no discussion of these documents or how they will be utilized was provided in the PIP write-up.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Recommendations: A thorough description of the PIP team is needed, as is participation/input of stakeholders (e.g., beneficiaries) who are the target of the PIP outcomes. While the MHP states that no literature search or research is needed beyond the language in the MHP Contract and DHCS Information Notices, the PIP does need to reflect evidence suggesting that a wait time of no more than 15 business days for new services is clinically indicated. Considerable additional information and data are needed to fully describe the problem and to justify the PIP process for this topic. The study question needs to be clear and measureable. Step 6 needs to be fully completed, with a detailed data analysis plan included. Individual, specific interventions should be listed, each able to be individually measured to determine their impact on the indicators, and in terms of being able to answer the study question. The MHP is encouraged to implement a non-clinical PIP as soon as possible and to seek technical assistance from CalEQRO early and often to ensure that the PIP meets the standards and requirements as per CMS Protocol 3.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time