

FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Santa Barbara MHP

*Conducted on
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SANTA BARBARA MENTAL HEALTH PLAN SUMMARY FINDINGS

- Beneficiaries served in CY15—4,868
- MHP Threshold Language(s)—Spanish
- MHP Size—Medium
- MHP Region—Southern
- MHP Location—Santa Barbara
- MHP County Seat—Santa Barbara

Introduction

The MHP has continued to instill the philosophy of wellness and partnership. Rebranding the MHP two years ago as the Behavioral Wellness Department reflected this principle. Partnership means working collaboratively and cohesively with individuals and groups in settings within and beyond the behavioral health system. In addition, the MHP created the Change Agent Committee, comprised of self-selected volunteer staff, managers, consumers, and leadership coming together as Change Agents. This team works together to identify needed changes and hold those able to enforce change as accountable to the vision to the degree possible.

The MHP operates clinics and services regionally-based, secondary to its geographic layout. The three primary regions are identified as the Central (Santa Barbara), the North (Santa Maria), and the West (Lompoc) regions.

Access

In October 2016, the MHP launched its centralized access in which all phone calls, walk-ins and referrals are logged and tracked for timely access. Intake appointments and services have expanded in the Carpinteria region where transportation was noted as a barrier. Following the initial contact, orientation groups serve as an introduction to services and a venue for those in attendance to receive a timely assessment.

Three regional teams specialize in access and assessment, with special attention to cultural considerations, such as unique presentations of crises among minorities and the importance of accessing family and community supports. The new regional teams are based in Lompoc, Santa Maria and Santa Barbara. The teams are guided by recovery and resiliency concepts and will improve access to services.

Timeliness

Timeliness reports are reviewed for each clinic and each region at the monthly Quality Improvement Committee meetings. Strategies are discussed and prioritized for system-wide improvements. A Performance Improvement Project was continued for improved timely access to psychiatry appointments and decreased no-show rates.

Quality

The MHP has adopted the 3-4-50 as a community health improvement strategy based on evidence that three (3) health behaviors elevate risk of four (4) chronic conditions that together cause more than fifty (50) percent of deaths. Studies show that individuals with mental illness and substance use disorders (SUD) are more likely to engage in the three behaviors than the rest of the population, increasing susceptibility to the four conditions. These co-occurring physical and behavioral health conditions can significantly impact prognosis, quality of life and lifespan. By acknowledging the consequences of these behaviors and employing strategies that address them, Behavioral Wellness staff can tackle the underlying issue that slow and challenge a client's progress towards meaningful, lasting recovery.

Outcomes

The MHP utilizes the Child and Adolescent Needs and Strengths (CANS) and the Milestones of Recovery Scales (MORS) as indicators to measure consumer needs and treatment progress.

Various services and strategies are initiated to address the ongoing and expansive needs consumers may require. Examples include the submission of the Drug Medi-Cal Expansion Waiver to extend treatment services for substance use disorders and the establishment of a five-bed residential facility for homeless women.

INTRODUCTION

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

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

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

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

(1) VALIDATING PERFORMANCE MEASURES¹

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

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

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS²

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES³

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

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

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

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

Key Recommendations from FY15-16

- Recommendation #1: Adequate staffing for this MHP remains a challenge with implications for access, timeliness and quality of services. Hiring of clinical staff, case management staff and bi-lingual Spanish speaking staff need to be priority in recruitment as well as retention.

Fully addressed Partially addressed Not addressed

- The hiring of staff remains a department priority. The managers have worked with the county's Human Resources Department to assist in prioritizing the hiring of bi-lingual Spanish-speaking employees.
- Limitations exist at the county level with an imposed freeze on backfilling line staff positions as they are vacated.
- To date, the MHP reports it provides line staff to meet the needs of the Spanish-speaking consumers and it continues to recruit to meet the needs for psychiatry. Reportedly, nearly 40% of staff are bi-lingual Spanish-speaking.

- Recommendation #2: A lack of consistent understanding and adherence to policies and procedures across the MHP's three regions continues to be reported. Develop and implement a system of policies and procedures with checks for compliance to ensure all staff are aware of and compliant with policies and procedures as well available training opportunities.

Fully addressed Partially addressed Not addressed

- New staff are provided an orientation and trained in the policies and procedures. Online access is available through the database. Frequent updates occur with email announcements.
 - Supervisors receive and discuss new policies at the monthly supervisor meetings.
 - In the past year, several trainings were offered and attendance tracked through the Relias Learning module.
 - CalEQRO suggests the MHP consider a pre-test and post-test survey to evaluate the level of knowledge integrated from the trainings which may provide evidence of change, representing standardized learning or gaps in learning.
- Recommendation #3: Issues arising from the shortage of psychiatrists is reported across the system and programs. Create a plan to increase telepsychiatry options while continuing to develop a recruitment and retention policy for effectiveness in filling psychiatry positions.

Fully addressed Partially addressed Not addressed

- Current recruitment and retention efforts have resulted in filling 90% of psychiatrist positions. This included a new full-time civil service clinic psychiatrist at the Santa Barbara Children's Outpatient Clinic.
- The MHP expanded the range of providers to include psychiatric mental health nurse practitioners (NPs) and physician assistants (PAs). The MHP placed a nurse practitioner in a permanent position with the Santa Barbara Assertive Community Treatment (ACT) team. A second nurse practitioner position awaits recruitment and hiring.
- Contracts were negotiated with four temporary staffing agencies (locum tenens; MD, NP and PA). Staff are contracted between three months to one year. Additionally, these companies offer the option of buying out the employee to become a full-time provider. This option was exercised in the case of the ACT nurse practitioner, and plans using this mechanism in the future are possible.
- The County Human Resources application process for psychiatrist positions is open and ongoing, offering cash incentives, a vacation and sick time bank, available at hiring time.

- Recommendation #4: Continue to monitor the twice monthly outcome measure report to assure the Child and Adolescent Needs and Strengths (CANS) and the Milestones of Recovery Scale (MORS) is used in compliance with MHP standards.

Fully addressed Partially addressed Not addressed

- The MHP developed semi-monthly automatically generated CANS and MORS reports over the past two years. This was to further institutionalize the utilization of the measures, improve compliance with MHP administration requirements, and assist program staff with monitoring client outcomes. The reports are designed to help staff and management monitor completion of the CANS and MORS at specified intervals.
 - These reports continue to be distributed to the Research and Program Evaluation Manager, Chief of Compliance, Clinical Operations Division Chief, Regional Managers and Team Supervisors (both MHP and the organizational providers), who disperse the reports to appropriate staff.
 - In the last year, a significant change to the report was to ensure that the CANS due dates and scores follow the client rather than at program admission and closure. This method ensures that the client receives the CANS every six months regardless of what program the client is enrolled in, producing one thread of data for each client during their admission to the system.
 - In FY2015-16, the MHP began producing semi-annual and annual departmental reports for the Board of Supervisors and the community for both the CANS and the MORs.
 - The MHP has also engaged in a Performance Improvement Project (PIP), which uses the CANS and the MORS scores as an indicator of treatment progress with the implementation of its Team-Based Treatment.
- Recommendation #5: Complete development of the Clinical Reporting System to allow users the ability to create custom reports as well as expand the capacity to refresh “canned” reports with current data as needed.

Fully addressed Partially addressed Not addressed

- In collaboration with the project consulting vendor the MHP has completed phase one of the Clinical Reporting System (CRS) project. The first phase is accessible through the MHP Provider Portal and consists of two public facing web based solutions: CRS Dashboard and CRS Details.
- The second phase of the CRS project was halted in FY 16-17 and is under review due to concerns over the planned security model. User authentication is required to access the reports presented in phase two which contain personally identifiable information.
- The planned security model would require management of a user repository in addition to the MHP’s existing user databases for Clinician’s Gateway and ShareCare. The process of maintaining consistency across the three systems is

- manual and the potential exists for an inadvertent PHI breach under this model. A method to maintain consistency with audit control is needed.
- A broader analysis from a technology perspective revealed the lack of a modern internal service management tool. ServiceNow has been selected to fill this void and implementation is underway.
 - The staff onboarding and off boarding processes will be expanded to include tasks for ensuring appropriate user access control across all MHP information systems.
 - The MHP anticipates that this new service management solution will be in active use by the end of FY16-17. The CRS project remains a high priority and the MHP currently anticipates proceeding with second phase when ServiceNow is in production.
- Recommendation #6: Maintain consistent contact with The Echo Group to assure a timely resolution to the MHP's inability to submit Client Service Information (CSI) data files to the State.

Fully addressed

Partially addressed

Not addressed

- The MHP began the catch-up process on the eight months of reporting backlog in June 2016. The full process was originally anticipated to be completed by early July bringing the MHP current on CSI data submissions.
- The data export for the reporting month of September 2015 was exceptional in size and required multiple uploads and additional time to complete. Successful processing of the September 2015 reporting month was achieved in July 2016.
- The data export for the reporting month of October 2015 generated the first set of data with the Echo Group's new ICD-10 reporting specification in ShareCare. Many errors were encountered during validation by the State. The MHP worked closely with The Echo Group and the State over the next three months to produce correct CSI data output from ShareCare.
- The Echo Group released a software patch in August 2016 that resolved the reporting output, but database issues required an additional two months of work to resolve. Successful processing of the October 2015 reporting month was achieved in October 2016.
- During the months of November and December 2016 catch-up reporting was successfully completed and submitted to the State for reporting months November 2015 through November 2016. Reports are now submitted on-time and the MHP is current with required State CSI data submissions.

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

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

- Access to Care
 - Expansion of substance use disorder treatment is underway as the MHP develops its Drug Medi-Cal expansion services.
 - The MHP restructured its Access by establishing a centralized call-in Access Unit which provides initial screening, referrals and the first scheduled appointment for an orientation.
 - Community based residential facilities were increased by the addition of a new five-bed residence for homeless women.
 - Mobile and Triage Teams were integrated into Crisis Stabilization Unit operations.
- Timeliness of Services
 - Revisions for the centralized access process are intended to result in more timely appointments.
 - Orientation groups are offered and the initial assessment is conducted for those in attendance, decreasing wait time.
- Quality of Care
 - The strategy using the model of the “3-4-50” method for groups is offered countywide. “3-4-50” is a community health improvement strategy based on evidence that three health behaviors elevate risk for four chronic conditions that together cause more than fifty percent of deaths.
 - The MHP uploads multiple reports and newsletters on its public website, contributing to transparency.
 - The Relias Training portal is fully implemented and has facilitated achieving the goal of 100% compliance with mandatory training requirements.
 - Completed publication of a Principles and Practice series highlighting Behavioral Wellness system guiding principles is available on the website.
- Consumer Outcomes
 - The MHP continues to utilize the CANS and the MORS to indicate consumer needs and consumer progress in treatment.
 - The MHP increased mobile crisis teams deployed countywide can deflect the potential for higher level services.

- The MHP expanded community based residential facilities, adding a new five-bed residence for homeless women.

PERFORMANCE MEASUREMENT

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

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

TOTAL BENEFICIARIES SERVED

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

Table 1—Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity Santa Barbara				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	78,968	70.4%	3,198	65.7%
Hispanic	17,195	15.3%	719	14.8%
African-American	1,685	1.5%	187	3.8%
Asian/Pacific Islander	6,724	6.0%	163	3.3%
Native American	354	0.3%	25	0.5%
Other	7,300	6.5%	576	11.8%
Total	112,225	100%	4,868	100%
<i>*The total is not a direct sum of the averages above it. The averages are calculated separately. The actual counts are suppressed for cells containing n ≤11.</i>				

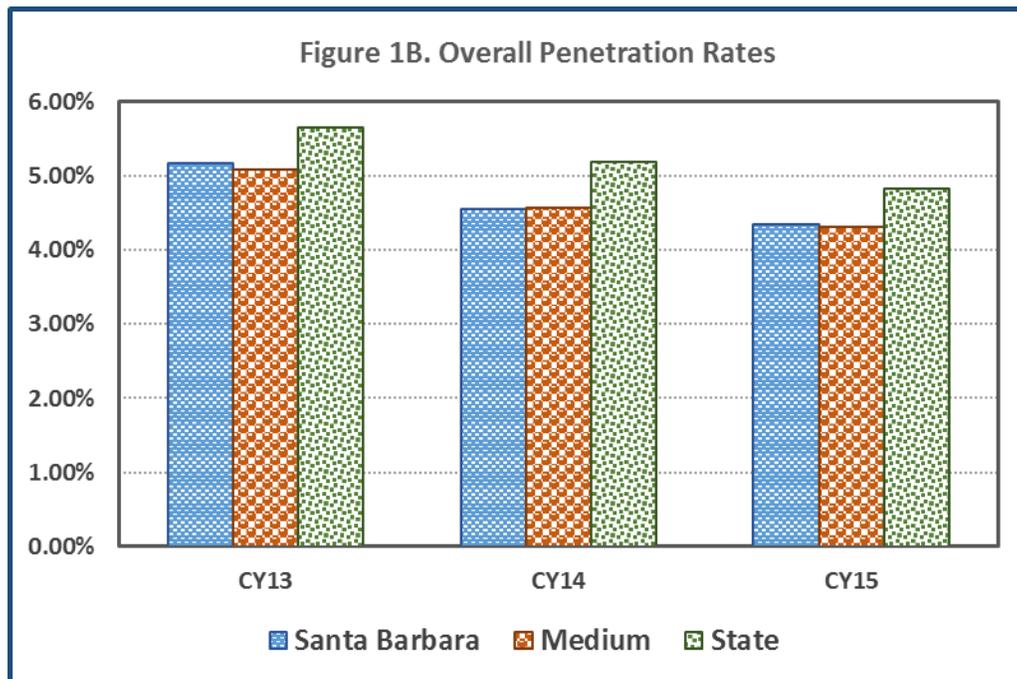
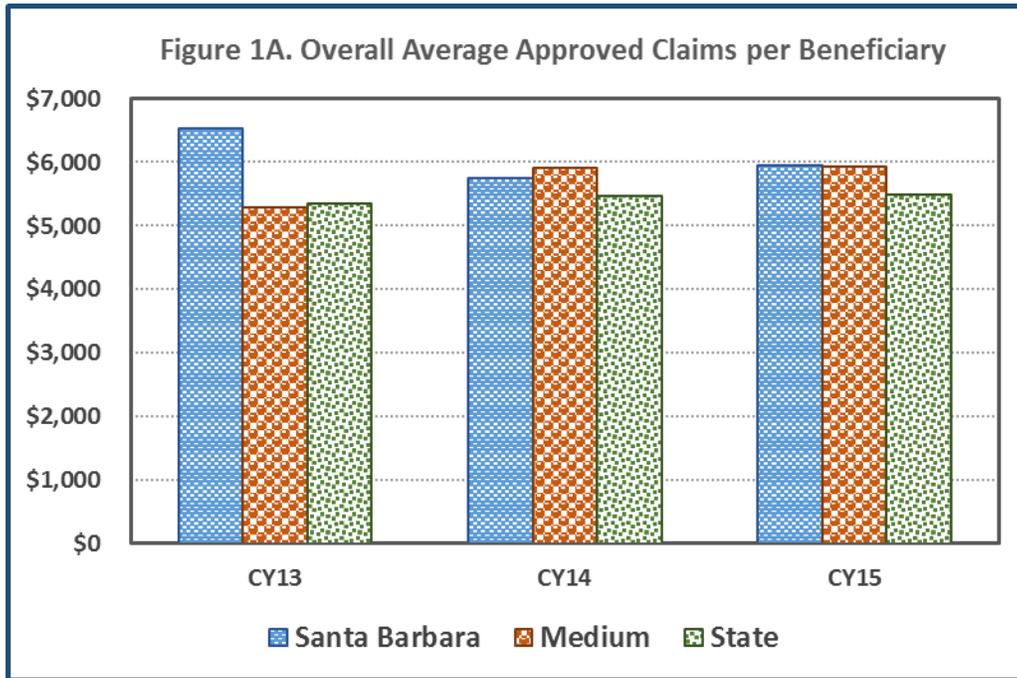
PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

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

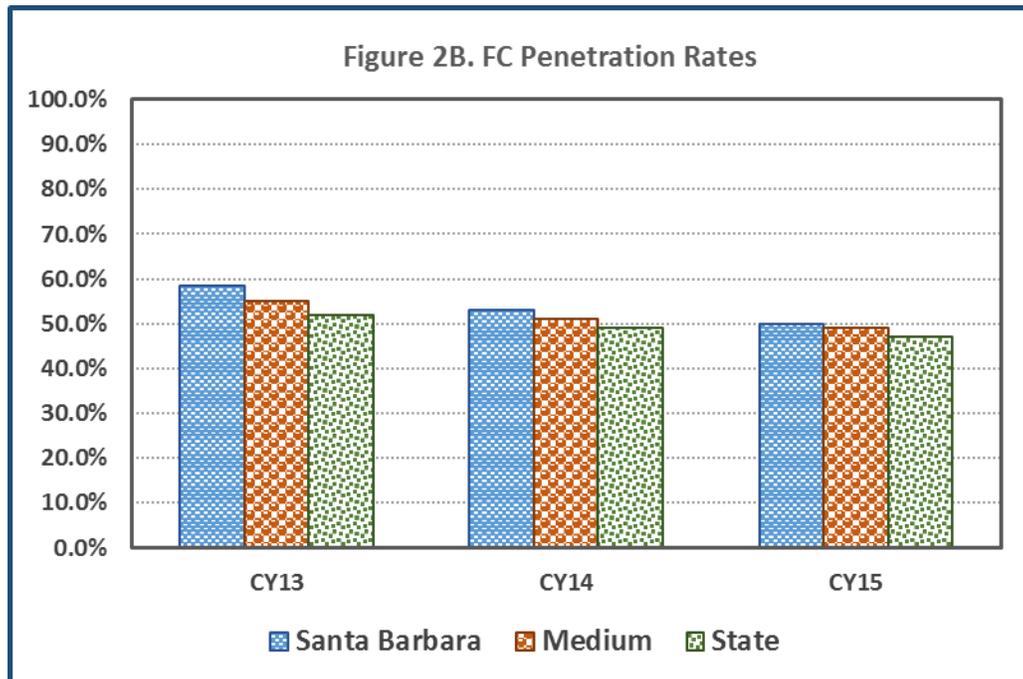
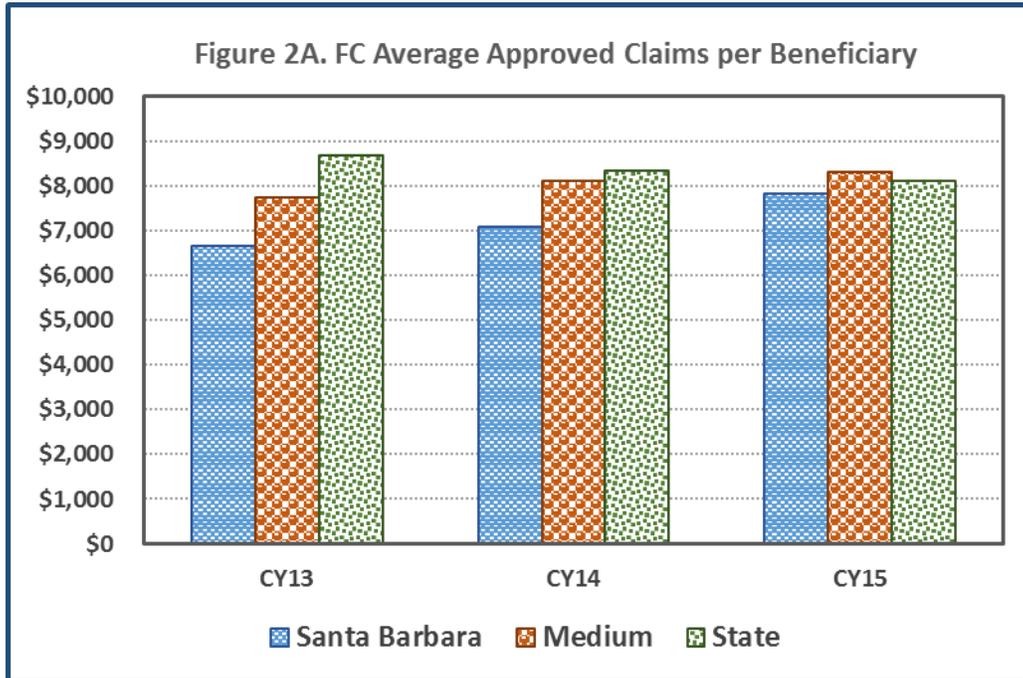
Regarding calculation of penetration rates, the Santa Barbara MHP:

- Uses the same method as used by the EQRO.
- Uses a different method.
- Does not calculate its penetration rate.

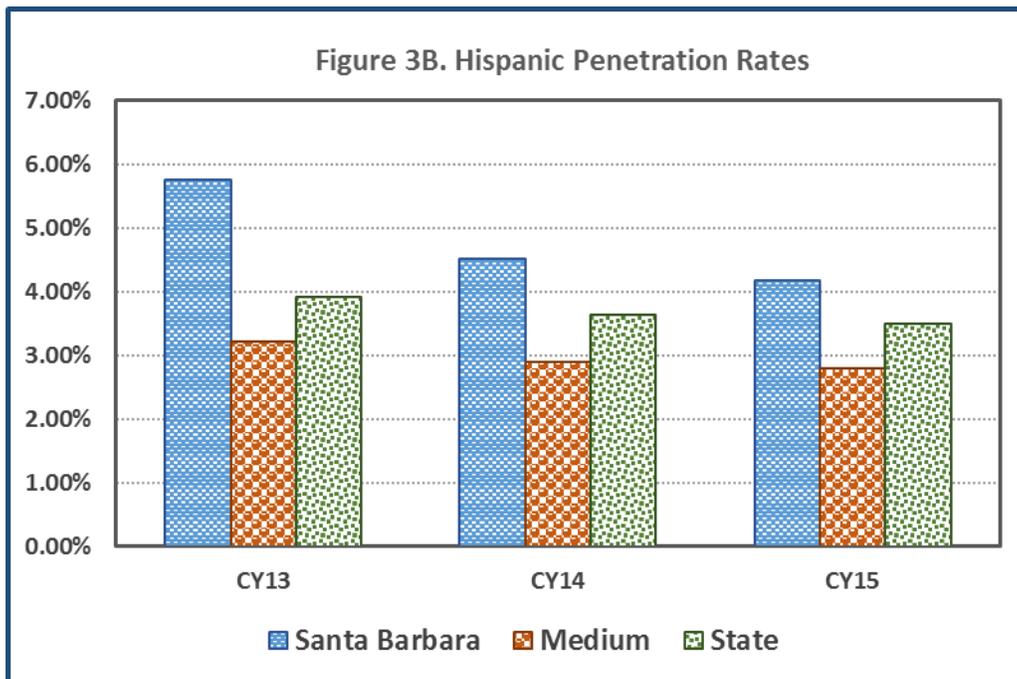
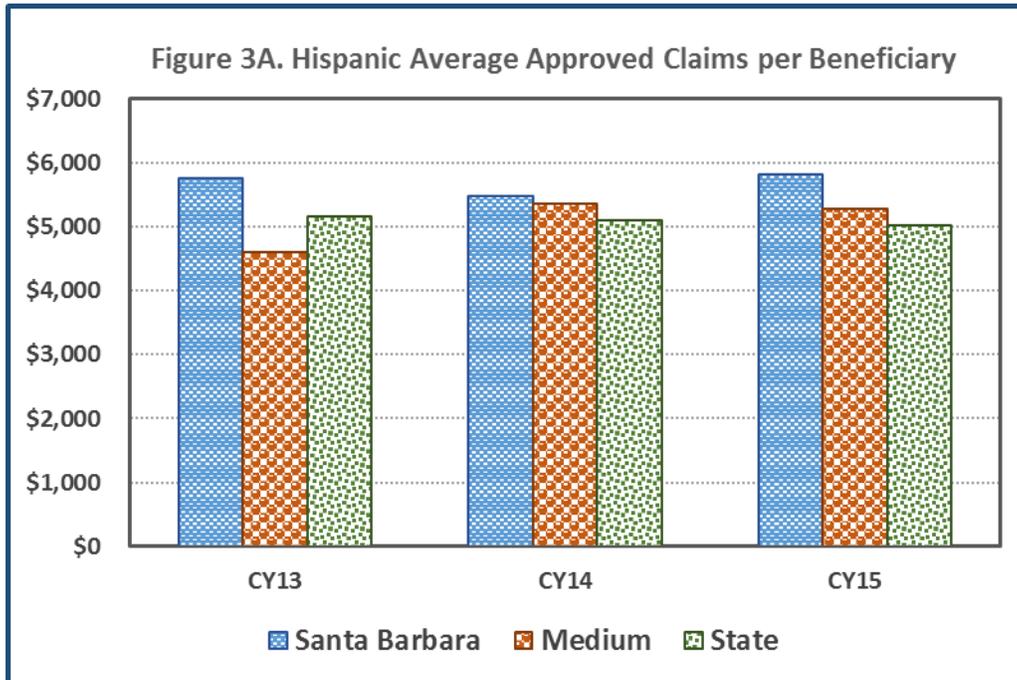
Figures 1A and 1B show 3-year trends of the MHP’s overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for medium MHPs.



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



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



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

HIGH-COST BENEFICIARIES

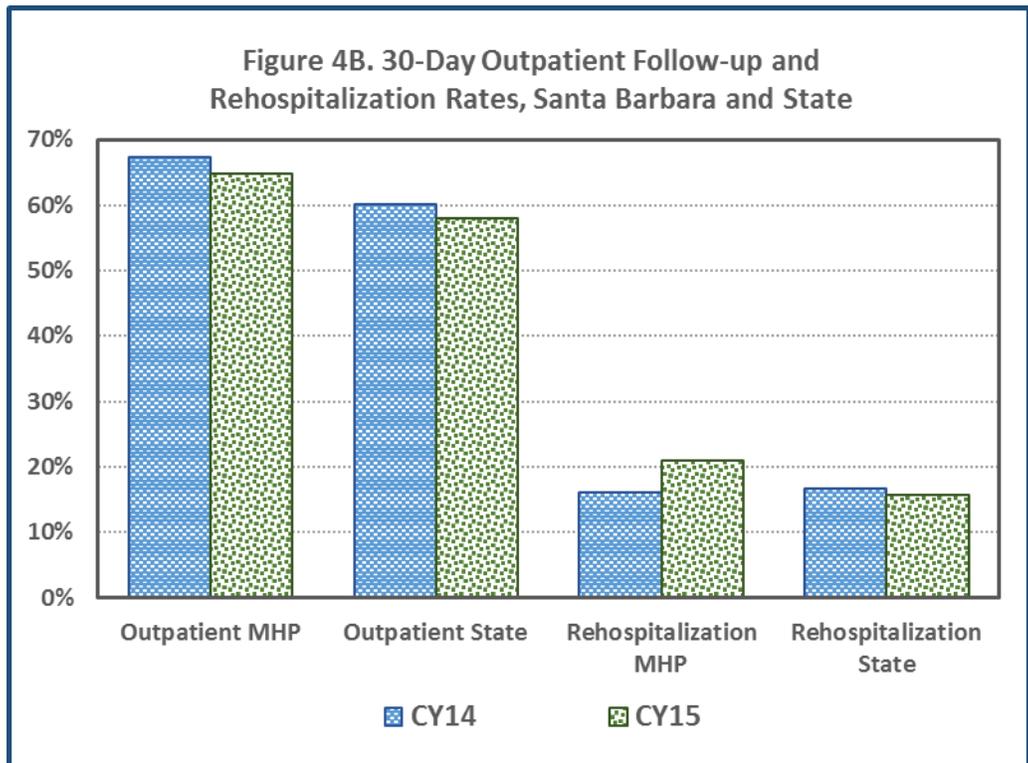
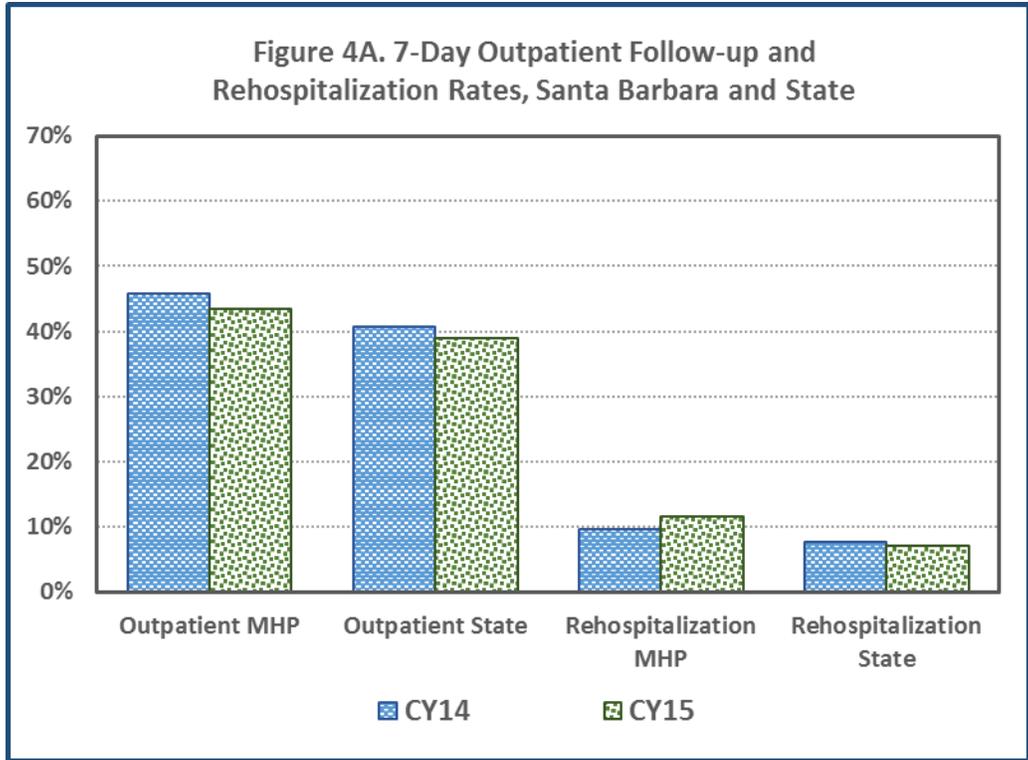
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than \$30,000 in a year.

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	\$51,635	\$715,196,184	26.96%
Santa Barbara	CY15	171	4,867	3.51%	\$46,789	\$8,000,918	27.67%
	CY14	154	4,822	3.19%	\$49,176	\$7,573,149	27.83%
	CY13	230	4,920	4.67%	\$51,628	\$11,874,480	36.96%

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

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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

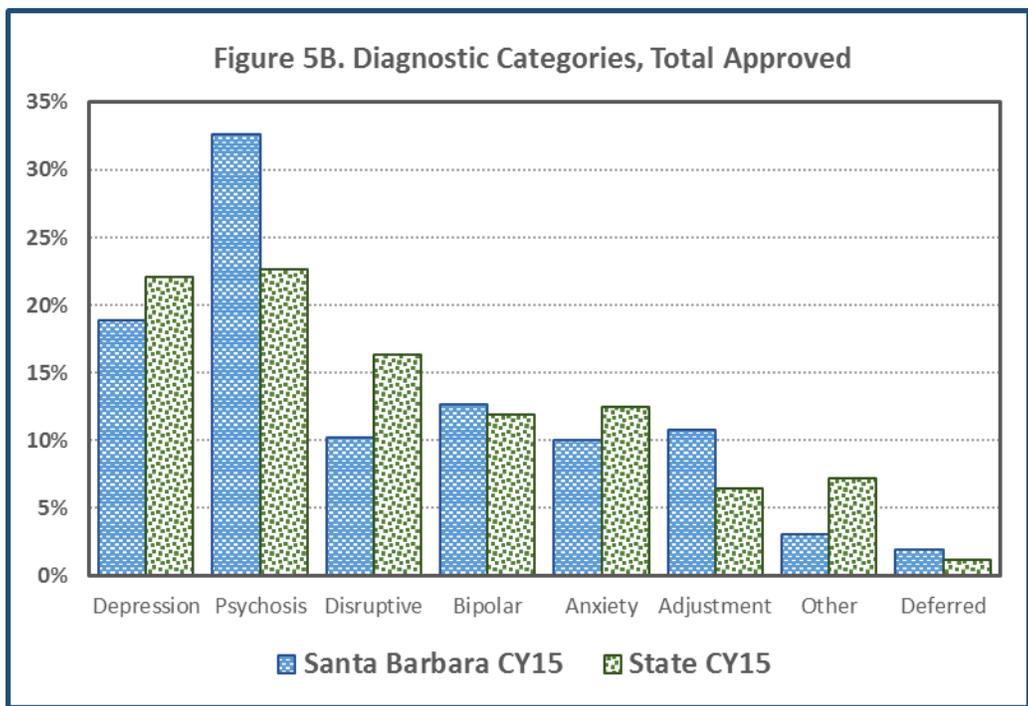
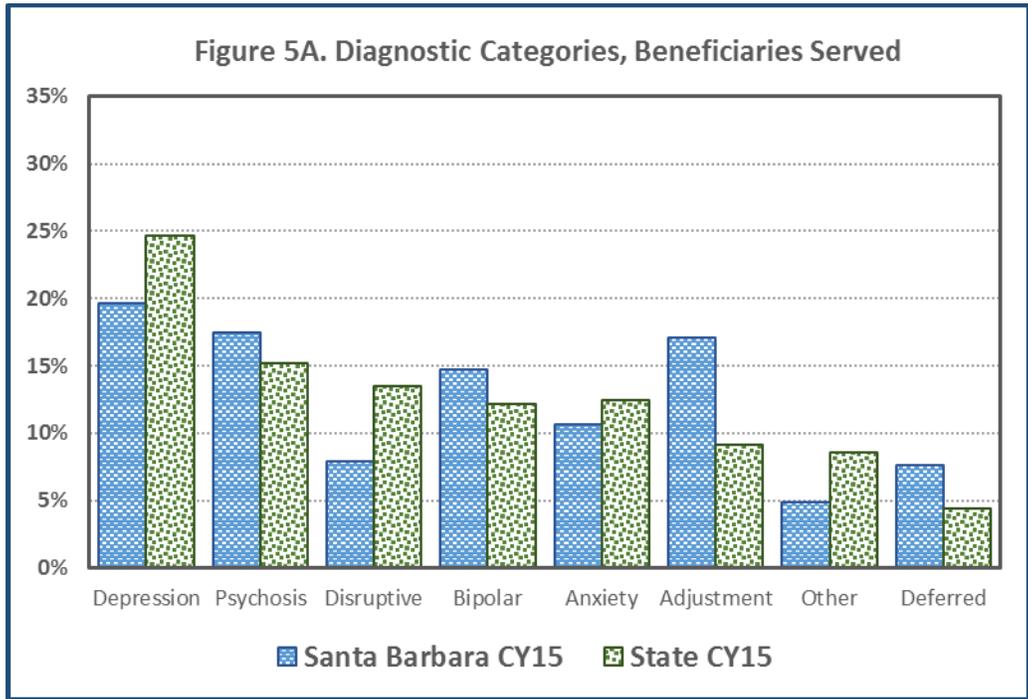


DIAGNOSTIC CATEGORIES

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

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

14.6%



PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP's number of eligibles rose from 106,121 in CY14 to 112,225 in CY15 and beneficiaries increased from 4,828 to 4,868 during this period. This correlates to a penetration rate drop from 4.55% in CY14 to 4.34% in CY15. The MHP's Overall CY15 penetration rate is now comparable to the Medium County average (4.31%) and less than the statewide (4.82%) average.
 - The MHP served 1,293 Affordable Care Act (ACA) beneficiaries of 25,070 eligibles in CY15 for a penetration rate of 5.16% for this sub-group (see Table C1 in Appendix C).
 - When combining the Medi-Cal and ACA data, the MHP's CY15 average monthly eligibles increased to 137,295 with 6,161 beneficiaries for a combined increase from CY14 Medi-Cal only data of 31,174 eligibles and 1,333 additional beneficiaries.
 - The MHP's Foster Care penetration rate decreased from 53.10% in CY14 to 50.00% in CY15, but remains greater than both the Medium County (48.98%) and statewide (47.19%) averages.
 - The MHP's Hispanic penetration rate dropped from 4.51% in CY14 to 4.18% in CY15 but remains greater than both the Medium County (2.80%) and statewide (3.49%) averages.
- Timeliness of Services
 - In CY15, the MHP's 7-day and 30-day outpatient follow-up rates after discharge from a psychiatric inpatient episode decreased when compared to the corresponding CY14 rates and remain above statewide averages.
- Quality of Care
 - The MHP's average overall approved claims per beneficiary increased from \$5,747 in CY14 to \$6,115 in CY15, and is greater than the Medium County (\$5,943) and the statewide averages (\$5,522).
 - The MHP's Foster Care approved claims per beneficiary increased from \$7,101 in CY14 to \$7,823 in CY15, and remains less than both the Medium County (\$8,324) and statewide averages (\$8,127). The MHP had 566 Foster Care beneficiaries in CY15.
 - The MHP's CY15 average Hispanic approved claims per beneficiary increased from \$5,481 in CY14 to \$5,979 in CY15 and remains greater than both the Medium County (\$5,287) and statewide (\$5,045) averages.
 - The MHP's percentage of high-cost beneficiaries (HCBs) in CY15 (3.51%) increased slightly from CY14 (3.19%) and is greater than the statewide average (2.86%).

- The percentage of total HCB claim dollars was slightly greater than the statewide average in CY15 (27.67% vs. 26.96%). The MHP's average approved claims per HCB declined from CY14 (\$49,176) to CY 15 (\$46,789), and is less than the CY15 statewide average (\$51,635). The MHP had 171 HCBs in CY15.
- The MHP had a notably higher rate of Adjustment and Deferred diagnoses and a lower rate of Depressive, Disruptive and Other diagnoses when compared to statewide averages. Deferred diagnosis was twice the statewide average (8% vs. 4%).
- Varying from the MHP's diagnostic pattern, the percentage of total approved claims for individuals with psychotic disorders was significantly higher than that of any other diagnostic category and proportionately higher than the statewide average when comparing diagnostic category percentage and approved claims dollars. Other diagnostic approved claims dollars generally aligned with the MHP's diagnostic pattern.
- Consumer Outcomes
 - The MHP's 7-day re-hospitalization rate rose from 10% in CY14 to 12% in CY15, exceeding the CY15 statewide average (7%). The MHP's CY15 30-day re-hospitalization rate rose from 16% in CY14 to 21% in CY15, exceeding the CY15 statewide average (16%).

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

SANTA BARBARA MHP PIPS IDENTIFIED FOR VALIDATION

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

Table 3—PIPs Submitted		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Treatment: Training, Client Engagement and Team-Based Care
Non-Clinical PIP	1	Timeliness to Psychiatry Services

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

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

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

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

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

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

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

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	15	17
Number Partially Met	4	7
Number Not Met	0	0
Number Applicable (AP) (Maximum = 28 <u>with</u> Sampling; 25 <u>without</u> Sampling)	19	24
Overall PIP Rating ((#Met*2) +(#Partially Met))/(AP*2)	89.5%	85.4%

CLINICAL PIP—IMPROVING TREATMENT: TRAINING, CLIENT ENGAGEMENT AND TEAM-BASED CARE

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

- “Are client outcomes, as measured by the Consumer Perception Survey (CPS), the Child and Adolescent Needs and Strengths (CANS), and the Milestones of Recovery Scale (MORS) improved by implementing:
 - Training for clinical staff
 - Team-based care model and tools; and

- Improved MIS treatment related reports (for managers and supervisors)?”
- Date PIP began: November 2015
- Status of PIP:
 - Active and ongoing
 - Completed
 - Inactive, developed in a prior year (*Not Rated*)
 - Concept only, not yet active (*Not Rated*)
 - Submission determined not to be a PIP (*Not Rated*)
 - No PIP submitted (*Not Rated*)

This is a revision from the prior year PIP with an increased focus to measure consumer care in the current year. This PIP focuses on improving client experience of treatment in terms of: a) ensuring that all clients have high quality current/active treatment plans, b) implementing team-based care, and c) improving client engagement.

As the name suggests, team-based care is not individual care or care that is organized between a single client and a single helping professional. While client care is individualized, treatment is not provided by a single professional but by a team of professionals, all of whom are available to help the client at any given time, regardless of client needs.

Each team member may be licensed, certified or have a specific set of skills, but they are also generalists and able to provide a wide range of support and interventions. Team-based care does not eliminate treatment caseloads. All clients have a single point of contact, counselor or therapist, but are managed (and supported) by an entire team. This differs from the previous organization and delivery of care wherein a client was assigned to a clinician or case manager and if that person was unavailable, the client would see the “officer of the day”.

The hypothesis is that this improved experience of treatment will result in improved outcomes as measured by improvements in three client survey measures through the bi-annual Consumer Perception Survey, an improved score for youth through the Child and Adolescent Needs and Strengths, and an improved score for adults through the Milestones of Recovery Scale.

The problem identified through chart review and anecdotal stakeholder feedback was that clients are not getting the benefit of a timely, high quality treatment plan that engages them. Based on the timeliness metric manner, within 60 days of assessment and annually thereafter, the MHP infers the treatment plan is not being fully utilized as a clinical tool; both in that staff are not working together as a team and are not engaging clients in the development and ongoing utilization of the treatment plan. Moreover, clinicians are not initially completing or renewing plans on time (as indicted by MIS Treatment plan report), indicative that plans are not being utilized as intended.

The MHP decided to refocus the PIP on the clinical improvement of treatment planning and provision in terms of client engagement and team-based care, while continuing the focus on timeliness towards treatment planning. It was expected that this clinical improvement in treatment planning and provision will have an impact on important client outcomes as measures by the CPS, CANS and MORS.

The overarching goal of the PIP is to improve client outcomes by improving the process and the provision of treatment. The interventions planned for this PIP should result in timely, high quality treatment plans that engage clients and their care team, expected to see improved client outcomes in the CPS, CANS and MORS.

Goals for the PIP included:

- Consumer Perception Survey (5% improvement in three client survey measures related to treatment care and functioning)
- Improved Child and Adolescent Needs and Strengths (CANS) scores for youth (5% improved scores)
- Improved Milestones of Recovery Scale (MORS) scores for adults.

The MHP will need to clarify the indicators for change based on improved scores for the MORS for adults and will need to be defined with quantifiable goals.

Data analysis done to date indicated some improved consumer outcomes. During FY15/16, there were 226 clients who received CANS scores for three timelines: An initial, at 6-months, and at 12-months. Results indicated a reduction in the average scores on the four domains of Behavioral/Emotional Needs, Life Functioning, Child Risk Behaviors and School Behaviors indicated that children have made progress and reduced the severity of their needs, distress and challenges. The data was reported in detail in the submission document.

Results of MORS data analyses are reported separately, for Transitional Age Youth (TAY) programs, Adult Outpatient and Assertive Community Treatment (ACT).

- The Transitional Age Youth (TAY) programs began using MORS instead of the CANS in spring 2016. At six months, more than eighty-five percent (85%) improved or stayed the same.
- The adult outpatient clinics began completing the MORS in December 2015/January 2016.
- At six months, more than eighty percent (80%) of clients improved or stayed the same.
- The Assertive Community Treatment (ACT) programs implemented MORS in July 2015. The ACT programs are intended to serve the most challenged clients in the outpatient system, which can make improvement in treatment slower and uncertain. Results at six months indicated close to eighty percent (78.3%) improved or stayed the same. ACT scores were also examined between 6-months and 12-months; results were similar:

some (13.9%) improved, most (71.2%) remained the same and some (14.9%) declined over time.

The results of the CPS over time from the Fall 2014 to the Spring 2016 indicate improvements in satisfaction and ability to choose services, ability to cope and self-efficacy as reported by consumers

The MHP distributed a survey to staff (September 2016 and February 2017) to review the overall use of the team-based approach with results showing an improvement in the use of the model.

The MHP intends to continue its data analysis and complete this PIP by the end of this fiscal year.

The recommendations for the MHP are to quantify the goals for improvement on the MORS measures.

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

The technical assistance provided to the MHP by CalEQRO consisted of emphasizing the focus on client care, measurable and quantifiable goals, and interventions that address consumer progress or benefit and not the interventions directed towards staff improvements. Staff benefits from training, lays the groundwork for improved treatment and ultimately contributes to improved client functioning. The MHP is encouraged to seek consultation as it outlines clear goals, defines interventions, and establishes the measurable indicators for its PIP.

NON-CLINICAL PIP—TIMELINESS TO PSYCHIATRY SERVICES

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

- “Will implementing the six (6) interventions of the PIP result in a reduction in client no-show rates and a reduction and wait time between admission and first psychiatric appointment in the adult and children’s systems of care?”

Interventions include:

- Appointment reminder calls
- Team-based appointment management
- Increasing clinical/peer contacts prior to psychiatric assessment
- Implementing of a singular, standardized appointment scheduling system
- Enhancing recruitment of psychiatrists and physician assistants
- Incentivizing psychiatrist productivity.
- Date PIP began: April 2014
- Status of PIP:

Active and ongoing; The MHP intends to complete this by the end of FY16/17 and will be considered complete.

Completed

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

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

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

No PIP submitted (*Not Rated*)

This is year two for the submission of this PIP. The goal is to reduce time between admission and psychiatric assessment, and to decrease the no-show rates, thus improving system functioning, the process of client care and, ultimately, client outcomes.

As no standard was in place for time to the first psychiatry appointment for new clients, several stakeholder meetings were devoted to reviewing the wait time data, discussing how wait time data are collected in the Management Information System/ Information Technology (MIS/IT) system, gaps in that process, and client flow through the access/intake system.

The stakeholders determined that a more accurate and meaningful measure of access to psychiatry would be the time between admission and the first psychiatric appointment (rather than time between first system contact and psychiatry appointment). Using this new definition of timeliness, FY 2013/14 data were examined, which revealed that the adult system wait time was 30.13 days, and in the children's system wait time was 29.89 days. It established a twenty-one-day policy between first system contact and psychiatry appointment.

The goal is to reduce time to twenty-one days between admission and psychiatric assessment, thus improving system functioning, the process of client care and, ultimately, client outcomes. An additional goal is to reduce no-show rates to 5%. Inferred in this goal is the hope that earlier appointments will address symptoms earlier, engage consumers, and lead to improved functioning.

The objective of this ongoing and evolving PIP is to implement a variety of strategies, in phases, to reduce the time new clients wait before having their first psychiatric appointment. The MHP is utilizing the NIATx principles and practices of Plan, Do, Study, and Act (PDSA) model to implement and evaluate the impact of various interventions over time, such as:

- Appointment reminder calls
- Team-based appointment management
- Increasing clinical/peer contacts prior to psychiatric assessment
- Implementing of a singular, standardized appointment scheduling system
- Enhancing recruitment of psychiatrists and physician assistants
- Incentivizing psychiatrist productivity

The results reported in December 2016, indicated the MHP has successfully reduced adult wait time and achieved the PIP goal to 19.6 days, and reduced child wait time, to 25.5 days.

It has not met its goals for reduced wait times for children nor reduced its no-show rates. The MHP indicated it is training staff in standardized documentation of the no-shows and has captured more accurate data collection via electronic methods.

The MHP intends to complete this PIP by the end of the fiscal year with the intent to reduce wait times further and to reduce the no-show rates.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommending early consultation regarding defining its new PIP study question, interventions and goals associated with consumer quality of care.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - Reduced wait times for appointments can lead to engagement and potentially address symptoms earlier.
- Timeliness of Services
 - Decreased no-show rates can lead to increased availability of providers, increased time-slots and improved timeliness to service with increased accessible appointments.
 - Timely treatment planning provides groundwork for measured consumer progress.
- Quality of Care
 - Standardized processes and metrics inform the MHP of its consumers' service needs.
 - Team-based treatment establishes coordinated care for consumer benefit.
- Consumer Outcomes
 - Improved show rates can impact consumer functioning via consistent care.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	<p>The MHP moved to a Centralized Access System and launched orientation groups at the outpatient clinics.</p> <p>The MHP monitors service data by age, gender, ethnicity and language preference.</p> <p>The Cultural Competence Plan, including a three-year long-term plan, was updated.</p> <p>The Ethnic Services and Diversity Manager facilitates the monthly Cultural Competency Action Team meeting and addresses training and cultural enrichment for the MHP.</p> <p>Strengthening Families, a pilot program funded by the Inter-Agency Policy Council, will launch in Santa Maria in April 2017. Services are targeted to serve monolingual Spanish-speaking families affected by substance use disorders (SUD).</p> <p>The contract for Interpreter services was expanded county-wide to provide for face-to-face interpretation in several languages. A protocol accompanies this activity.</p> <p>Promotoras do outreach for Spanish speaking persons with no insurance or under insured and they are on cultural competence team.</p> <p>Cultural trainings include Safe-Guarding Elders, Mental Health First Aid, LGBT focused and Trauma Informed Care and Team-Based Care.</p> <p>LGBTQ outreach provided training and sensitivity of staff. Designated staff participated in the Pacific Pride Santa Barbara. It is developing a policy for transgender issues in the Psychiatric Health Facility (PHF).</p> <p>A survey of staff for Cultural Competency and Language Proficiency continues to be distributed. Currently, 39%</p>

Table 6—Access to Care		
Component	Compliant (FC/PC/NC)*	Comments
		of direct care staff are bilingual and 35% direct care speak Spanish. Staff are initially trained to do culturally-responsive assessments/treatment.
1B	FC	<p>The MHP has focused on systems change with multiple meetings dedicated to its target populations, such as children, older adults, co-occurring disorders, and transition-age youth. The MHP designated a multi-discipline Change Agents team across its system to discuss and implement its initiatives.</p> <p>The MHP dedicated staff to some of these endeavors, for example, it has hired a Forensic Services Manager, Housing Development Coordinator, and a Crisis Services Manager.</p> <p>The MHP awaits approval of the Drug Medi-Cal Waiver to implement its Organized Delivery Services for the Substance Use Disorder population.</p> <p>Mobile and Triage Teams were integrated into Crisis Stabilization Unit operations.</p> <p>Services to the Katie A. subclass have increased and resulted in provisions to the subclass youth members. Collaborative efforts are in place and youth are assessed within ten days of referral. Combined meetings and trainings have facilitated increased communication and coordination of services resulting, in improved care for our most vulnerable youth.</p> <p>Outreach to the homeless population expanded with the opening of New Hope Community Center in Santa Barbara. Community and faith-based agencies have co-funded this service and provides monthly assistance to consumers.</p> <p>The MHP published a semi-annual report of its performance measures. Data included timeliness to service, co-occurring data, outcome measures results, inpatient utilization, and staff service provision.</p> <p>The MHP additionally published its findings for its high utilizers of services, adult crisis services, and crisis residential treatment. All documents are posted on-line.</p> <p>Secondary to unfilled positions, under-staffed programs lead to increased caseloads, possibly inadequate to serve clients and by stakeholder report increased stress and burnout among line and supervisory staff.</p>
1C	FC	<p>Multiple endeavors with a wide variety of entities continues to spread across the MHP. As mentioned, programs with homeless, faith-based, Latinos, SUD and peer services has enriched this area.</p> <p>Community based residential facilities established in coordination with faith-based groups were increased by</p>

Table 6—Access to Care		
Component	Compliant (FC/PC/NC)*	Comments
		<p>the addition of a new five-bed residence for homeless women.</p> <p>The Resiliency Intervention for Sexual Exploitation (RISE) project developed and utilized an interagency, multi-layer treatment and educational approach which includes partners and various support systems throughout the community.</p> <p>Improved integration of care with Alcohol and Drug Programs, physical health, and hospitals continues to be prioritized.</p>

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

Timeliness of Services

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

Table 7—Timeliness of Services		
Component	Compliant (FC/PC/NC)*	Comments
2A	FC	<p>The MHP reported a standard of 10 days to first appointment, with an overall average of 11.9 days, and met this 70%.</p> <p>Adult services reported an average of 12.3 days and met this 72.2%.</p> <p>Children’s services reported an average of 11.7 days and met this 67.2%.</p>
2B	FC	<p>The MHP reported a standard of 30 days to first appointment, with an overall average of 26.9 days, and met this 71.8%.</p> <p>Adult services reported an average of 25.9 days and met this 70.4%.</p> <p>Children’s services reported an average of 27.8 days and met this 73.1%.</p> <p>The MHP engaged in a PIP which decreased wait times to first psychiatric appointments and continues to address the no-show rate which it intends to reduce.</p>
2C	FC	<p>The MHP reported a standard of one day response to urgent conditions, with an overall average of 2.05 days, and met this 93.8%.</p>

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
	conditions		<p>Adult services reported an average of 1.81 days and met this 95.4%.</p> <p>Children’s services reported an average of 2.9 days and met this 79.5%.</p> <p>The goal is that 100% of urgent needs are seen within 24 hours, with some clients referred directly to Emergency Room hospital care.</p> <p>Crisis calls received at the Access Line are logged in ShareCare with the date and time of the first service following the crisis and logged into ShareCare and Clinician’s Gateway.</p>
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	<p>The MHP reported a standard of seven days for timely access to follow-up appointments post- hospitalization, overall averaging 14.1 days and met this 59%.</p> <p>Adult services reported an average of 14.5 days and met this 57%.</p> <p>Children’s services reported an average of 10.4 days and met this 73%.</p>
2E	Tracks and trends data on rehospitalizations	FC	<p>The MHP reported a readmission goal of no more than 15%, striving for no readmissions. Overall it reports a readmission rate during FY15-16 of 14.3%, with a total of 166 readmissions.</p> <p>Adult services reported a rate of 13.9% with 146 readmissions.</p> <p>Children’s services reported a rate of 18% with 20 readmissions.</p>
2F	Tracks and trends no-shows	PC	<p>The MHP reported a standard of 20% for clinicians and an overall rate of 4%.</p> <p>Adult services reported an average of 3%.</p> <p>Children’s services reported an average of 7%.</p> <p>The MHP reported a standard of 20% for psychiatrists and an overall rate of at 12%.</p> <p>Adult services reported an average of 10%.</p> <p>Children’s services reported an average of 18%.</p> <p>The MHP indicated its data collection for this metric may be unreliable secondary to the lack of standardized documentation methods. Training staff continues to address this concern. This may warrant a quality review given the high no-show for children’s psychiatry.</p> <p>The MHP was also encouraged to review the standard it has established since it exceeds its own standard and review this standard with any impact on the capacity to serve.</p>

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

Quality of Care

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

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	<p>The MHP presented the customary minutes, Quality Improvement work plan, and an evaluation of the prior year activities in a standardized format inclusive of the goals, objectives, results and follow-up activities.</p> <p>Its overarching philosophy includes the principle of Continuous Quality Improvement (CQI) and promotes integration of planning, outcomes, data measurement, and coordination of performance improvement activities to support quality of care. This applies to both its county run and organizational provider system.</p> <p>The MHP has formed a System Change Steering Committee. The Change Agent team is comprised of multi-disciplinary staff and consumer representatives dedicated to transform the system to its vision and values.</p> <p>Each month, the Department of Behavioral Wellness examines and distributes a flyer indicating how its guiding principles are being put into practice across the County. The ten principles were adopted by the System Change Steering Committee to guide the department in changing practices.</p> <p>The MHP has adopted the 3-4-50 as a community health improvement strategy based on evidence that three (3) health behaviors elevate risk of four (4) chronic conditions that together cause more than fifty (50) percent of deaths.</p>
3B	Data are used to inform management and guide decisions	FC	<p>The MHP uses the training module Relias and can electronically track trainings completed by staff for quality and compliance standards.</p> <p>The MHP generates semi-monthly CANS and MORS reports. These reports help staff and management monitor completion of the CANS and MORS at specified intervals.</p> <p>The MHP generates a bi-annual report which includes extensive consumer demographic data as well as</p>

Table 8—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
		penetration rates, service utilization, timeliness to service and outcome measures. It reports data to the Board of Supervisors and posts its data reports and survey results on-line.
3C	PC	The MHP leadership appears to have taken extensive measures to communicate both internally and in the greater community. Its commitment to transparency is witnessed on its website, its published newsletters and documents and data outcomes are all shared. Change agents work at all levels to support the basic tenets of an evolving system of care. Based on stakeholder feedback, information may flow inconsistently with rapid change. Direct input may not be made available prior to changes. Improvements in the venues for input from consumers, organizational providers and staff for bi-directional feedback for issues that directly affect these segments are encouraged. Among the leaders, the intent for inclusivity is apparent and the experience for others may take time.
3D	PC	Peer employees, staff and organizational providers indicated opportunities may exist, yet the dynamics and reality for involvement may not be realistic. An understaffed system has built up the pressure to be productive, often leaving the option for input placed second. Examining a balance for this conundrum between the realistic workload and creative opportunities requires further adjustment.
3E	FC	The MHP was instrumental in collaborating with the New Hope Community Center in Santa Maria. This is the result of about nine years of planning and collective work on the part of the New Hope Missionary Baptist Church, its members and many local organizations. The community center provides monthly assistance to homeless individuals. Crisis Intervention Training (CIT) was held as an annual training for law enforcement professionals and other first responders in dealing effectively with individuals experiencing behavioral health crises. The MHP has effectively trained officers who now conduct this for the community. A Trauma Informed Care conference hosted by the MHP was attended by organizational providers, partner agencies, schools and other stakeholders. Integration of Behavioral Health Care in Community Clinics is apparent among The Community Health

Table 8—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
		<p>Centers of the Central Coast (CHCC). They offer mental health services at three clinics in Santa Maria and one in Lompoc for individuals with mild or moderate mental illness. Expanded mental health resources in each community health clinic strengthen the capacity to assess, treat, and refer individuals at risk of developing a serious mental health condition.</p> <p>Specialized primary care teams in each region of the county serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60 years of age and over.</p> <p>Teams will also develop ongoing partnerships with all relevant agencies, including, but not limited to, Public Health, alcohol and other drug providers and organizations serving seniors.</p>
3F	FC	<p>The MHP launched a centralized access process for call-in services followed by a scheduled orientation group as a tool to link to assessments. Weekly groups are conducted and an assessment is offered for attendees. Monitoring the engagement of this could provide useful information.</p> <p>Extensive group therapy is conducted, especially for the adult population for depression, anxiety, trauma, and SUD.</p> <p>It initiated an Assisted Outpatient Treatment (AOT) pilot project in Santa Barbara.</p> <p>The MHP expanded with a community-based residential facility at Cottage Grove and established a new e five-bed residential home in downtown Santa Barbara for homeless women.</p> <p>Crisis services include mobile crisis, triage team, a Crisis Stabilization Unit (CSU), two Crisis Residential units for stays up to 30 days (30 beds), and is about to open a third unit (10 additional beds).</p> <p>Inpatient services provide a sixteen bed PHF for inpatient involuntary care.</p> <p>Implementation of Medication Assisted Treatment (MAT) is underway system wide as well as enhanced tracking and monitoring of psychotropic medications.</p> <p>The MHP has designed its ODS and submitted it and awaits approval of this waiver.</p> <p>The MHP is executing a contract with Department of Rehabilitation for three transition-age youth (TAY) workers who will be embedded in three regional TAY teams. The primary goal is to achieve marketable job skills.</p> <p>Intensive residential services provide 24/7 structured</p>

Table 8—Quality of Care		
Component	Compliant (FC/PC/NC)*	Comments
		<p>mental health rehabilitation services and residential care at Mountain House and Crescend Health for individuals at high risk for acute inpatient or long-term residential care.</p> <p>Stakeholder feedback shared on-site noted that parenting education groups for monolingual Spanish-speaking parents would be valuable.</p>
3G	PC	<p>Strengthening Families program is tailored around development of community with a formal curriculum for families to share a meal. It consists of a ten-session intervention. The first pilot will be conducted in Spanish in Santa Maria for families with youth experiencing co-occurring issues. Treatment will include family therapy and incentives to engage and maintain treatment with child care offered.</p> <p>Customary methods such as Child and Family Teams (CFTs), and treatment plans are standardized practice. Consumers were familiar with satisfaction surveys.</p> <p>Given the full array of service provisions, treatment is unique to individual needs.</p> <p>The Team-Based Care model is underway and is a primary strategy to address care coordination.</p> <p>With the expansion of SUD services, a more comprehensive system will be established.</p> <p>Peers are employed, serve as Change Agents and attend MH committees.</p> <p>Provision for consumer access to individual records electronically could enhance quality of care principles.</p> <p>Methods to measure consumer involvement are underway with the use of the team-based model.</p>
3H	FC	<p>The Consumer Empowerment Manager reports to the Deputy Director and attends multiple administrative meetings.</p> <p>It published a Peer Integration Framework to outline the philosophy of consistent peer voices at the executive level, to hire more peer recovery specialists, peer navigators, other peer program staff, including a substantial number of bilingual/bicultural persons.</p> <p>In spite of this comprehensive effort, peer employees indicated the MHP could provide peer staff with the training and support necessary for success. The MHP could re-visit its current orientation and follow up</p>

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
			training for peer employees. Recruitment is underway for three Peer Navigators and will be located at each of the three Behavioral Wellness adult clinics.
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	Recovery Learning Community (RLC) are peer-run centers in each region of the county that offer support groups, classes and social opportunities. Hours are aligned with the business hours of the MHP. Events such as the Art for Recovery Show, Cottage Hospital Art Fair and the summer Mental Health Arts Festival create opportunities for consumers to showcase multi-media art. These are co-hosted by the Santa Maria Recovery Learning Center and the Transitions-Mental Health Association, recovery centers inspiring hope and growth within the region. The centrally located RLC Wellness Center posts its calendar on-line; conducts groups for consumer support, families and in Spanish. Hours and days are aligned with the MHP business schedule.
3J	Measures clinical and/or functional outcomes of consumers served	FC	The Child and Adolescent Needs and Strengths (CANS) for youth and the Milestones of Recovery Scale (MORS) for adults are the identified outcome tools. Both child and adult outcome reports are published and used for treatment and system evaluations.
3K	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP conducts the bi-annual Consumer Perception Survey, surveys its staff for best practices and for language capacity. It reports its results and implements strategies for improvements. The MHP conducted PIPs for timeliness and wait times from feedback it received from survey results.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP implemented system orientation groups, in English and Spanish, for clients and family members, and take place at least monthly at outpatient sites in each region of the County. The goals are to support people immediately as they seek help, empower them to continue their recovery process and decrease in no-shows.
 - The Crisis and Recovery Emergency Services (CARES) unit consolidates intake, mobile crisis response and access to service for mental health and alcohol and

drug emergencies. Staffed by mental health professionals, CARES provide crisis support on a 24/7 basis, serves children and adults, and works closely with the Safe Alternatives for Treating Youth (SAFTY) children's mobile crisis program.

- The SAFTY program is a mobile crisis response program for children, youth, and their families throughout Santa Barbara County.
- Carpinteria Outreach expanded as Behavioral Wellness staff members are available two days a month to see individuals by appointment or on a walk-in basis. Behavioral health education and support, resource and referral guidance, brief therapeutic interventions and behavioral health screenings are available.
- Timeliness of Services
 - Psychiatry capacity and wait times for appointments in conjunction with the general staffing level was addressed through the Non-Clinical PIP. The shortage of psychiatrists had previously led to long wait times for appointments, concern for client care, and frustration on the part of staff and clients. Wait times have since been reduced with efforts used in the PIP.
- Quality of Care
 - The issue of how clients move between levels of care in the system was noted as a potential barrier to access and correlates to communication and stakeholder involvement barriers. Stakeholders noted changes occur more rapidly than implementing them which evokes frustration and confusion.
 - With the approval of the Drug Medi-Cal waiver, substance use disorder services will increase the capacity to provide access to mental health and substance use.
 - Change Agents participate in monthly training meetings where ideas are generated for system change projects specific to programs in a manner consistent with system change values and principles. As change projects are successful in one region, other sites may adopt the intervention to produce standard improvements across the system of care.
- Consumer Outcomes
 - Standardized use of the CANS and MORs offer consumers progress reports for points in time and are encouraged to be shared on-going.
 - The lack of clarity in processes as they change can create confusion and stress for staff, which may be felt by clients.
 - Promotoras work as community health educators to provide culturally and linguistically appropriate services and ensure linkages to services. Cultural wellness practices are integrated into outreach, consultation and early intervention activities.

- Ongoing specific training for peer employees may enhance the lived experience this group brings.
- There has been an expansion of delivery of evidence-based practices used in consumer recovery.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested focus groups with 8 to 10 participants each, the details of which can be found in each section below.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This was a group of culturally diverse mono-lingual Spanish-speaking adult parents/caregivers of youth beneficiaries representing both high and low utilizers of service. The group was held at the office the Santa Maria Outpatient Clinic at 500 West Foster Road, Santa Maria.

Number of participants – 9

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

- Parents knew how to access crisis services if needed for their child.
- Some of the group participants expressed a need for transportation to appointments.
- The majority of the youth received psychiatry appointments, language was not a barrier.
- Some parents noted the appointments were spread out among several regional locations, centralizing these would assist.
- Navigation of appointment scheduling at the clinic is problematic for the various services. Capacity to offer bundled services for multiple children in a family created added stress for some families.

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

- Group participants with longer service experience noted improved service delivery.
- All of the group noted that cultural stigma exists for mental health treatment which makes it difficult for group participants to be open in their community about receiving services.

Recommendations for improving care included the following:

- Consider an awareness campaign in the Latino community to reduce stigma.
- Increase community education and informational workshops regarding available services.
- Coordinate services between family and the schools for treatment needs.
- Schedule groups for parent education to develop competency in recovery support. Provide support groups for mono-lingual Spanish-Speaking parents.
- Informational workshops on how to speak to the therapist/psychiatrist where consumers can ask about specific situations.

Interpreter used for focus group 1: No Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This was a group of culturally diverse adult beneficiaries representing both high and low utilizers of service. The group was held at the office of the Behavioral Wellness Administration at 315 Camino Del Remedio, Santa Barbara.

Number of participants – 8

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

- Group participants had knowledge about how to access crisis care, current mental health news, completed satisfaction surveys and were involved in their treatment planning.
- Some of the group indicated call-backs from staff were slow which left them frustrated.
- Group participants thought increased coordination between agencies was warranted, especially with primary care and law enforcement.
- Attendees were positive about group therapy and attended specific groups. Examples given were the bipolar group, anger management, harm reduction, and addiction groups.
- Group participants indicated access to first appointment is timely, however subsequent appointments are scheduled up to eight weeks which for some felt delayed.

Recommendations for improving care included the following:

- Ensure communication and coordination between community providers regarding treatment.
- Increase opportunities for jobs or volunteer positions.
- Provide education to help reduce stigma in community.

- Coordinate information exchange between primary care doctors and psychiatrists.
- Decrease appointment cancellations by staff.

Interpreter used for focus group 1: No Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
 - Group members indicated access was efficient.
 - Limited groups for monolingual Spanish-speakers were noted.
- Timeliness of Services
 - Appointments were scheduled in a timely manner.
 - Some staff cancel appointments which impacted stress levels for consumers.
- Quality of Care
 - Overall, the majority of participants felt positive about treatment.
 - Group treatment appeared to be effective for this cohort.
- Consumer Outcomes
 - Consumers and parents were aware of treatment plans.
 - It was widely known how to access crisis care.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 9—Distribution of Services by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	40.88%
Contract providers	57.68%
Network providers	1.45%
Total	100%

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

3%

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

Yes
 In Testing/Pilot Phase
 No

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

Yes
 In Testing/Pilot Phase
 No

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

2

- Telepsychiatry is available in the Crisis Stabilization Unit and Santa Maria clinic offices.
- Direct services through telepsychiatry practitioners are available in the following languages (does not include the use of additional translators): English, Spanish.
- The MHP reports 222 adults, 47 children/youth and 15 older adults were served via tele-psychiatry in calendar year 2016.
- MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

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

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

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
6	0	0	1

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

- Technology staffing consists of 10 Full Time Employee (FTE) positions. As of April 2016, there were two unfilled technology positions: Programmer Analyst (1 FTE), and Computer Support Specialist (1 FTE). These positions are vacant as the MHP is currently leveraging the funds for the ServiceNow project. The need for these positions will be re-assessed upon completion of the ServiceNow project.
- The MHP has seven analyst staff and one analyst vacancy, EDP Analyst. This position is in recruitment.

CURRENT OPERATIONS

- The MHP continues to utilize ShareCare from The Echo Group to support practice management, billing, and state-reporting functionality. Clinician’s Gateway, from Platton Technologies, is utilized for electronic health record (EHR) functionality including progress notes, treatment plans and assessments. Data is exchanged between the two systems.

- The MHP reports that 40.88% of services are provided by county operated clinics, 57.68% by contract providers, and 1.45% by network providers. It reported 87.27% of services are claimed to Short Doyle Medi-Cal (SD/MC).
- Contract provider staff logon to the Santa Barbara County secure network to access ShareCare and Clinician’s Gateway. Providers use file transfer protocol (FTP) process to upload service transactions and other data to ShareCare.
- The MHP generates a bi-annual report which includes extensive service data including demographic data, penetration rates, service utilization, timeliness to service and outcome measures. Cal-EQRO data is also reviewed.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12— Primary EHR Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
ShareCare	Practice Management, Managed Care, Master Patient Index	The Echo Group	10	MHP
Clinician’s Gateway	EHR	Platton Technologies	11	MHP
RxNT/eRX	e-Prescribing	RxNT	9	MHHP/Vendor

PLANS FOR INFORMATION SYSTEMS CHANGE

- While there are no current plans to replace the ShareCare/Clinicians Gateway system, the MHP plans to continue its EHR replacement module evaluation.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts			x		
Assessments	CG/Krassons	x			
Document imaging/storage	CG/Krassons		x		
Electronic signature—consumer	CG/Krassons	x			
Laboratory results (eLab)	CG/Krassons	x			
Level of Care/Level of Service		x			
Outcomes	CG/Krassons	x			
Prescriptions (eRx)	RxNT/RxNT	x			
Progress notes	CG/Krassons	x			
Treatment plans	CG/Krassons	x			
Summary Totals for EHR Functionality		8	2	0	0

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

- All outpatient clinics, PHF doctors and social workers are now utilizing the EHR.
- The EHR contains a red-flag notification when a client treatment plan is due.
- Staff have begun the process of scanning archived records for the PHF.
- Consumer’s Chart of Record for county-operated programs (self-reported by MHP):

Paper Electronic Combination

MAJOR CHANGES SINCE LAST YEAR

- Clinical Reporting System project phase one is complete. Phase one data is accessible through the MHP Provider Portal and allows filtering based on 19 selectable parameters and data can be viewed on screen or exported in a variety of formats. No personally identifiable information is contained within the data presented.
- 42 CFR ADP Specific Security Enhancements for Clinician’s Gateway and ShareCare were completed in September 2016.
- The pre-consumer module and access screening was completed and implemented in Clinician’s Gateway in October 2016. Concurrent with the pre-consumer module, the

MHP developed an enhanced service-specific access template that tracks all client encounters in one place (routine, urgent, crisis, sex-trafficking, alcohol & drug services, request for information, and outreach and engagement).

- CSI file submission to DHCS is now current.
- ServiceNow was selected as the Service Management solution.
- A Clinical Supervisor Documentation Activity Report was released in Clinician's Gateway.
- A Clinician's Gateway notification was created for Treatment Plan due date.
- A psychiatric referral template that tracks psychiatrist wait times was created.
- The MHP is now electronically tracking Child and Family Team meeting progress notes for Intensive Care Coordination (ICC) services. Previously paper notes were utilized.
- All client assessment tools have been updated within Clinician's Gateway.
- Alcohol and Drug Program (ADP) contract providers have been transitioned to Clinician's Gateway to complete their documentation.

PRIORITIES FOR THE COMING YEAR

- Improve system security based on suggestions provided by a prior cyber security review.
- Create a more robust Clinician's Gateway notification system to facilitate improved clinician productivity.
- Go-live with ServiceNow.
- Upon implementation of ServiceNow, review security protocols required to proceed with Clinical Reporting System phase 2.
- Continue to create Clinician Gateway reports to meet ongoing department needs.

OTHER SIGNIFICANT ISSUES

- While the MHP and a local hospital, Cottage Health, held four meetings to discuss a community health information exchange, which would grant the MHP read-only access to hospital and other participant provider records, these meetings have been put on hold by Cottage Health until internal security concerns can be addressed. Cottage Health is not currently able to advise the MHP when or if they will continue with this initiative.
- The MHP continues to work with CenCal Health, a County Organized Health System (COHS) model, to improve integrated care for Medi-Cal beneficiaries who live in Santa

Barbara and San Luis Obispo counties. The MHP recently gained access to CenCal’s provider portal, allowing MHP staff to look up information regarding a client’s primary care provider.

MEDI-CAL CLAIMS PROCESSING

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

If yes, product or application:

EOB database, ShareCare Medi-Cal Reconciliation, SQL database, Excel.

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

Table 14—Summary of CY15 Processed SDMC Claims—Santa Barbara

Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
160,180	\$36,061,324	\$1,741,183	4.83%	6,354	\$34,320,141	\$6,896,663	\$27,423,478

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

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
 - The MHP is currently utilizing telepsychiatry in Santa Maria and at the CSU during the overnight hours.
 - ADP contract providers have access to Clinician’s Gateway for the documenting of services.
- Timeliness of Services

- A pre-consumer module was developed to allow for the capability to track an individual's first encounter with the mental health plan.
- A psychiatric referral template that tracks psychiatrist wait times was created.
- Quality of Care
 - Clinical Reporting System project phase one is complete.
 - All outpatient clinics, PHF doctors and social workers are now utilizing Clinician's Gateway.
 - The MHP generates a bi-annual report which includes extensive service data including demographic data, penetration rates, service utilization, timeliness to service and outcome measures.
 - A Clinical Supervisor Documentation Activity Report was released in Clinician's Gateway.
 - A Clinician's Gateway notification was created for Treatment Plan due date.
 - The MHP is now electronically tracking Child and Family Team meeting progress notes for ICC services.
 - The MHP recently gained access to CenCal Health, the local Medi-Cal provider portal, allowing MHP staff to look up information regarding a client's primary care provider.
 - Deferred diagnosis is twice the statewide average (8% vs. 4%).
- Consumer Outcomes
 - The MHP has semi-monthly, auto-generated Child and Adolescent Needs and Strengths and Milestones of Recovery Scale reports.

SITE REVIEW PROCESS BARRIERS

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

- No barriers were noted in conducting this review.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
 - Orientation groups are designed to help consumers understand how the system works, meet peers in recovery, provide a personal connection to staff, and increase sustained engagement.
 - The MHP initiated a system-wide centralized access line with standardized response information and processes.
 - The MHP is currently utilizing telepsychiatry in Santa Maria and at the CSU during the overnight hours to provide increased access.
- Opportunities:
 - Although the orientation group provides a venue for early consumer engagement, the MHP does not consistently collect data for attendance nor for those consumers continuing care following this strategy.
 - Determining the rate of engagement with services following the initial assessment may inform the MHP of the success of its new centralized access.
 - Given the high rate in the deferred diagnosis category, due diligence suggests review and improvement activities may be needed to train staff.
 - Two Information Technology positions are currently vacant, with funds allocated for the ServiceNow project. The need for these positions is encouraged to be re-assessed upon completion of the ServiceNow project.

Timeliness of Services

- Strengths:
 - A module was developed to allow for the capability to track an individual's first encounter with the mental health plan prior to the opening episode.

- A psychiatric referral template that tracks psychiatrist wait times was created to monitor adherence to this metric.
- The MHP has developed a PIP that is demonstrating success in reducing the wait time to the first psychiatric appointment.
- Opportunities:
 - The no-show metric is not consistently documented in a standardized manner among the providers. As a result, data collected is not considered reliable.
 - Attention to the no-show standard may warrant further consideration as the data becomes more reliable to improve the capacity to serve by reducing no-show rate.

Quality of Care

- Strengths:
 - The MHP documents its quality activities on its website, in the newsletters and in routine minutes. The QI work plan documents the results of these actions.
 - The MHP is electronically tracking Child and Family Team meeting progress notes for the Child Family Treatment team meetings, providing access for all team members.
 - The MHP regularly implements updates to its forms and policies, although this may inadvertently cause miscommunications if not dispersed uniformly.
 - The MHP recently gained access to CenCal Health, the local Medi-Cal provider portal, allowing MHP staff to look up information regarding a client's primary care provider, lending to coordination of care.
 - A notification in Clinician's Gateway was created for Treatment Plan due date to establish early consumer involvement in care.
- Opportunities:
 - Review of the potential reasons for the deferred diagnosis is warranted in that it is reported to be twice the statewide average (8% vs. 4%).
 - Review the documentation and diagnostic training for staff for improved confidence in diagnosing. Consider using peer discussions.
 - An unintended consequence of striving to rapidly improve its service delivery may impact the ability of providers to determine the most current practice, resulting in inconsistent communications.
 - Although the MHP has produced a commendable Peer Integration Manual, training reviews and refresher modules could benefit peer employees.

Consumer Outcomes

- Strengths:
 - The MHP has semi-monthly, auto-generated CANS and MORS reports to track for treatment progress and service needs.
 - Consumer employees are represented in multiple productive assignments and sit on committees across the system.
- Opportunities:
 - Consumer feedback indicated a need for increased training to boost consumer employee confidence in completing job assignments.
 - Periodic reviews of peer employee tasks for scope of practice discussions appears limited with the Consumer Empowerment Manager.
 - Provisions for scheduling flexibility for consumers may contribute to increased job satisfaction.
 - Peer employees desire increased time with managers to discuss current challenges, build job skills, and advance.
 - Provisions for health information exchange with Cottage Health have been tabled secondary to further examination of the security regulations.
 - Improving the ability to exchange information among providers and for consumers to access health information is suggested.

RECOMMENDATIONS

- Track, monitor and examine the follow-up data from the orientation group for consumer engagement with services, including organizational provider referrals.
- Review and provide adequate training for consumer employees to perform their job duties. Engage in regular meetings for the Peer Support Specialists with the Consumer Empowerment Manager for bi-directional communication.
- Upon implementation of ServiceNow, assess the need to fill or deploy staff to the two vacant Information Technology positions. Assess data security and the viability to move forward with phase two of the Clinical Reporting System project.
- Identify reasons, analyze and implement solutions regarding the rate for deferred diagnosis as it is twice the statewide average.
- Maintain communication with Cottage Health to create a clear strategy to proceed with the community health information exchange.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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

Table A1—EQRO Review Sessions - Santa Barbara MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Employee Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Wellness Center Site Visit
Contract Provider Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Jovonne Price, Quality Reviewer Consultant
Saumitra SenGupta, Executive Director
Lisa Farrell, Information Systems Reviewer
Luann Baldwin, Consumer/Family Member Consultant
Robert Greenless, Information Systems Reviewer Consultant

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

SITES OF MHP REVIEW

MHP SITES

Behavioral Wellness Department
Santa Barbara Children's Clinic
429 North San Antonio Road
Santa Barbara, CA 93454

Behavioral Wellness Department
Administration
315 Camino Del Remedio
Santa Barbara, CA 93454

Santa Maria Recovery Learning Center
225 East Inger Drive, Suite 101A
Santa Maria, CA 93454

Santa Maria Outpatient Clinic
500 West Foster Road
Santa Maria, CA 93454

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
Alice Gleghorn	Director	Behavioral Wellness Department
Amanda Pyper	Regional Manager	Behavioral Wellness Department
Ana Vicuna	Division Chief Clinical Operations	Behavioral Wellness Department
April Howard	Research & Program Evaluation Manager	Behavioral Wellness Department
Barbara Watts	Peer Recovery Assistant	Behavioral Wellness Department-Crisis Triage
Careena Robb	Quality Care Coordinator	Behavioral Wellness Department
Celeste Andersen	Chief of Compliance	Behavioral Wellness Department
Chris Ribeiro	Chief Financial Officer	Behavioral Wellness Department
Dana Gamble	Assistant Deputy Director	Public Health Department
David L. Scott	Community Action Commission of Santa Barbara	Behavioral Wellness Department
Deana Huddleston	Quality Care Manager	Behavioral Wellness Department
Debbie Trinidad Wilson	Practitioner Intern	Behavioral Wellness Department
Deborah Hartman	Child Welfare Services Manager	Behavioral Wellness Department
Denys Medel	Quality Care Coordinator	Behavioral Wellness Department
Dipak Neupame	Financial Systems Analyst	Behavioral Wellness Department
Emma Cummings	Peer Recovery Assistant	Behavioral Wellness Department-Assertive Community Treatment
Evoli Pateris	Santa Maria Team Supervisor	Behavioral Wellness Department
Frank Ricceri	Division Director	Behavioral Wellness Department
Gizelle Mendoza	Quality Care Coordinator	Behavioral Wellness Department
Hadisha Persen	Practitioner Intern	Behavioral Wellness Department
Heidi Raren	Assistant Director	The Holman Group
Ivan Onofre	Peer Recovery Specialist	Behavioral Wellness Department
James Nichols	Registered Nurse	Behavioral Wellness Department
Janet Alexander	Santa Barbara Adult Supervisor	Behavioral Wellness Department
Jonathan Gee	Intern	Behavioral Wellness Department
Kassie Knudsen	Quality Care Management	Behavioral Wellness Department
Ken Opdyke	Santa Barbara Adult Supervisor	Behavioral Wellness Department
Kristen Isaac	Crisis Stabilization Unit Supervisor, RN	Behavioral Wellness Department
Larisa Traga	Team Supervisor	Behavioral Wellness Department

Name	Position	Agency
Lilia Bazan	Peer Recovery Assistant	Behavioral Wellness Department
Lisa Conn	Team Supervisor	Behavioral Wellness Department
Lourdes Syslo	Peer Recovery Specialist	Behavioral Wellness Department
Lupe Varela	Peer Recovery Assistant	Behavioral Wellness Department-Spirit
Marcus Sola	Senior Vice President	The Holman Group
Maria Gardner	Deputy Director	Social Services Department
Marshall Ramsey	Division Chief Information Technology	Behavioral Wellness Department
Marshall Ramsey	Division Chief Information Technology	Behavioral Wellness Department
Michaela R-Ballard	Justice Alliance Supervisor	Behavioral Wellness Department
Nadine Van Cleeve	Day Coordinator	The Holman Group
Nick Tatomer	Peer Recovery Specialist	Behavioral Wellness Department
Nicole Becker	Lompoc Adult Supervisor	Behavioral Wellness Department
Ole Behrendtsen	Medical Director	Behavioral Wellness Department
Pam Fisher	Deputy Director	Behavioral Wellness Department
Rae Vargas	Practitioner Intern	Behavioral Wellness Department
Richelle Bucayu	Administrator	Behavioral Wellness Department
Sandy Fahey	Regional Manager	Behavioral Wellness Department
Sara Bazan	Team Supervisor-Santa Barbara	Behavioral Wellness Department
Selena Pavlov	Senior Program Analyst	Behavioral Wellness Department
Shantal Hover	Health Educator	Public Health Department
Shereen Khatapoush	Research & Evaluation Associate	Behavioral Wellness Department
Suzann Uffelman	Internal Audit	Behavioral Wellness Department
Suzanne Grimmesey	Chief Quality Care & Strategy Officer	Behavioral Wellness Department
Tammy Summers	Adult Manager	Behavioral Wellness Department
Thelma Macias-Guerra	Team Supervisor-Lompoc	Behavioral Wellness Department
Tina Wooton	Consumer Empowerment Manager	Behavioral Wellness Department
Tom Sodergren	Casa Pacifica	Behavioral Wellness Department
Yaneri Munoz	Policy and Project Coordinator Ethnic Services and Diversity Manager	Behavioral Wellness Department

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

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

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

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	\$533,318,886	\$4,060
Medium	444,730	17,965	4.04%	\$79,457,048	\$4,423
Santa Barbara	25,070	1,293	5.16%	\$4,496,508	\$3,478

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

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
\$0K - \$20K	4,529	93.06%	94.46%	\$16,886,606	\$3,729	\$3,553	58.40%	61.20%
>\$20K - \$30K	167	3.43%	2.67%	\$4,029,663	\$24,130	\$24,306	13.94%	11.85%
>\$30K	171	3.51%	2.86%	\$8,000,918	\$46,789	\$51,635	27.67%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

CLINICAL PIP

GENERAL INFORMATION

MHP: Santa Barbara

PIP Title: Improving Treatment: Training, Client Engagement and Team-based Care

Start Date: 11/01/15

Completion Date: in process

Projected Study Period (#of Months): over 24 months

Completed: Yes No

Date(s) of On-Site Review: 04/05-04/06/17

Name of Reviewer: Jovonne Price

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

Rated

- Active and ongoing (baseline established and interventions started).
- Completed since the prior External Quality Review (EQR)

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

- Concept only, not yet active (interventions not started)
- Inactive, developed in a prior year
- Submission determined not to be a PIP
- No Clinical PIP was submitted

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

The problem is that clients are not getting the benefit of a timely, high quality treatment plan that engages them and reports 70% were completed timely.

The treatment plan is not being fully utilized as a clinical tool; both in that staff are not working together as a team and are not engaging clients in the

development and ongoing utilization of the treatment plan. Moreover, clinicians are not initially completing or renewing plans on time (as indicted by MIS Treatment plan report), which is another indicator that plans are not being utilized as we would hope.

The MHP decided to refocus the PIP on the clinical improvement of treatment planning and provision in terms of client engagement and team-based care, while continuing the focus on timeliness. The overarching goal of the PIP is to improve client outcomes by improving the process and the provision of treatment by training and using the Team-based Care model. The interventions planned for this PIP should result in timely, high quality treatment plans that engage clients and their care team, and expects to see improved client outcomes in the CPS, CANS and MORS.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	A multi-functional team including consumer stakeholders was assembled.

<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	<p>The MHP’s previous inquiry and interventions regarding treatment plans were administrative and focused on compliance and billing. The interventions included: a) creating new reports for managers, and b) implementing a new “business rule” that blocked services from billing without an active treatment plan.</p> <p>Broadly, the goal of these interventions was to decrease incomplete treatment plans, in terms of three identified problem areas: 1) incomplete provider or service information; 2) missing signatures; and, 3) expired treatment plans.</p> <p>In the process of identifying these issues and implementing the interventions, it became clear to MHP staff that problems with the treatment plans were not merely administrative, but that there were additional issues, namely, that there is a lack of use among staff and with clients, as well as the ongoing concern about timeliness.</p> <p>The MHP used the MIS Monthly Treatment Plan Report (developed October 2013, and revised in January 2016), as well as anecdotal and qualitative data from regional managers and team supervisors indicating that the treatment planning process did not adequately include the client’s perspective, goals or voice on a consistent basis.</p> <p>Treatment plans are to be completed within 60 days of assessment and annually thereafter. Without this documented, it is inferred that treatment involving the consumer may not be adequately reflected.</p>
<p>Select the category for each PIP:</p> <p><i>Clinical:</i></p> <p> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions </p>		<p><i>Non-Clinical:</i></p> <p><input type="checkbox"/> Process of accessing or delivering care</p>

<p>1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Specifically, the MHP intends to show improved care via the Team-based Care Model leads to improved scores on the CANS for youth (5% Improvement in domain scores over time) and the MORs for adults (Stability /Improvement in score over time).</p> <p>The MHP also used 5% improved satisfaction based on the Consumer Perception Survey as an indicator of change.</p> <p>The MHP will need to define its metric for improvement for the MORs score as such it is non-specific and non-measurable.</p> <p>As the name suggests, team-based care is not individual care or care that is centered between a single client and a single helping professional. While client care is individualized, treatment is not provided by a single professional but by a team of professionals, all of whom are available to help the client at any given time, regardless of client needs.</p> <p>Generally, the PIP is being used to improve the process and ultimately outcomes of care by providing:</p> <ul style="list-style-type: none"> ○ Focus - in the form of the study question and problems being addressed ○ Structure – in the form of the stakeholder group and meetings ○ Interventions and accountability – in the form of the planned interventions and a timeline with measurable goals and indicators.
<p>1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The primary consumer population for this PIP is all clients directly served by the MHP with demographic data for FY 2014/15 serving as the baseline figures.</p>
Totals		<p>4 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 2: Review the Study Question(s)									
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> Are client outcomes, as measured by the CPS, CANS and MORS, improved by implementing:</p> <p>1) training for clinical staff 2) the team-based care model and tools; and 3) improved MIS treatment related reports (for managers and supervisors)?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Although the question includes the intervention of the Team-based Care model, the indicators for change will need to be quantified for the MORS scores in the indicator section.</p>							
Totals		1	Met	0	Partially Met	0	Not Met	0	UTD
STEP 3: Review the Identified Study Population									
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The primary consumer population for this PIP is clients directly served by the MHP with demographic data for FY 2014/15.</p>							
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i> <input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP presented data for the CPS, CANS and MORS scores, staff Treatment Planning Survey, and the Treatment Plan report.</p>							
Totals		2	Met	0	Partially Met	0	Not Met	0	OUTD

STEP 4: Review Selected Study Indicators									
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <p>--Consumer Perception Survey (5% improvement in three client survey measures related to treatment care and functioning)</p> <p>--Improved Child and Adolescent Needs and Strengths (CANS) scores for youth (5% improvement in scores)</p> <p>--Improved Milestones of Recovery Scale (MORS) scores for adults</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Goals for the CPS and the CANS (youth) scores have been noted for measurable improvement, yet the MORS scores have not been quantified or defined with measurable data.</p> <p>The MORS does indicate improved scores in its goals, however, without a measurement, the MHP does not have a quantifiable indicator to objectively measure the metric.</p>							
<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input checked="" type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Goals for the CANS (youth) and MORS (adult) scores, CPS, and staff survey for best practices have been noted for improvements. Details are included in the PIP Submission Tool.</p>							
Totals		1	Met	1	Partially Met	0	Not Met	0	UTD
STEP 5: Review Sampling Methods									
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine								

<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		Met Partially Met Not Met UTD
STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>See Item 4.2.</p> <ul style="list-style-type: none"> • Consumer Perception Survey (CPS) is administered twice a year • CANS (Child and Adolescent Needs and Strengths) is administered at intake and every 6 months thereafter) • MORS (Milestones of Recovery Scale) is administered monthly
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p> <p><input checked="" type="checkbox"/> Member <input type="checkbox"/> Claims <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: client chart</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study’s indicators apply?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	

<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input checked="" type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool</p> <p><input checked="" type="checkbox"/> Outcomes tool <input checked="" type="checkbox"/> Level of Care tools</p> <p><input type="checkbox"/> Other:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Data were collected quarterly and bi-annually, depending on the data source/availability, and have been compared to the baseline.</p> <p>Reports have been prepared for the PIP stakeholder group and the MHP’s leadership and stakeholders (e.g., Leadership Team, Behavioral Wellness Commission) have been given regular reports on the progress of the study.</p> <p>If untoward results are found, they will be immediately brought to the attention of the appropriate stakeholders (e.g., MHP Executives, Managers) and addressed.</p>
<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i></p> <p>Name:</p> <p>Title:</p> <p>Role:</p> <p><i>Other team members:</i></p> <p>Names:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>Data has been collected by multiple MHP staff. For example, one or more staff at each outpatient clinic has assisted with CPS data collection, while Shereen Khatapoush, PhD, Research and Program Evaluation Associate, has administer the supervisor surveys. Dr. Khatapoush has conducted data analysis and reporting, with supervision by April Howard, PhD, the MHP’s Research and Program Evaluation Manager. Jelena Pavlov, MS, MIS Programmer Analyst Senior, has produced data for analysis from the electronic health record.</p>
Totals		<p>6 Met 0 Partially Met 0 Not Met 0 UTD</p>

STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ul style="list-style-type: none"> -Trainings for staff in Treatment Planning (goal=at least 6) -Attendance by staff in trainings (goal=100%) -Current Treatment Plan active (goal=90%) -Team Supervisory survey of Team Care (goal=all 8 teams) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP included 70% of treatment plans completed timely as the baseline.</p>
Totals		1 Met 0 Partially Met 0 Not Met 0 NA 0 UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		

<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine </p>	<p>Initial data was collected, the MHP reported it is continuing this PIP, thus analysis has not been completed.</p> <p>During FY15/16, 226 clients received CANS scores for three timelines: An initial, at 6-months, and at 12-months.</p> <p>Results from the CANS in the four domains of Behavioral/Emotional Needs, Life Functioning, Child Risk Behaviors and School Behaviors indicated that children have made progress.</p> <p>Results of MORS data analyses are reported separately, for Transitional Age Youth (TAY) programs, Adult Outpatient and Assertive Community Treatment (ACT).</p> <p>The Transitional Age Youth (TAY) programs began using MORS instead of the CANS in spring 2016. The vast majority of TAY clients had a baseline MORS score (N=69) of five or six – poorly coping and engaged, to coping and rehabilitating (65.2%). The average baseline score was 5.5.</p> <p>The relationship between baseline and 6-month MORS scores reports was: About thirty-five percent (35.6%) of TAY clients improved, half (50.2%) had no change in score and fourteen percent (14.2%) of clients declined over time. Thus, more than eighty-five percent (85%) improved or stayed the same.</p> <p>The adult outpatient clinics began completing the MORS in December 2015/January 2016. The vast majority of adult outpatient clients had a baseline MORS (N=372) of five or six – poorly coping and engaged, to coping and rehabilitating (69.2%). The average baseline score was 5.41.</p> <p>The relationship between baseline and 6-month MORS scores reports was: Twenty-nine percent (29%) of clients improved, slightly more than half (54%) remained the same, while seventeen percent (17%) declined over time. Thus, more than eighty percent (80%) of clients improved or stayed the same.</p> <p style="text-align: right;">Page 72</p> <p>The Assertive Community Treatment (ACT) programs implemented MORS in July 2015. The ACT programs are intended to serve the most challenged clients in the outpatient system, which can make</p>
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<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The results are in the initial stages of data collection and findings cannot be conclusive at this point.</p>
<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The initial baseline data for current treatment plans was 60%. As the MHP reviewed the data, it made a few modifications to the inclusion criteria (taking out facilities and programs that do not do treatment plans). The adjusted/recalculated baseline was 70%</p> <p>No issues were found with data analysis thus far.</p> <p>No statistical analyses were used as they were deemed unnecessary as sums, means, percentages and percentage change were used.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p><i>Recommendations for follow-up:</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The MHP stated it is not yet complete and expected to complete the PIP by the end of FY1617.</p>
Totals		<p>0 Met 3 Partially Met 0 Not 1 NA 0 UTD</p>

STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated?</p> <p><i>Ask: At what interval(s) was the data measurement repeated?</i></p> <p><i>Were the same sources of data used?</i></p> <p><i>Did they use the same method of data collection?</i></p> <p><i>Were the same participants examined?</i></p> <p><i>Did they utilize the same measurement tools?</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		0 Met 0 Partially Met 0 Not Met 5 NA 0 UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
<i>Conclusions:</i>	
<i>Recommendations:</i>	
<p>Specifically, the MHP intends to show improved care via the Team-based Care Model leads to improved scores on the CPS, the CANS for youth and the MORs for adults. Improvements for the MORs needs to be defined with measurable indicators. The MHP also used 5% improved satisfaction based on the Consumer Perception Survey as an indicator of change.</p> <p>Generally, the PIP is being used to improve the process and ultimately outcomes of care by providing improved models and increased timely treatment plans involving consumers.</p>	
Check one:	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible <input type="checkbox"/> Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17

NON- CLINICAL PIP

GENERAL INFORMATION

MHP: Santa Barbara

PIP Title: Timeliness to Psychiatry Services

Start Date: 04/01/2014

Completion Date: 04/01/2017

Projected Study Period (#of Months): over 24 months

Completed: Yes No

The MHP intends to complete this by the end of FY1617.

Date(s) of On-Site Review: 04/05-04/06/17

Name of Reviewer: Jovonne Price

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

Rated

- Active and ongoing (baseline established and interventions started); the MHP intends to complete this by the end of FY1617 and will be considered complete. A new PIP is anticipated.
- Completed since the prior External Quality Review (EQR)

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

- Concept only, not yet active (interventions not started)
- Inactive, developed in a prior year
- Submission determined not to be a PIP
- No Non-Clinical PIP was submitted

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

The goal is to reduce time between admission and psychiatric assessment, thus improving system functioning, the process of client care and, ultimately, client outcomes.

In November of 2013, the Quality Improvement Committee (QIC) Timeliness Sub-Committee focused on psychiatry wait times as a potential PIP. The committee began reviewing the MHP’s policies, the data presented in the TriWest report and available wait time data generated by MIS/IT. The MHP established a policy in1998 that clients would be seen by a mental health provider within 10 days of contact with the Access Team or inpatient

discharge; however, a standard for psychiatry services was not determined or set forth in policy. As no standard in place for time to the first psychiatry appointment for new clients, several stakeholder meetings were devoted to reviewing the wait time data, discussing how wait time data are collected in the MIS/IT system, gaps in that process, and client flow through the access/intake system.

The stakeholders determined that a more accurate and meaningful measure of access to psychiatry would be the time between admission and the first psychiatric appointment (rather than time between first system contact and psychiatry appointment). Using this new definition of timeliness, FY 2013/14 data were examined, which revealed that the adult system wait time was 30.13 days, and in the children's system wait time was 29.89 days. A standard of 21 days between admission and the first psychiatric appointment was established.

The objective of this ongoing and evolving PIP is to implement a variety of strategies, in phases, to reduce the time new clients wait before having their first psychiatric appointment. The MHP is utilizing the NIATx principles and practices of Plan, Do, Study, and Act to implement and evaluate the impact of various interventions over time, such as:

- appointment reminder calls
- team-based appointment management
- increased clinical/peer contacts prior to psychiatric assessment
- implementation of a singular, standardized appointment scheduling system throughout the county
- enhanced recruitment of psychiatrists and physician assistants
- incentivizing psychiatrists' productivity.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	A multi-functional team consisted of a broad-based group of stakeholders, including contracted organizational providers, and consumer representation.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP did not have an established standard goal for timeliness to psychiatry appointments. Baseline data collected in January 2014 indicated the wait time was reduced to 40 days for adults and 45 days for children.</p> <p>The stakeholders determined that a more accurate and meaningful measure of access to psychiatry would be the time between admission and the first psychiatric appointment FY 2013/14 data were examined, which revealed that the adult system (all clinics combined) wait time was 30.13 days, and in the children’s system (all clinics combined) wait time was 29.89 days.</p> <p>As there was no standard in place for time to the first psychiatry appointment for new clients, several stakeholder meetings were devoted to reviewing the wait time data and determined a PIP was warranted.</p>
<p>Select the category for each PIP:</p> <p><i>Clinical:</i></p> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<p><i>Non-Clinical:</i></p> <input checked="" type="checkbox"/> Process of accessing or delivering care
1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The goal is to reduce time between admission and psychiatric assessment, thus improving system functioning, the process of client care and, ultimately, client outcomes.</p> <p>Inferred in this goal is the hope that earlier appointments will address symptoms earlier, engage consumers, and lead to improved functioning.</p>

<p>1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP will include all new clients entering the system though one of the MHP’s adult or children’s service sites.</p>
Totals		<p>4 Met 0 Partially Met 0 Not Met 0 UTD</p>
STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> Will implementing the six (6) interventions of the PIP: result in:</p> <p>a) a reduction in client no-show rates b) a reduction and wait time between admission and first psychiatric appointment in the adult and children’s systems of care?</p> <p>(Interventions: 1. appointment reminder calls; 2. team-based appointment management; 3. increased clinical/peer contacts prior to psychiatric assessment; 4. implementation of a singular, standardized appointment scheduling system throughout the county; 5. enhanced recruitment of psychiatrists and physician assistants; and 6. incentivizing psychiatrists’ productivity)</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Reducing no-show rates and reducing wait times implies increased availability for appointments and hopefully earlier engagement. Both are consumer benefits. Results on these metrics should be the core of the PIP.</p> <p>Standardizing systems, hiring staff and incentivizing are activities which contribute to overall quality of care, yet do not directly benefit consumers.</p>
Totals		<p>1 Met 0 Partially Met 0 Not Met 0 UTD</p>
STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The PIP will include all new clients entering the system though one of the MHP’s adult or children’s service sites.</p>

<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input checked="" type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification</p> <p><input type="checkbox"/> Other:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		2 Met 0 Partially Met Not Met UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <p>The primary indicators for the PIP are:</p> <ul style="list-style-type: none"> • the average wait time between admission date and first psychiatric appointment • no-show rates for first psychiatric appointment <p>The other indicators the MHP measured are:</p> <ul style="list-style-type: none"> • psychiatric staffing levels • physician assistant staffing levels. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The first 2 indicators measure outcomes which affect consumers. The other 2 indicators are useful to the MHP to inform them of capacity issues.</p>
<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.</p> <p><input type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The goal is to reduce time between admission and psychiatric assessment, and to reduce no-shows thus improving system functioning, the process of client care and, ultimately, client outcomes.</p>
Totals		2 Met 0 Partially Met 0 Not Met 0 UTD

STEP 5: Review Sampling Methods					
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine				
5.2 Were valid sampling techniques that protected against bias employed? <i>Specify the type of sampling or census used:</i>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine				
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)	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine				
Totals		Met	Partially Met	Not Met	UTD
STEP 6: Review Data Collection Procedures					
6.1 Did the study design clearly specify the data to be collected?	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	-Psychiatric appointment wait time (Goal=21 days) -No-shows (Goal= <5%) -Number of Psychiatrist FTEs (Goal =25.62 FTEs) -Number of Physician Assistant FTEs (Goal=4 FTEs) -% clinical time (service & doc) -% face time (client engagement)			
6.2 Did the study design clearly specify the sources of data? <i>Sources of data:</i> <input type="checkbox"/> Member <input type="checkbox"/> Claims <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: E HR	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data will be reported separately for adults and children. Wait time and no-show data will be drawn from the MHP’s electronic health record system. Human Resources will provide data on the number of new psychiatrist hired and number of psychiatrist FTEs in the system. In addition to the primary indicators, the MHP will monitor performance of the specific interventions			

<p>6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?</p>	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	<p>The MHP reported its data collection system is changing and it may not have reliable data due to this for its show-rate.</p> <p>The data to be collected are the following:</p> <ol style="list-style-type: none"> 1. Client no-shows to psychiatric appointments for adult and child clients: Quarterly reports are provided by the MIS/IT department for no-shows for the adult and child systems of care 2. Time between admission to the system and first appointment with a psychiatrist: Quarterly reports are provided by the MIS/IT department for wait times for the adult and child systems of care 3. Number of FTE psychiatrists and physician assistants working in the system: Human Resources and/or Medical Director provide staffing level data 4. Psychiatrist productivity: The percent of clinical time (direct service & documentation) and percent of face-to-face time (client engagement) will be monitored by the medical director (data provided by the MIS/IT department)
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<p>6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?</p> <p><i>Instruments used:</i></p> <p><input type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool</p> <p><input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools</p> <p><input checked="" type="checkbox"/> Other: E HR</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The MHP is aware of some threats to the data, both in terms of collection and analysis. Specifically, the no-show data in the MIS/IT system is incomplete and therefore not accurate. The only mechanism to collect this data at present is a written progress note in Clinician’s Gateway indicating that the client did not appear for the appointment. These progress notes are not, however, consistently written. Therefore, the data were certainly under-reported at baseline and thereafter.</p> <p>Additionally, the wait time data in the children’s system of care is recorded at the time of referral. Unless there is an immediate need for a psychiatric assessment, children’s clinicians do not automatically schedule a psychiatric appointment upon admission to the system. Child wait times have been reported and evaluated with this consideration. As of January 2017, the MHP has the capacity to indicate/track the need for/referral to psychiatry for adults and children, are training staff to use, and anticipate being able to report on the data in FY2017/18.</p>
<p>6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>See Item 6.3 and Item 6.4.</p> <p>Yes, the initial results, together with the inability to implement the intended MIS/IT changes for some time, made it clear that the interventions were not going to be implemented as hoped, and that some of the interventions were not having the level of anticipated impact. Therefore, an additional intervention was added - namely incentivizing productivity - which went into effect on 3/1/16. This intervention again, has no direct impact on consumers, but allows the system to function.</p>

<p>6.6 Were qualified staff and personnel used to collect the data? <i>Project leader:</i> Name: Title: Role: <i>Other team members:</i> Names:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Shereen Khatapoush, PhD, Research and Program Evaluation Associate, will conduct data analysis and reporting, with supervision by April Howard, PhD, the MHP’s Research and Program Evaluation Manager. Jelena Pavlov, MS, MIS Programmer Analyst Senior, will produce data for analysis from the electronic health record. A Human Resources staff person will provide psychiatrist FTEs and the Medical Director, Ole Behrendtsen, MD, will provide data on Psychiatrist productivity.
Totals		3 Met 3 Partially Met 0 Not Met 0 UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? <i>Describe Interventions:</i> -All MHP clinics will make daily (M-F) appointment reminder calls -MHP team meeting upcoming psychiatric appointment review -Pre-psychiatric appointment contact and services -Standardized appointment scheduling system -Enhanced recruitment of Psychiatrists -Enhanced recruitment of Physician Assistants - Incent psychiatrist productivity</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Interventions directed toward consumers include: -All MHP clinics will make daily (M-F) appointment reminder calls -MHP team meeting upcoming psychiatric appointment review -Pre-psychiatric appointment contact and services. The other interventions focus on the system’s requirements.
Totals		1 Met 0 Partially Met 0 Not Met 0 NA 0 UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine </p>	<p>For the most part, analyses have occurred as planned. The MHP has requested and reviewed MIS data quarterly. The MHP also analyzed the data for the Mental Health Commission’s Vital Signs Committee meeting and for presentations to the Board of Supervisors. In late summer 2015, the MHP lost the MIS /IT Manager, which slowed down the implementation of planned modifications to the management information system. This negatively impacted the ability to collect and analyze some data central to this study. To more accurately track timeliness to psychiatry services, the MHP was delayed in modifying the electronic health record to include a field to note the point in time when a clinician determines a psychiatric referral is necessary.</p> <p>As stated above, this has been resolved. Also, due to this vacancy, the adoption of a new system or revision to the previously developed appointment scheduling system has been and is still delayed. The MHPs capacity to centralize the scheduling function in the outpatient clinics and electronically monitor scheduled appointments against kept appointments has therefore not been developed. A new MIS/IT Manager was hired in 2016 and these items are in the queue.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine </p>	<p>The most recent results indicted the wait time for adults was reduced to 19.6 days; for children, an increase to 25.5 days was reported.</p> <p>Goals for the no-show rates were not met.</p>

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: _____% _____ Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The initial results, together with the inability to implement the intended MIS/IT changes for some time, made it clear that all the interventions were not going to be implemented as hoped, and that some of the interventions were not having the level of anticipated impact. Therefore, an additional intervention was added, namely incentivizing productivity, and went into effect on 3/1/16.</p> <p>Again, this intervention has no impact on consumer benefit but contributes to a functioning system.</p> <p>Since no-show rates increased, the MHP plans to review to confirm if this is a result of more accurate documentation and data collection.</p>
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p><i>Recommendations for follow-up:</i></p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The PIP has been successful in generating several positive changes to the system. As a result of implementing the PIP interventions, wait time to routine psychiatric appointments improved and client contact increased due to both reminder calls and orientation groups. Reminder calls have been standardized throughout the system and all sites are conducting orientations with clients to warmly welcome and orient them to the system of care. Psychiatrists also increased their client engagement time. The PIP has also been successful in its evolution and as a generative activity (developing more interventions over time).</p> <p>The MHP has since focused more pointedly on interventions directly related to recruitment, retention and productivity. The MHP hired one physician’s assistant (PA) in 2015 and hired one more in January 2016, both of whom have specialized training in psychiatry. And, an additional intervention was added - incentivizing productivity – in March of 2016.</p> <p>The MHP has:</p> <ul style="list-style-type: none"> •successfully reduced adult wait time and achieved the PIP goal •reduced child wait time, but not quite met the goal <p>No show rates appear to have increased which was not intended; this may be a result of more accurate data collection.</p>

Totals		2	Met	2	Partially Met	0	Not Met	0	NA	0	UTD
STEP 9: Assess Whether Improvement is "Real" Improvement											
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated? <i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The MHP's MIS created the programming scripts to generate reports at baseline; subsequently, the same scripts were utilized to generate reports.</p>									
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Yes, there have been some documented improvements in client wait times and some in staff FTE's and productivity.</p> <p>Though the evidence base is anecdotal, it appears that some of the PIP interventions have had a positive impact. For example, the orientation groups have been well received by clients and family members. They have also provided a meaningful vehicle for peers in the system to connect with clients. The MHP anticipates that the groups are improving engagement and that will thus ultimately improve outcomes.</p>									
<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? <i>Degree to which the intervention was the reason for change:</i> <input type="checkbox"/> No relevance <input type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The number of psychiatrist and physician assistants FTEs has increased; The psychiatrist incentives are demonstrably changing behavior and leading to more productivity, evidenced not only by staff productivity data, but also by improvement in client wait times.</p> <p>Reduction in wait times benefits consumer access to care. It is unclear as to what led to the reduction other than the incentives for psychiatry time. To roll this out to other programs, the successes could be reproduced.</p>									

<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement? <input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>No sophisticated statistical analyses were appropriate/utilized.</p>
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Improvements in wait times have been sustained which benefit consumers. The MHP did not meet its goals for no-show rates. Although an increase in productivity occurred, this has impact on staff rather than consumers.</p>
Totals		<p>2 Met 2 Partially Met 0 Not Met 1 NA 0 UTD</p>

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS	
<i>Conclusions:</i>	
The improvements seen are reduced wait times and increased psychiatrist productive time.	
<i>Recommendations:</i>	
Repeat activities which benefit consumer outcomes, i.e., continue the Orientation group to create early engagement opportunities for consumers. CalEQRO suggests retiring this PIP due to the two years it has submitted this with limited results. Consultation is recommended as a new PIP develops.	
Check one:	<input type="checkbox"/> High confidence in reported Plan PIP results <input type="checkbox"/> Low confidence in reported Plan PIP results <input type="checkbox"/> Confidence in reported Plan PIP results <input type="checkbox"/> Reported Plan PIP results not credible <input type="checkbox"/> Confidence in PIP results cannot be determined at this time