



Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2019-20 MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SANTA BARBARA MHP FINAL REPORT

Prepared for:

**California Department of
Health Care Services (DHCS)**

Review Dates:

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2019-20 findings of an EQR of the Santa Barbara MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Medium

MHP Region — Southern

MHP Location — Santa Barbara

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 5,885

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures¹

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

Performance Improvement Projects²

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

MHP Health Information System Capabilities³

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

In accordance with the California Governor’s Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site focus group was conducted as part of CalEQRO’s desk review of Santa Barbara County MHP this year.

Consequently, the scope of validation for EQR activities and resulting recommendations were limited.

PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

Status: Not Met

- The MHP submitted two projects, but only the clinical PIP was rated as active.
- While the MHP's aim was to address polypharmacy, in practice, the clinical PIP vacillated between a project to improve prescriber documentation and rationale for medications and a project to decrease polypharmacy.
- The MHP has conducted extensive work in the past year to expand the co-response team and crisis services. However, as related to advancing a PIP, the only progress on the non-clinical PIP in the past year has been in conceptualization, not in implementation.
- The challenges to both PIPs were related to conducting projects for which no empirical data have been gathered previously. In response to this feedback (from

the previous EQR), the PIP team collected retrospective data; however, the retrospective data did not substantiate the need for the project.

Recommendation 2: Determine the true baseline for polypharmacy within the system.

Status: Partially Met

- The MHP determined an estimated polypharmacy rate for FY 2016-17 of 27.5 percent, based on a sample of 109 records.
- The MHP did not determine polypharmacy for its entire system. The data on medications in the EHR (Clinician's Gateway) and the e-prescribing system (RxNT) are not congruent with each other and do not provide reliable information on polypharmacy.
- Additionally, the MHP had determined that prescribers are not reliably deprescribing (i.e., discontinuing) some medications in RxNT, which can inflate the polypharmacy rate.
- This recommendation will not be carried forward as the MHP was advised to develop a new PIP. Nevertheless, the MHP can continue it as a quality improvement project.

Recommendation 3: Develop an intervention that reduces polypharmacy but does not jeopardize beneficiary care.

Status: Partially Met

- While the MHP's polypharmacy rate has decreased from the start of the project to the time of reporting for this review, it cannot be directly attributed to the intervention with any confidence. The focus of the interventions is actually on bringing prescriber's attention to potential polypharmacy and the lack of rationale for medication orders, not to reduce polypharmacy explicitly.
- The MHP's response to this recommendation does not state whether the intervention (i.e., sending a Polypharmacy Notice to the prescriber after a chart review) led to reduced polypharmacy.
- If medications were deprescribed, the MHP did not address how it safeguarded beneficiaries' care and treatment after medications were reduced.
- The results of the monthly chart reviews described in the clinical PIP suggest progress is being made. Because the chart reviews are based on a limited subset of the MHP's population, the results are insufficient to definitively confirm sustained progress on reducing clinically unsupported polypharmacy.
- This recommendation will not be carried forward as the MHP was advised to develop a new PIP.

Access Recommendations

Recommendation 4: Provide more consistent psychiatry coverage, substantiated by tracking turnover and change in providers (i.e., relative to beneficiaries).

Status: Partially Met

- The MHP increased psychiatric coverage during the past year. The MHP provided a table of current psychiatric providers, their start dates, and, when applicable, contract end dates. The table shows that eight providers were added in 2019.
- However, the MHP did not address turnover or stability in psychiatric coverage from the beneficiary perspective. There was no evidence of more consistent psychiatric coverage.
- The MHP had 34 psychiatric providers in 2019 and 14 vacated positions in 2019. According to the table, there are 25 regular providers and 8 provider's contracts are up for renewal. Should half of them leave, the MHP's turnover rate is likely between 16 and 32 percent.

Recommendation 5: Track beneficiary time to second and subsequent appointment after participation in the orientation group. *(This recommendation is a carry-over from FY 2017-18.)*

Status: Partially Met

- The MHP has not been tracking the time to second and subsequent clinical appointments since its initiation of the orientation groups.
- The orientation groups have had the most impact on decreasing the time to the assessment.
- The MHP provided additional information about: (1) the time from assessment to first clinical appointment and (2) the time to the second clinical appointment.
 - Prior to the orientation groups, the time to first clinical appointment was 20.2 days and the time to the second clinical appointment was 12.9 days.
 - After the orientation groups, the time to first clinical appointment was 11.5 days and the time to the second clinical appointment was 18.8 days.
 - According to this, the orientation groups have helped to decrease the time to the first clinical appointment, but the time to second appointment has actually increased.
- This recommendation will not be continued, as the MHP has demonstrated some improvement in beneficiary access to ongoing services.

Timeliness Recommendations

Recommendation 6: As required by the MHP contract, refer beneficiaries, particularly children, to out-of-network psychiatric providers to improve the time to first psychiatric appointment.

Status: Not Met

- The MHP provided a table that shows average days to a psychiatrist appointment for CY 2019. The average days to psychiatry appointment for children was 12.9 days. The response does not address the recommendation.
- According to the MHP Assessment of Timely Access, between 57 and 75 percent of children had appointments within 15 days, which is an improvement in timeliness from the previous year.
- The MHP revised its policy to approve out-of-network provision of services if/when the MHP is not able to meet time and distance standards. The MHP did not indicate if out-of-network providers were actually used to supplement county-operated psychiatry services or not.

Recommendation 7: Review the process for response to urgent conditions for children and implement interventions to increase the compliance with the 1-day standard (from 35 percent).

Status: Met

- The MHP has increased compliance with the request for urgent response for children. For 2019, 55 percent of children received a response within 1 day.
- The MHP has implemented a process whereby Access staff contact clinics to schedule urgent appointments that could not be scheduled used their 48-hour response process.
- The MHP met the 48-hour response to urgent conditions for children 61.9 percent of the time compared to 96.9 percent of the time for adults, indicating need for ongoing improvement with children.

Recommendation 8: Capture and include time to services metrics for contract providers.

Status: Not Met

- The MHP's Assessment of Timely Access did not include information from contract providers.
- The MHP is developing a SmartSheet platform to gather data on time to services from contract providers. This SmartSheet reporting appears to require additional or double data entry by contract providers of information that they likely have in their own EHRs.

Recommendation 9: Track the hours of psychiatrists at the hub for a period and determine whether this 16-hour model is sustainable.

Status: Met

- The MHP tracked and reported the hours for the two remaining psychiatrists assigned to the hub, a nexus for crisis services that includes the psychiatry health facility (PHF) and crisis stabilization unit (CSU). Originally, there were four who were part of the 16-hour model.
- Since the departure of two psychiatrists, other providers including those covering the PHF have provided coverage at the hub.
- The 16-hour model has worked for some providers, who enjoy the flexibility that this schedule brings. The MHP intends to maintain this model as a scheduling option.

Recommendation 10: Improve data tracking from initial contact for services to further support Network Adequacy standards.

Status: Not Met

- The MHP's Assessment of Timely Access only included first offered appointment by directly-operated programs. Statements regarding the use of the Access Screening Template did not include information about contract provider data capture.

Quality Recommendations

Recommendation 11: Modify or make improvements to the EHR data entry workflow to require clinicians to either complete or tab-through the co-occurring diagnosis field.

Status: Met

- The MHP changed the Comprehensive Assessment in January 2020. Co-occurring diagnosis is now a required field with an option for 'not applicable.'
- From FY 2015-16 through FY 2018-19, the MHP showed declining co-occurring disorders rate. With the addition of the co-occurring field, the rates are expected to increase.

Beneficiary Outcomes Recommendations

Recommendation 12: Obtain rehospitalization data for contract hospitals.

Status: Met

- Per the MHP Assessment of Timely Access for FY 2018-19, the rehospitalization rate included hospitalizations for all hospitals.

- The MHP has a quarterly Hospital Admissions Report, presented at the Quality Improvement Committee (QIC), which captures data from contract hospitals.

Foster Care Recommendations

Recommendation 13: Incorporate the review of data from California Child Welfare Indicators Project and the EPSDT Performance Outcome System (POS) in QIC meetings and other relevant forums (e.g., the Interagency Placement Committee) or the medical practice committee.

Status: Not Met

- There was no evidence of reviews of the California Child Welfare Indicators Project and EPSDT POS pertaining to use and monitoring of psychotropic medications for children in foster care in the MHPs QIC meeting minutes from 2019.
- In the QIC minutes from January 2020, there was a review of child welfare statistics; however, these were not related to use and monitoring of psychotropic medications. Rather, there was a general overview of child welfare cases, including entries, exits, placements, days in foster care, and abuse allegations.
- The MHP plans to form a QIC work group to review this data in depth and provide further feedback.

Information Systems Recommendations

Recommendation 14: Increase technology and data analytical subject matter expertise by hiring contract staff with EHR expertise; hiring management analyst or data analytical staff; creating new permanent FTE analyst positions; and providing in-house training and staff development.

Status: Met

- The MHP reported adding three new FTEs to their IT resources.
- All Data Management team members in the IT department are participating in Tableau training as the MHP moves to a new portal-based data reporting system.
- The Data Management team is developing knowledgebase documentation for future staff training.
- The Research & Program Evaluation group is leveraging interns to increase data analysis capacity and continues to hire additional FTE.

Recommendation 15: Select and implement a software application for centralized appointment management and has features that enable reporting of time to services. *(This recommendation is a carry-over from FY 2017-18.)*

Status: Partially Met

- The MHP is currently using the Access Screening Template within the EHR for reporting time to services.
- The MHP is piloting the RxNT Scheduler, which facilitates centralized scheduling of beneficiaries and management of clinician calendars. RxNT Scheduler has been implemented in the Lompoc clinic and the MHP expects to deploy it across the entire department by the end of CY 2020. The MHP response was not explicit about whether the RxNT Scheduler will include contract providers as well.
- The RxNT Schedule will be semi-integrated with the existing EHR. Client demographic data from the EHR is currently pulled into RxNT ePrescriber and will be used in the new RxNT Scheduler application as well.

Structure and Operations Recommendations

Recommendation 16: Provide additional technology and data analytical subject matter expertise that includes a wide range of staffing solutions to implement key initiatives: Information Notice (IN) 18-011, CMS Final Rule, and appointment management application.

Status: Met

- This past fiscal year, the MHP added three new positions to the IT Division: a Department Business Specialist and two Electronic Data Processing Office Automation Specialists (OAS). The Department Business Specialist position has been filled but the OAS positions have not.
- The MHP is contracting with vendors to assist in improving clinical data reporting and expanding the use of ServiceNow.
- The MHP is in the process of implementing RxNT's Scheduler application to manage appointments, but it is unclear that the application will address both directly-operated and contract providers.

PERFORMANCE MEASUREMENT

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

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

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

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

⁴ Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:

<http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx>

3. Psychotropic Medication and HEDIS Measures:

http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

4. Assembly Bill (AB) 1299 (Chapter 603; Statutes of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:

The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at <https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx>.

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

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

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

Total Beneficiaries Served

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

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Santa Barbara MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	90,405	60.4%	3,322	56.4%
Latino/Hispanic	37,455	25.0%	1,182	20.1%
African-American	2,118	1.4%	207	3.5%
Asian/Pacific Islander	3,079	2.1%	84	1.4%
Native American	535	0.4%	44	0.7%
Other	16,006	10.7%	1,046	17.8%
Total	149,595	100%	5,885	100%

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

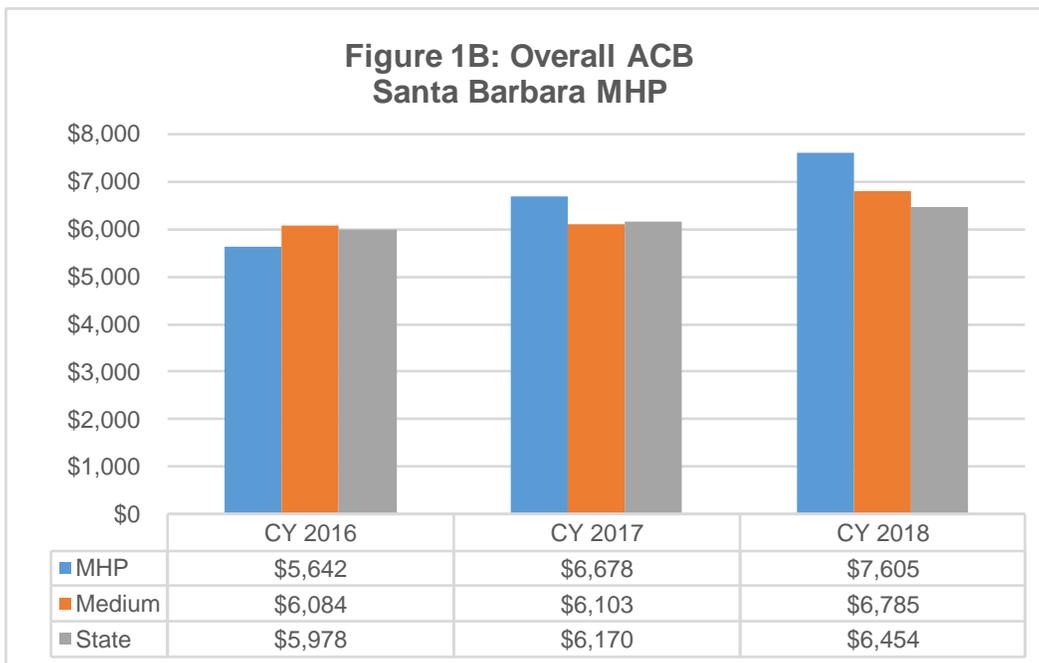
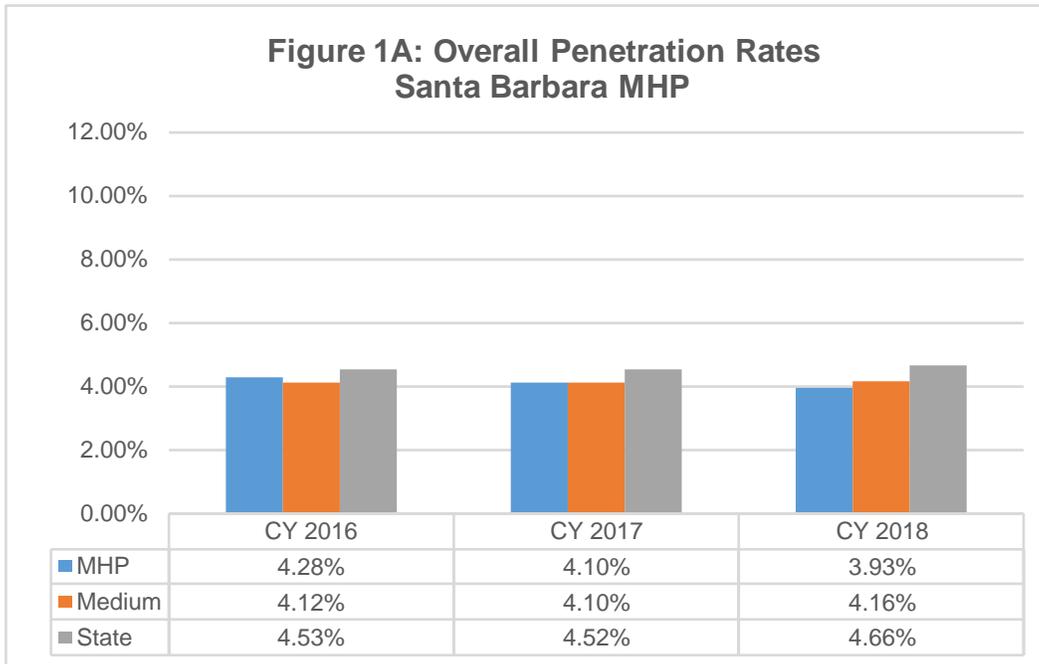
Penetration Rates and Approved Claims per Beneficiary

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

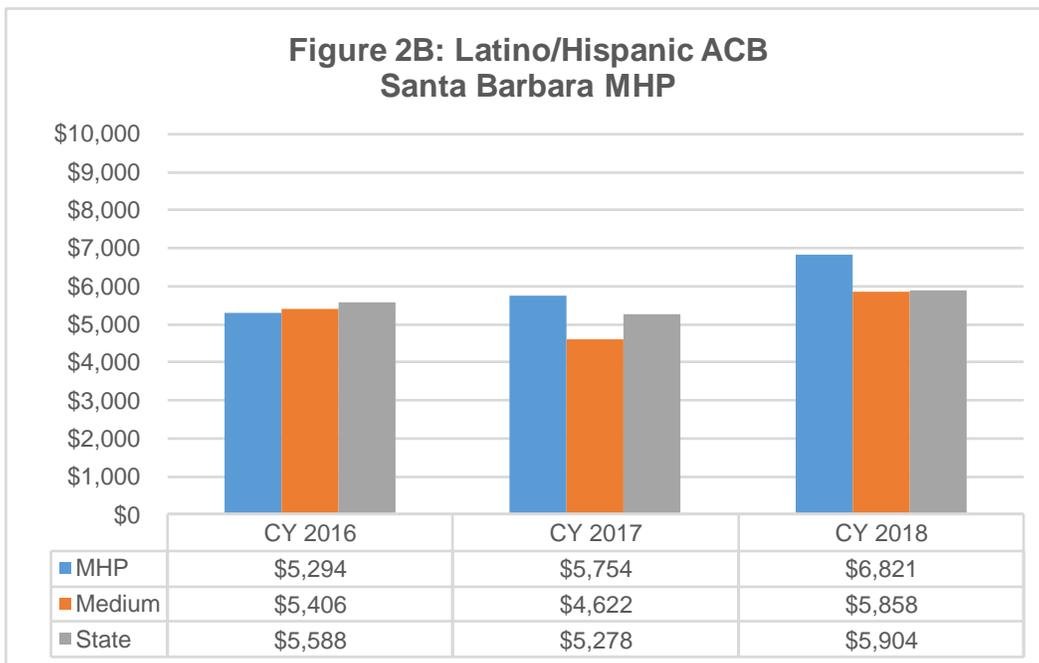
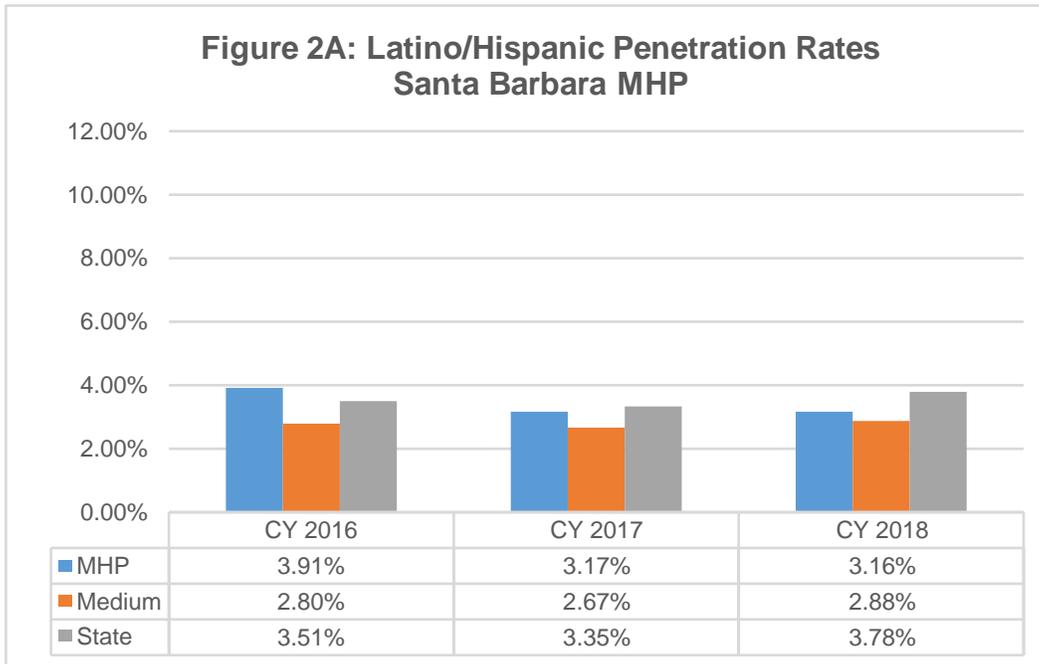
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

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

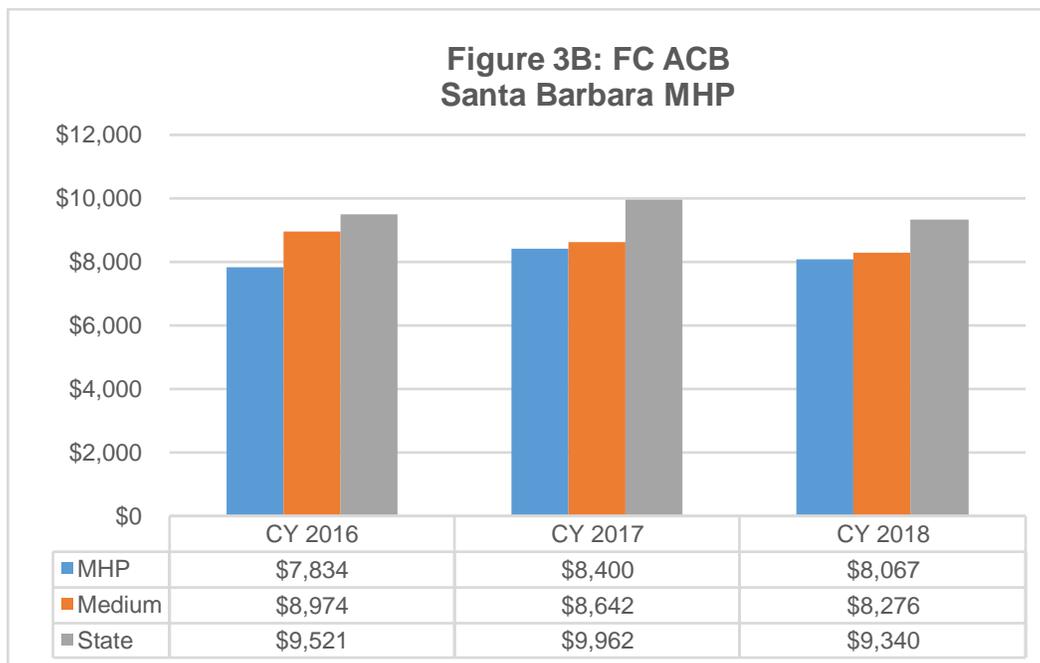
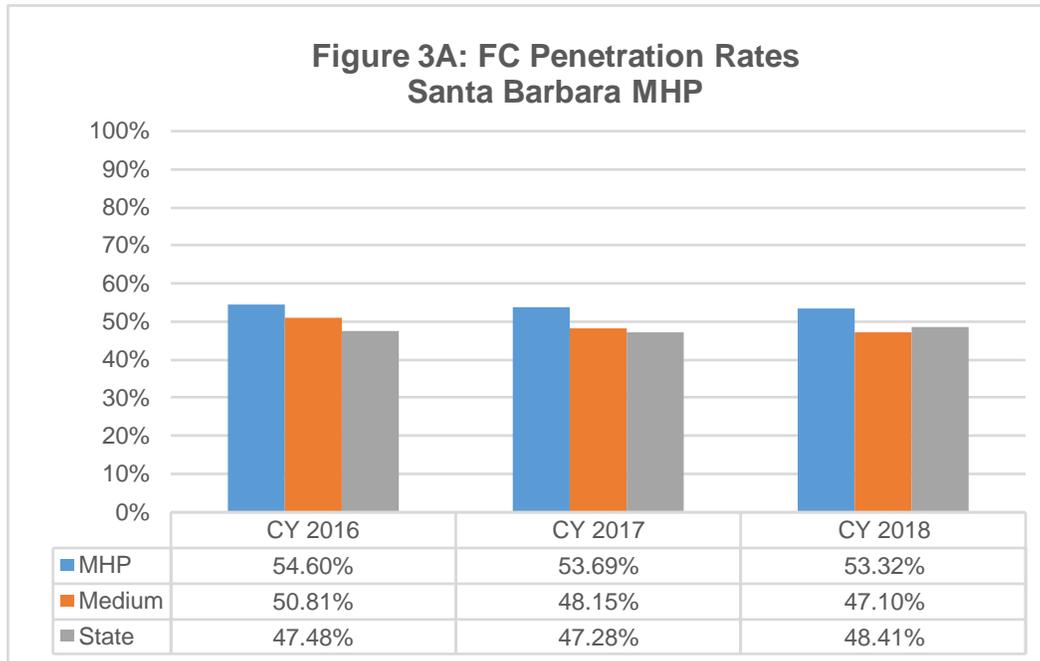
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.



High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than \$30,000 in a year.

Table 2: High-Cost Beneficiaries Santa Barbara MHP							
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	\$57,725	\$1,337,141,530	33.47%
MHP	CY 2018	303	5,885	5.15%	\$54,816	\$16,609,158	37.11%
	CY 2017	240	6,148	3.90%	\$49,544	\$11,890,629	28.96%
	CY 2016	206	6,316	3.26%	\$47,599	\$9,805,420	27.52%

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

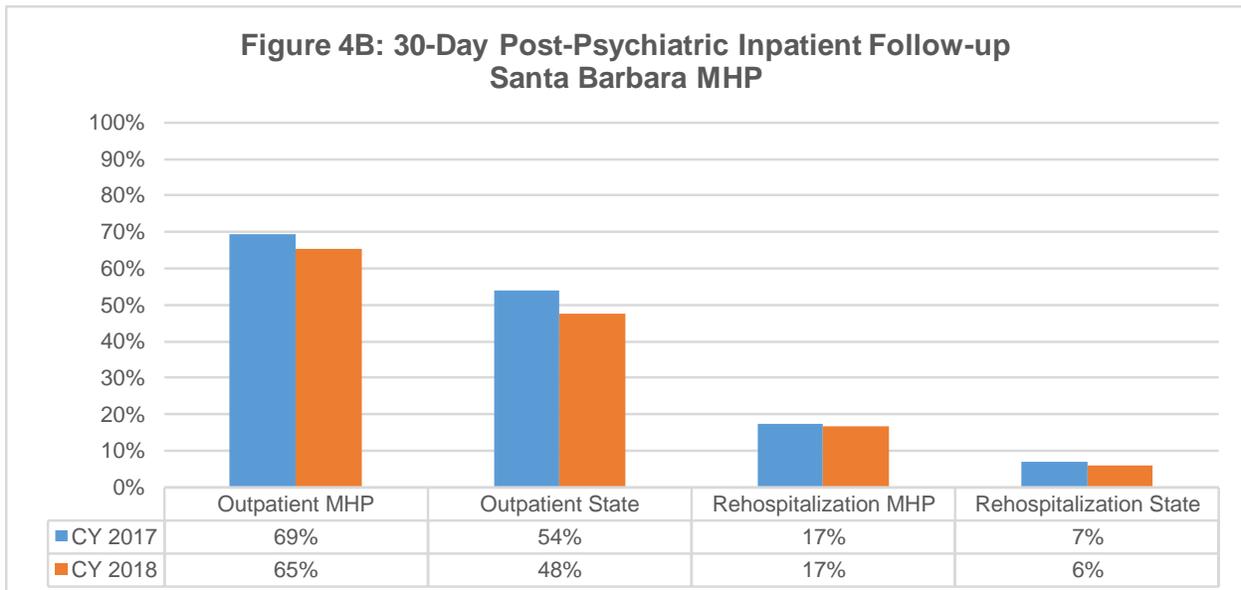
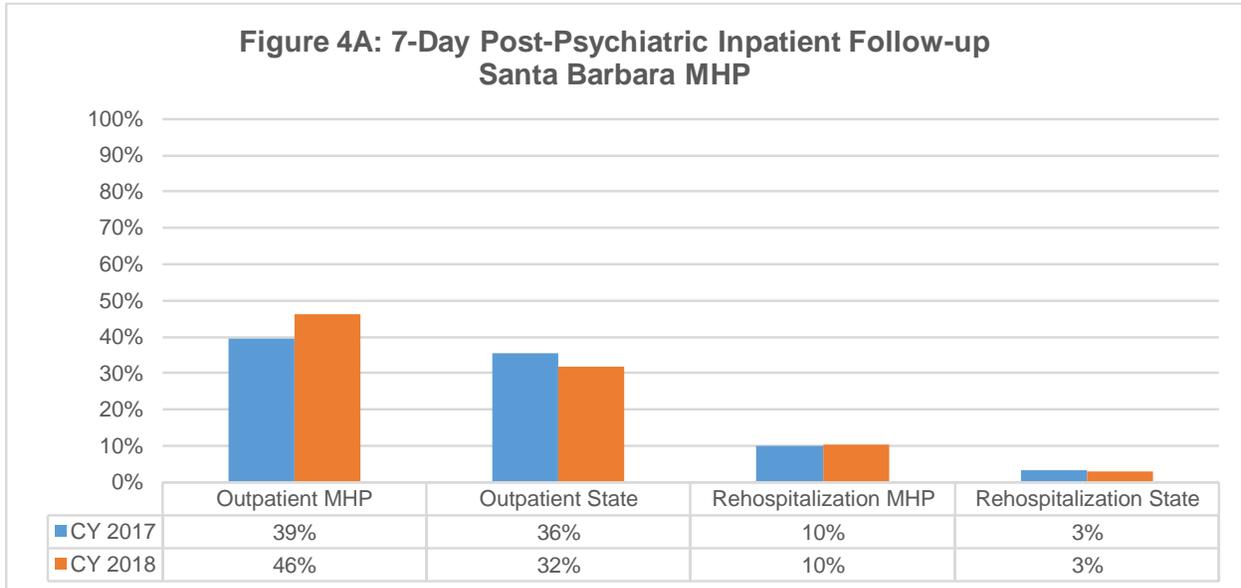
Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 3: Psychiatric Inpatient Utilization - Santa Barbara MHP					
Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	568	1,256	6.10	\$10,898	\$6,189,994
CY 2017	469	1,110	5.73	\$9,198	\$4,313,747
CY 2016	469	963	6.55	\$7,777	\$3,647,203

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

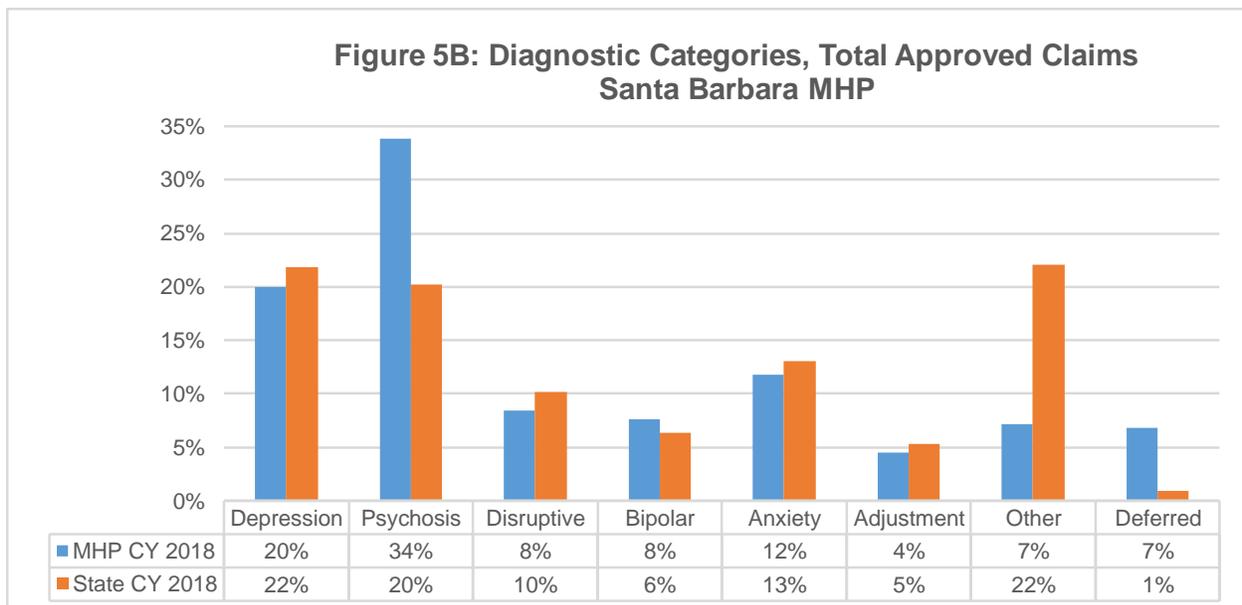
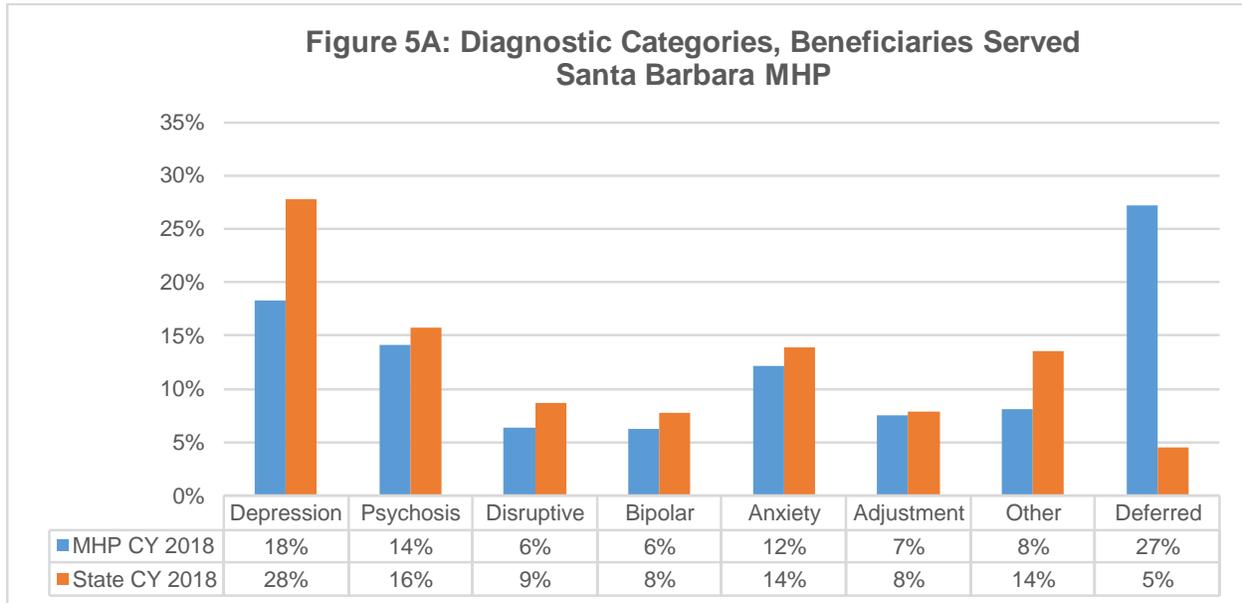
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.



Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

The MHP’s self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 6.5 percent.



PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Santa Barbara MHP PIPs Identified for Validation

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

Table 4 lists the PIPs submitted by the MHP.

Table 4: PIPs Submitted by Santa Barbara MHP		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Polypharmacy
Non-clinical PIP	1	Crisis System Continuum of Care

Clinical PIP—Polypharmacy

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

“Do interventions to reduce polypharmacy result in:

- a) a reduction in prescribed medications
- b) improved rationale for prescribed medications
- c) better self-reported client outcomes.”

Date PIP began: July 2017

End date: July 2020

Status of PIP: Completed

This is the second year of the MHP’s project to reduce polypharmacy, defined as beneficiaries of any age taking two or more antipsychotic medications, or adult beneficiaries taking four or more psychotropic medications, or children taking three or

more psychotropic medications. The impetus for the project was a review of records in FY 2016-17 that showed polypharmacy rates of 6.4 percent for children and 21.1 percent for adults. The MHP stated that the literature on polypharmacy show rates ranging from 13 to 90 percent. Given that the MHP's rates fall well below the maximum and do not suggest a problem, it would have behooved the MHP to identify a rationale and specific target for improvement. Nevertheless, the MHP implemented three interventions to decrease polypharmacy: sending notifications to prescribers of potential polypharmacy; providing training on prescribing practice; and, conducting case-specific reviews at medical staff and medical practice committee meetings. The interventions were indirect; none actually aimed to decrease polypharmacy. In a beneficiary survey, only 34.3 percent endorsed that their medications had been reduced. However, the interventions were successful in raising prescriber's attention to appropriate documentation and providing sufficient rationale for prescriptions. Sufficient rationale increased from 56.3 percent at the start of the project to 77.0 percent by December 2019. The polypharmacy rate did decrease from 42.6 percent at the start of the project to 26.0 percent by December 2019. Coincidentally, the rate in December 2019, approximates the polypharmacy rate for FY 2016-17, from which the MHP based this project.

Suggestions to improve the PIP: The MHP has addressed a problem that is common in mental health treatment settings but was not necessarily germane to this MHP. The PIP would have been helped by MHP-specific information (e.g., an MHP-specific target for improvement).

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of recommendation to collect data prior to the start of future projects and to ensure that the data support the need for investing time and resources into improvement. The team was advised to solicit input on future projects from the subcommittees in the Quality Care Management (QCM) department, including Change Agents and the Community-based Organization Collaborative Meeting.

Non-clinical PIP—Crisis System Continuum of Care

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

“Will administrative interventions to improve client care in the crisis system in the following areas:

- a) Lanterman-Petris-Short (LPS) utilization and care, as measured by admission rate to LPS from a crisis service and PHF re-hospitalization rate
- b) Care coordination and timeliness to psychiatry, as measured by reduced wait time to psychiatry following a crisis service
- c) Use of lower levels of crisis care, as measured by increased stability in services for clients at the crisis residential treatment (CRT), and increased crisis stabilization unit (CSU) occupancy rates

- d) Law enforcement involvement, as measured by increased mental health outcomes for clients initially contacted by law enforcement?"

Date PIP began: 05/01/2017

Projected End date: 04/31/2020

Status of PIP: Inactive, developed in a prior year (not rated)

This was the second year of the MHP's project on improving beneficiary access to crisis services, but the PIP appears to have stalled in 2019. In the continuation, the MHP has changed the focus of the project, along with a new study question (above) and some new indicators. Beside those changes, which were conceptual in nature, there have been no appreciable updates to the PIP.

The team provided context that "...since this PIP started in May 2017, there have been three different PIP facilitators". With different facilitators, the focus of the PIP has shifted. This year, the MHP has presented a system improvement project, rather than a beneficiary focused project. Several statements by the team were consistent with this approach: "... this is a broad evaluation of our crisis system"; "Because our interventions were designed to impact the crisis system..."; and, "our mental health crisis system has experienced many positive successes as a result of the systemic changes over the past five years."

Suggestions to improve the PIP: The MHP reported that finding indicators to demonstrate changes to their system was difficult, but that many "felt" those changes. The MHP should focus future projects on a clear beneficiary problem, which would already be substantiated by data and relevant indicators.

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

The TA provided to the MHP by CalEQRO consisted of clarifying the timeline for the project. The team was advised to solicit input on future projects from the subcommittees in the Quality Care Management (QCM) program, including Change Agents and the Community-based Organization Collaborative Meeting. Per Title 42, CFR, §438.330, the MHP is required to have two PIPs; the MHP is urged to meet this requirement going forward.

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

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

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

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-clinical PIP
Number Met	6	NR
Number Partially Met	8	NR
Number Not Met	8	NR
Unable to Determine	5	NR
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	27	NR
Overall PIP Ratings $((\#M*2)+(\#PM))/(\text{AP}*2)$	37.04%	0%

INFORMATION SYSTEMS REVIEW

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

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

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations				
	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
Santa Barbara	3.50%	3.50%	3.00%	3.00%
Medium MHP Group	N/A	3.30%	2.80%	0.00%
Statewide	N/A	3.40%	3.30%	3.40%

The budget determination process for information system operations is:

<input type="checkbox"/> Under MHP control <input type="checkbox"/> Allocated to or managed by another County department <input checked="" type="checkbox"/> Combination of MHP control and another County department or Agency

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

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	52.4%

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	Distribution
Contract providers	47.0%
Network providers	0.6%
Total	100%*

*Percentages may not add up to 100 percent due to rounding.

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP’s EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	Percent Used	Frequency
Direct data entry into MHP EHR system by contract provider staff	Not Available	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	N/A	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not Available	Weekly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	N/A	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	N/A	Not used
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	N/A	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

- Yes
 No
 In pilot phase

- Number of county-operated sites currently operational: 6
- Number of contract provider sites currently operational: 0

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

<input checked="" type="checkbox"/> Hiring healthcare professional staff locally is difficult <input type="checkbox"/> For linguistic capacity or expansion <input checked="" type="checkbox"/> To serve outlying areas within the county <input type="checkbox"/> To serve beneficiaries temporarily residing outside the county <input type="checkbox"/> To serve special populations (i.e. children/youth or older adult) <input checked="" type="checkbox"/> To reduce travel time for healthcare professional staff <input checked="" type="checkbox"/> To reduce travel time for beneficiaries
--

- Telehealth services are available with English-speaking practitioners.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff				
Fiscal Year	IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2019-20	15	3	0	2
2018-19	11	2	2	2
2017-18	12	1	1	1

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

Table 11: Data Analytical Staff				
Fiscal Year	IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2019-20	3	0	0	1
2018-19	4	1	1	1
2017-18	5	0	0	1

The following should be noted about the above information:

- The number of data analytic staff have declined from five to three over the last three fiscal years, a time during which the MHP has been unable to consistently provide key data, such as timeliness data, from its contract providers.
- The number of IT employees has increased to 15, with a Department Business Specialist and two Electronic Data Processing Office Automation Specialists (OAS) added since the last EQRO. Only the Department Business Specialist position has been filled.

Current Operations

- The MHP continues to use ShareCare for practice management and managed care functionalities and Clinician’s Gateway for EHR functionality.
- The MHP is using RxNT Scheduler for clinical appointment scheduling. It does appear to be integrated with Sharecare or Clinician’s Gateway; RxNT Scheduler appears to be another stand-alone product.
- The MHP planned to launch a request for proposal (RFP) for a psychiatric health facility (PHF) electronic health record in March 2020. It is unknown if or when the RFP will be released.

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 (SDMC) 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 Mgmt, Managed Care, Master Patient Index	The Echo Group	13	MHP
RxNT	e-Prescribing	RxNT	12	MHP
Clinician's Gateway	EHR	Krassons, Inc.	14	MHP
Rx30	Pharmacy System - prescription processing	Rx30	2	MHP/Rx30
Pyxis	Medication dispensing @ PHF and CSU	Pyxis	2	MHP/Pyxis

The MHP's Priorities for the Coming Year

- Continue to address risk issues identified from the Clearwater Compliance Security Risk Assessment.
- Launch an RFP for an EHR system at the PHF.
- Implement Mental Health Services Act (MHSA) Innovations Tech Suite.
- Continue work on the opening of an outpatient pharmacy as part of the Calle Real Clinic by Genoa, a contract provider.
- Implement telehealth program for New Cuyama site.
- Pilot contract provider reporting using Smartsheet.
- Launch the Help@Hand Project, which is a multi-county and -city collaboration supported through MHSA Innovations.
- RxNT Scheduler implementation at outpatient clinics.
- Residential Treatment Facility placement management application.
- Clinical reporting development and distribution upgrades (Tableau).
- Vertical Change development, collaborative data collection.
- ServiceNow HR Onboarding and Transitions implementation.

- Rollout of ServiceNow contract management implementation.
- County-wide security audit and continued remediation of identified security risk items.

Major Changes since Prior Year

- The MHP implemented the RxNT scheduling program at several clinics.
- The MHP expanded and fully integrated SUD and MH Access Line Team and strengthened the organizational leadership structure.
- The MHP increased IT staffing and hired several new management staff: a second QCM Manager; a new Clinical Services Division Chief; a new Cultural Competency Manager; and, a Fiscal Manager.
- The MHP established a Re-Credentialing Committee.

Other Areas for Improvement

- The MHP is not operating an integrated EHR system. The MHP has a collection of legacy systems and stand-alone applications, with gaps filled through in-house developed applications to support CMS Final Rule provisions and Ins. The systems do not enable a focus on improvements to clinical operations or providers' efficient use of the EHR.
- The IT Director is not a part of the senior leadership team. Rather, the IT Director reports to the chief financial officer. This structure lessens the voice and input for technology planning to support the MHP's strategic business initiatives.
- The MHP is currently unable to report timeliness data for contract providers.
- MHP does not track time to urgent appointments in hours as required in the MHP Assessment of Timely Access; urgent appointments are currently measured in days.
- The decline in data analytical staff reported in Table 11 is a concern as the MHP continues to have difficulty using data to effectively tell its story.
- The RFP for an EHR for the PHF raises the concern that the MHP is continuing a siloed approach to data, rather than addressing the need for a comprehensive integrated system that supports both service delivery and data needs systemically.
- Compared to similar-size MHPs, this MHP does not have a comprehensive data view of its entire operation.

- Many of the MHP’s ISCA list of IS Priorities for the Coming Year are repeated from the FY 2018-19 ISCA. Of these, only one of the eight projects appears on the MHP’s FY 2019-20 Priorities for the Coming Year.

Plans for Information Systems Change

- The MHP is actively searching for a new EHR system.
- Despite the ISCA stating that the MHP is searching for a new system, with a plan and team at the ready, the MHP’s list of Priorities for the Coming Year does not include this plan for a new EHR.

Current EHR Status

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

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	Clinicians Gateway/ Krassons	X			
Assessments	Clinicians Gateway/ Krassons	X			
Care Coordination	Clinicians Gateway/ Krassons	X			
Document Imaging/ Storage	Clinicians Gateway/ Krassons		X		
Electronic Signature— MHP Beneficiary	Clinicians Gateway/ Krassons	X			
Laboratory results (eLab)	Clinicians Gateway/ Krassons	X			
Level of Care/Level of Service				X	
Outcomes	Clinicians Gateway/ Krassons	X			
Prescriptions (eRx)	RxNT/RxNT	X			
Progress Notes	Clinicians Gateway/ Krassons	X			
Referral Management	Clinicians Gateway/ Krassons	X			
Treatment Plans	Clinicians Gateway/ Krassons	X			

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		10	1	1	0
FY 2018-19 Summary Totals for EHR Functionality:		10	1	1	0
FY 2017-18 Summary Totals for EHR Functionality:		10	1	1	0

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

- The MHP continues to support look-only for document imaging function for both county-operated and contract providers.

Personal Health Record (PHR)

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

Yes In Test Phase No

If no, provide the expected implementation timeline.

<input type="checkbox"/> Within 6 months <input type="checkbox"/> Within the next year <input type="checkbox"/> Within the next two years <input checked="" type="checkbox"/> Longer than 2 years
--

Medi-Cal Claims Processing

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

Yes No

If yes, product or application:

EOB Database / Sharecare Medi-Cal Reconciliation / SR2000 / Excel

Method used to submit Medicare Part B claims:

Paper Electronic Clearinghouse

Table 14 summarizes the MHP’s SDMC claims.

Table 14: Summary of CY 2018 Short Doyle/Medi-Cal Claims Santa Barbara MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	151,665	\$57,068,223	5,328	\$2,785,567	4.88%	\$54,282,656	\$43,453,080
JAN18	13,691	\$5,028,119	772	\$407,626	8.11%	\$4,620,493	\$3,709,691
FEB18	13,097	\$4,719,838	793	\$375,323	7.95%	\$4,344,515	\$3,513,540
MAR18	15,488	\$6,076,124	434	\$194,580	3.20%	\$5,881,544	\$4,946,001
APR18	14,666	\$6,173,590	468	\$267,756	4.34%	\$5,905,834	\$4,913,635
MAY18	14,456	\$4,612,724	429	\$172,472	3.74%	\$4,440,252	\$3,486,428
JUN18	12,187	\$4,203,310	415	\$290,269	6.91%	\$3,913,041	\$2,950,205
JUL18	12,286	\$4,934,132	421	\$273,425	5.54%	\$4,660,707	\$3,607,530
AUG18	12,208	\$4,708,164	378	\$194,036	4.12%	\$4,514,128	\$3,625,027
SEP18	10,857	\$4,352,389	284	\$124,410	2.86%	\$4,227,979	\$3,329,252
OCT18	12,589	\$4,635,271	346	\$152,205	3.28%	\$4,483,066	\$3,598,360
NOV18	10,794	\$4,277,403	335	\$237,777	5.56%	\$4,039,626	\$3,122,712
DEC18	9,346	\$3,347,158	253	\$95,689	2.86%	\$3,251,469	\$2,650,700

Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2018 was **3.25 percent**.

Table 15 summarizes the top three reasons for claim denial.

Table 15: Summary of CY 2018 Top Three Reasons for Claim Denial Santa Barbara MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code.	2,085	\$1,190,001	43%
Medicare or Other Health Coverage must be billed before submission of claim.	1,002	\$617,056	22%
Payment denied - prior processing information incorrect. Void/replacement condition.	1,489	\$588,442	21%
TOTAL	5,328	\$2,785,567	N/A

The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.

- Denied claim transactions with reason ‘Beneficiary not eligible or emergency services or pregnancy indicator must be “Y” for this aid code’ and ‘Medicare or Other Health Coverage must be billed before submission of claim’ are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site beneficiary focus group was conducted as part of CalEQRO's desk review of Santa Barbara County MHP this year.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP’s use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO’s findings in each of these areas.

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 16: Access to Care Components			
Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	10
<p>The MHP uses a variety of methods to communicate access information to beneficiaries and stakeholders. The MHP’s Access unit monitors walk-in, telephone, and external referral sources. The MHP’s website provides necessary information about available services and is presented in the threshold languages; however, it is not especially intuitive to navigate unless one is already familiar with the mental health service delivery. The provider directories, including the separate directories for adults, children, transitional age youth (TAY), and Alcohol and Drug Program (ADP) are not searchable by zip code or type of service; they are simple lists of providers. The MHP’s strategic plan features transportation as a challenge and includes a three-phase plan for improvement, including the provision of transportation cards informing beneficiaries of their transportation benefit through CenCal. The MHP director issues a monthly report of past and future activities in the MHP.</p>			
1B	Capacity Management	10	10
<p>The MHP has an active cultural competency committee, the Cultural Competency and Diversity Action Team (CCDAT), that meets monthly. Over the past year, the committee has undertaken a number of initiatives and projects that demonstrates the MHP’s efforts to reflect and serve beneficiaries of different cultural, ethnic/racial, and/or linguistic backgrounds, including African-American, the faith/religious communities, Mixteco and the deaf and hard of hearing and others with disabilities. To meet Network Adequacy, the MHP increased the number of psychiatric providers for</p>			

Table 16: Access to Care Components			
Component		Maximum Possible	MHP Score
<p>children. The MHP also revised policy to approve out-of-network provision of services if/when the MHP is not able to meet time and distance standards. During the past year, the MHP established a TAY full-service partnership program (FSP) program because the presentation and needs of this population were different than that of established, adult, FSP beneficiaries. The MHP expanded its Forensic Program.</p>			
1C	Integration and Collaboration	24	23
<p>The MHP demonstrated broad collaboration and integration with community-based organizations to improve and facilitate access for beneficiaries. There is evidence of partnerships with primary care providers, hospitals, child welfare, educational systems, department of rehabilitation and several other agencies. The MHP's collaboration with law enforcement has continued, with an increase in the co-response teams in both Santa Barbara and Santa Maria. The MHP hired a hospital liaison to coordinate transition and care for beneficiaries discharged from LPS hospitals. The MHP's efforts to facilitate housing for beneficiaries have expanded over the past year: Polly's House, an adult residential facility, opened in September 2019; Agnes Avenue, a crisis residential facility opened in October 2019; and, The Residences at Depot Street in Santa Maria, a permanent support housing unit, opened in December 2019. In addition to the local housing authority, the MHP has collaborated with the United Way North and others. The MHP plans to contract with a foster family agency for the provision of therapeutic foster care (TFC). The MHP has posted a request for qualifications (RFQ) for TFC services, but has yet to receive any responses. Per the CCDAT, an area that the MHP would like to gain more traction is collaboration with the faith-based community.</p>			

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	13
<p>The MHP uses the 10-business day standard for time to first offered appointment. The MHP met this standard, overall, 92.3 percent of the time, with a mean of 3.6 days and</p>			

Table 17: Timeliness of Services Components			
Component		Maximum Possible	MHP Score
<p>a median of 2 days. The times for adults, children, and youth in foster care each met the standard just over 90 percent of the time. The MHP's data only reflected county-operated services. While the MHP provides the majority of first appointments, some appointments are provided by/through contract providers.</p>			
2B	Assessment Follow-up and Routine Appointments	8	2
<p>The MHP has begun to track time to first and second clinical appointments. As the MHP made changes in the data capture after July 2019, this metric was not captured in any of the MHP's reports. As yet, this tracking does not include time to routine appointments for contract providers.</p>			
2C	First Offered Psychiatry Appointment	12	10
<p>The MHP uses the 15-business day standard for time to first offered psychiatry appointment. The MHP has only captured psychiatry appointments of county-operated providers, not contract providers or network providers. Based on available data, the MHP met this standard, overall, 83.2 percent of the time, with a mean of 8.1 days and a median of 6 days. While access for adults met the standard 90 percent of the time, access to psychiatry for children and youth in FC met the standard only 75.6 percent and 69.6 percent of the time, respectively. Nevertheless, the MHP has improved access to psychiatry by increasing the number of psychiatric providers, expanded contracts, and adjusted hours of psychiatric providers. Of note, the MHP reported different compliance rates in the MHP Assessment of Timely Access than in the QIC report of the same time period. For the latter, the MHP reported compliance with the 15-day standard at 83.3 for adults and 57.3 percent for children.</p>			
2D	Timely Appointments for Urgent Conditions	14	10
<p>The MHP presented county-operated data on response to urgent conditions within 48 hours; the MHP did not have urgent conditions that required prior authorization at 96 hours. The MHP's data are based on days, rather than the requested hours. The MHP met the standard 96.9 percent of the time for adults, 61.9 percent for children, and 57.1 percent for youth in FC. The MHP is developing an online platform for contract providers to capture response to urgent conditions.</p> <p>Two of the components of this key component were unable to be rated because of the desk review format: 96-hour response and focus group participant's knowledge of urgent services.</p>			

Table 17: Timeliness of Services Components			
Component		Maximum Possible	MHP Score
2E	Timely Access to Follow-up Appointments after Hospitalization	10	8
<p>The MHP uses the 7-day standard for follow-up appointments after hospitalization. The MHP reported on follow-up after hospitalization for all hospitals, including those out-of-county. The MHP included all services (i.e., being seen anywhere in the system of care, including crisis contact), in this indicator. Crisis may not be a good indicator of stability post-hospitalization. The MHP reported an overall compliance of 80.7, with a mean of 8.4 days and a median of zero days. The MHP met the standard 80.7 percent of the time for adults, 80.8 percent for children, and 100 percent for youth in FC. As reported during the prior review, the MHP has a daily dedicated timeslot for post-PHF discharge follow-up. Routine review of follow-up post-hospitalizations was not evidenced.</p>			
2F	Tracks and Trends Data on Rehospitalizations	6	5
<p>The MHP's 30-day rehospitalization rates for adults and children were 14.2 and 13.4, respectively. The rehospitalization rates were greater for youth in FC at 20 percent. The QIC meeting minutes referenced a spike in rehospitalization rates for children, attributed to one child having multiple hospitalizations. However, the QIC report only indicates 'children' and not whether they are in FC or not. In general, the MHP's quarterly review of timeliness for the QIC meetings did not have separate reporting for youth in FC.</p>			
2G	Tracks and Trends No-Shows	10	8
<p>The MHP uses a benchmark for no-shows of 10 percent for psychiatry and 5 percent for non-psychiatry clinicians. As with the other metrics, the MHP has only captured no-shows for county-operated providers. The MHP's no-show rate for children's psychiatry has increased. MHP representatives attributed this to the challenge in filling psychiatry positions; however, the MHP has increased psychiatry coverage in the past year. The clinician's no-show rate for children and children in FC increased have also increased. Per the MHP, this may be an artificial increase, attributed to improved documentation of no-shows by clinicians.</p>			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components			
Component		Maximum Possible	MHP Score
3A	Beneficiary Needs are Matched to the Continuum of Care	12	9
<p>In the past year, the MHP has adopted the Level of Care and Recovery Inventory (LOCRI) to determine level of care and the best type and frequency of mental health services for beneficiaries. The LOCRI was piloted in one clinic and has been rolled out to other clinics, with the intention of systemic use, including that of contract providers. The MP uses the LOCRI in combination with clinical assessment as part of treatment planning, and as a way to include beneficiaries in treatment planning. One example was the MHP's evaluation of the practice of requiring parental involvement for youth seeking treatment related to their LGBTQ+ identification, which, per feedback from youth, hindered their ability to self-disclose. The MHP's documentation did not evidence regular review and evaluation of transitions for beneficiaries.</p>			
3B	Quality Improvement Plan	10	4
<p>The MHP has both a current QI work plan and an annual evaluation. The evaluation was a cursory review of activities performed in the previous year and the evaluation did not appear to be connected to the current plan. The current work plan is short on measurable goals and/or objectives. The plan reads as a table or list of actions that the MHP will do.</p>			
3C	Quality Management Structure	14	10
<p>The MHP has a designated quality management unit, the QCM, that is responsible for the QI program of the MHP. QCM has a designated manager and a coordinator. The QI program membership is inclusive of executive level staff, line staff, beneficiaries, family members, and contract providers, but the minutes of the meeting do not indicate the roles or positions of attendees. Over the past year, QCM has focused on increasing line staff participation; QCM has been attending regional meetings to directly solicit input and communicate with regional line staff. QCM has also continued to produce and post a monthly newsletter. The MHP also has a Research and Evaluation Program that is responsible for data extraction and analysis across the department, including for substance use services. Given new services to monitor and new reporting requirements (e.g., network adequacy), the responsibilities of this program have increased, and the program appears to be challenged in meeting the demands to provide data.</p>			
3D	QM Reports Act as a Change Agent in the System	10	7
<p>The MHP produces various reports to monitor service access, timeliness, quality of care, and outcomes. The MHP also produced annual and semi-annual reports and</p>			

director’s report that are designed to be shared broadly. The MHP produces standing, routine reports and can produce *ad hoc* reports, but the latter appear to take more time to extract data from multiple systems. The MHP has continued its use of change agents, stakeholders who are part of a designated team to partner with and inform leadership on systemic change. The MHP endorsed use of continuous quality improvement practices, such as plan-do-study-act (PDSA) cycles to make improvements.

3E	Medication Management	12	8
<p>The MHP has a medication monitoring and psychiatrist review processes. The MHP’s medication monitoring captures some of the recommended HEDIS and national monitoring areas (e.g., use of multiple concurrent antipsychotics; therapeutic alliance; collaboration with primary care providers). The MHP’s review process includes records of contract psychiatrists and locums. The review process assesses care coordination. The review includes the beneficiaries’ system of care (e.g., adult, children), which is a proxy for age. Using the clinical PIP as an example, the MHP reviews prescriber practice; however, the MHP did not institute decisive procedural and practical change subsequent to the findings. The PIP also highlighted that medication reconciliation is an area of improvement for the MHP. A document related to medication monitoring showed review of children prescribed medications, but the frequency and audience for this review was not identified.</p>			

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP’s efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components			
Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	12
<p>The MHP uses the Child and Adolescent Needs and Strengths (CANS) assessment and Milestones of Recovery Scale (MORS), for children and adults, respectively. The MHP has practice guidelines on the integration and use of outcomes to inform/guide clinical practice. The MHP had aggregate reporting on MORS, but not on CANS.</p>			
4B	Beneficiary Perceptions	10	7

<p>The MHP participated in the Consumer Perception Survey (CPS) in May and November 2019. In September 2019, the MHP presented findings and analysis of the CPS from November 2017 and May 2018, which at that point, were over one and a half years old. The MHP attributed the delayed reporting to the inability to access eBHS, due to contracting issues between DHCS and California Institute for Behavioral Health Solutions (CIBHS). The MHP has administered other surveys and captured the input of beneficiaries in other ways, for example, through the cultural competency needs assessment. The findings of the surveys are shared at the QIC, in Clinical Leads group, at the CCDAT, and the Be Well Commission. In one of the QIC minutes, a participant informed the committee that dissemination of survey results had not occurred at the Recovery Learning Center.</p>			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
<p>The MHP has peer-run and peer-driven wellness centers, known as Recovery Learning Centers. The Recovery Learning Centers are located in Santa Barbara, Lompoc, and Santa Maria. The centers are open to any adult resident of Santa Barbara County who has a mental illness, but access requires a referral by a mental health professional.</p>			

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		Quality Rating	
5A	Capability and Capacity of the MHP	30	27
<p>The MHP offers most of the SMHS identified in the DHCS contract. The MHP has attempted to provide TFC, but no agencies have expressed interest in providing this service. Besides the PHF, the MHP does not have another inpatient psychiatric hospital, but contracts with several hospitals in and out of the county for hospitalization for adults and children. The MHP facilitates day treatment intensive and day rehabilitation through contracts and out-of-county placements.</p>			
5B	Network Adequacy	18	14
<p>The MHP utilizes a number of adjunctive services to increase its capacity to serve beneficiaries. The MHP uses telehealth. For this review period, the MHP delivered only a single telehealth session in Spanish. Per MHP representatives, the MHP has sufficient internal capacity for bilingual Spanish providers obviating the need for</p>			

<p>network providers for language needs. The MHP has co-located services (e.g., with Indian health centers, rural health providers, and child welfare services). The MHP has staff in all regions of the county that provide field-based services to persons experiencing homelessness and to the disabled. MHP representatives indicated that services are coordinated with a ‘whole-person’ approach. In the past year, the MHP began preparing for a formal Whole Person Care grant. The MHP does not utilize a behavioral health home model to provide services.</p>			
5C	Subcontracts/Contract Providers	14	8
<p>Contract providers provided 47 percent of the services to Medi-Cal beneficiaries. The MHP has the Community-based Organization (CBO) Collaborative Meeting for contract providers. Contract providers also attended the QIC meetings; minutes of which referenced increasing contractor attendance, particularly for ADP program. The MHP reported that its leadership and staff also attend the CBO Coalition that is run by the CBOs. The MHP’s reports and data analyses were notably missing data from contract providers as well as network providers.</p> <p>Given this desk review, collaboration and communication between the MHP and contract providers could not be verified.</p>			
5D	Stakeholder Engagement	8	7
<p>In addition to QIC and CCDAT meetings, the MHP has a Consumer and Family Member Advisory committee that raises concerns and advises the MHP on beneficiary and family member perspectives. The QIC are attended by different stakeholders; however, as only the names of attendees are included, the roles could not be ascertained. Other documents submitted by the MHP referenced input and feedback from stakeholders in one capacity or another, for example, beneficiary and family member representation on hiring panels.</p> <p>Given this desk review, collaboration and communication between the MHP and contract providers could not be verified.</p>			
5E	Peer Employment	8	8
<p>The MHP has robust peer employee program, integrating peers within the MHP and contract providers. The peer program is multiple level and recently has included a technology peer career ladder. Partners in Hope is a peer-run program providing peer support services to support the Recovery Learning Centers. Through the Recovery Learning Center and the Department of Rehabilitation, the MHP facilitates supported employment opportunities for beneficiaries (e.g., Vintage Clothing Care Closet in Santa Barbara and the Growing Grounds Farm in Santa Maria).</p>			
5F	Peer-Run Programs	10	8

There are three Recovery Learning Centers located in the three primary service areas in the county: Santa Barbara, Santa Maria, and Lompoc. The staff of the Recovery Learning Center are all peer employees. The MHP's process for informing beneficiaries of the Recovery Learning Centers or other peer opportunities and monitoring of the utilization of peer-run programs could not be verified.

5G	Cultural Competency	12	10
<p>The MHP incorporates cultural competency principles in its system of care. The CCDAT is attuned to and calls attention to the diversity among the MHP's beneficiary population. The MHP conducted a cultural competency needs assessment in June 2019, albeit with a low response rate, of 190 beneficiaries and family members. The MHP reported an "unknown" response rate. Two of the findings from the survey was that information about interpretation services was unclear (among staff) and availability of services was insufficient. Plans were discussed for outreach and education about language services. The MHP has a three-year cultural competency plan, but no clear annual update of the plan. The MHP conducted an implicit bias training series for staff in 2019. The MHP's documentation showed coordination and sharing of information between the QIC and CCDAT.</p>			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Santa Barbara MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Inactive, developed in a prior year (not rated)

Access to Care

Changes within the Past Year:

- As part of a Corrective Action Plan (CAP), the MHP hired 1.28 FTEs in child psychiatry and 0.6 FTE in adult. The MHP also increased FTEs for children's services by 30.83 FTEs by hiring new clinicians, reassigning clinicians, and correcting an undercount of clinicians serving children in certain areas.
- The MHP, in partnership with housing partners in Santa Barbara County, has opened three housing programs in Santa Maria for individuals with mental illness: Agnes Street Crisis Residential Program; Polly's House; No Place Like Home; and, the Residences at Depot Street.
- The MHP has expanded the Forensic Program, inclusive of several programs to divert beneficiaries from the criminal justice system. The Forensic Program is supported by Proposition 47 and Assembly Bill (AB) 180. The program enables three points of diversion: contact in the field by law enforcement, at jail booking, and prior to arraignment.
- The MHP launched a separate FSP program for TAY to address the needs of younger adults. The TAY FSP will incorporate the work of the Resiliency Interventions for Sexual Exploitation (RISE) program that services commercially and sexually exploited children.

Strengths:

- The MHP prioritizes housing as a critical social determinant of health.
- The MHP's law enforcement co-response teams are located in both north and south county, which increases beneficiary access to mental health services and decreases beneficiary involvement with criminal justice.
- The MHP's CCDAT is a good resource for the MHP in identifying access challenges and underserved populations within the county who may need mental health services.

Opportunities for Improvement:

- The MHP reported that there had only been one grievance in 2019 regarding frequent changes to psychiatrists. While grievance is a beneficiary tool to communicate satisfaction with services, it may not be an appropriate measure for the MHP to monitor turnover of psychiatrists and the impact of this on access to services.
- It is unknown if out-of-network providers were used to supplement county-operated psychiatry services.
- It is notable that not one telehealth session was delivered in Spanish, given that 25 percent of enrollees are Hispanic/Latinx. Last year's ISCA showed 91 telehealth sessions in Spanish compared to zero sessions this year.

Timeliness of Services

Changes within the Past Year:

- The MHP has begun to monitor and formally track time to first and second clinical appointment.

Strengths:

- None noted.

Opportunities for Improvement:

- The MHP's response to urgent condition for children and youth in FC lags behind that of adults.
- For all of the timeliness metrics, the MHP only reported on county-operated services. Almost 50 percent of services to Medi-Cal beneficiaries are facilitated through contract providers. Timeliness and NACT assessments should include contract provider data.

Quality of Care

Changes within the Past Year:

- The MHP expanded the Children's Triage Program in south county. The Children's Triage Program works closely with hospital emergency department to provide intensive services to youth experiencing a mental health crisis, including coordinating safety planning and assist in linking clients to preventative services. The Crisis Triage Program provides psychoeducation and support. The program includes a Parent Partner and one licensed mental health clinician.
- In prior years, Santa Barbara County had separate triage and mobile crisis teams. At the beginning of FY 2018-19, North and South County programs were

restructured to form regional County Crisis Services teams. West County has separate mobile and triage teams.

Strengths:

- Service expansion (i.e., to the north, south, and west county) promotes parity and enables access to beneficiaries residing throughout the county.

Opportunities for Improvement:

- The QI work plan contains neither measurable goals nor specific targets for improvement. The objectives were not operationalized and the identified 'point person' was the whole committee rather than a specific individual. The MHP's documents did not demonstrate a focused plan for improvement with an ability to evaluate the progress and achievement of those goals objectively.
- The MHP has determined that prescribers are not reliably recording the discontinuation of medications in RxNT, which may inflate the polypharmacy rate.
- There was a low response rate from the cultural competency needs assessment conducted in June 2019, which limits how representative the findings are to the general MHP population.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP launched a medication management clinic at a Recovery Learning Center.

Strengths:

- The MHP is engaged and active in supporting the community following crisis (e.g., the Cave Fire and the Metropolitan Transit District bus accident).

Opportunities for Improvement:

- While the MHP has and is taking steps to divert beneficiaries from hospitalization when possible, it has not been reflected in the EQRO data from CY 2018. There has been an increase in the number of beneficiaries receiving inpatient services in, as well as increases in the number of admissions, the length of stay, and the ACB since 2016.
- The status of the LOCRI utilization and reporting were not provided.
- While the MHP analyzed and presented an overview of the CPS, the results were outdated, from surveys over 1.5 years old. Improvement activities subsequent to those findings may not be relevant.

Foster Care

Changes within the Past Year:

- The MHP supported the opening of several Short-Term Residential Treatment Programs (STRTP) in the county, including Hope Refuge and 4Kids2Kids.

Strengths:

- The Interagency Placement Committee continues to enable the MHP and its partners to provide mental health and other supportive services to youth in FC. Fewer youth have been placed out-of-county because of the coordination of this team.

Opportunities for Improvement:

- Monitoring of medication utilization of children in FC has not been a regular part of the MHP's QIC.
- The MHP's QIC reporting and quarterly review of timeliness only indicated 'children' and did not have a separate category for youth in FC.
- The MHP's medication monitoring for children in foster care suffers from the same lack of accurate data that necessitates record sampling. The frequency and audience for this medication monitoring were not identified.

Information Systems

Changes within the Past Year:

- The MHP added three FTEs to IT support.
- The MHP is using RxNT Scheduling application in several clinics.
- The MHP has implemented/installed Tableau for improved data reporting. The MHP has negotiated a contract with SmartSheet for cloud-based workflow management solutions.

Strengths:

- None noted.

Opportunities for Improvement:

- The use of SmartSheet will likely require additional data entry or data upload by the contract providers into MHP's applications.
- The MHP's systems do not facilitate centralized appointment management and facile reporting of time to services.
- In the MHP's Strategic Plan, there are two strategies involving IT:
 - Move paper applications to electronic systems and suspend paper applications and documentation through e-signatures, verbal attestation, telephonic signatures, and other electronic means.
 - Prioritize investment in IT resources to enable the Department to update its IT infrastructure as well as implement IT solutions to improve system and program operations.

Both are essentially office automation or infrastructure initiatives that do not directly address better support for clinical service delivery and improving beneficiary outcomes.

- The MHP's Strategic Plan does not mention acquiring a comprehensive integrated EHR, which is the most strategic action the MHP could take at this time.
- Legacy systems and stand-alone applications make assembling and presenting a coherent data picture of the MHP (i.e., that includes contract providers) difficult. Consequently, the MHP faces challenges to its operations and use of data to tell a story to stakeholders.

Structure and Operations

Changes within the Past Year:

- The MHP increased IT staffing and hired several new management staff: a second QCM Manager; a new Clinical Services Division Chief; a new Cultural Competency Manager; and, a Fiscal Manager.

Strengths:

- The MHP has a multi-level peer program and recently added a technology peer career ladder.

Opportunities for Improvement:

- The responsibilities of the research and evaluation program have increased. Purportedly, there has not been a concomitant increase in staff and/or resources to this program. The program appears to be challenged in meeting the demands for reporting and providing consistent data.
- The IT Division reports to the chief financial officer. This peripheral placement relegates IT to an office automation/billing system within the MHP, rather than IT as a strategic asset to support the entire MHP. IT should be focused on how to improve clinical service delivery and beneficiary outcomes, first, then billing will follow.
- Even though contract providers account for 47 percent of services delivered, data regarding their services is conspicuously missing. This includes the MHP's Strategic Plan, the lists of accomplishments of the prior year, initiatives for the coming year, and the ISCA.
- Expenditures for institutions of mental disease (IMDs) have increased by over 500 percent in the last five years and continue to rise, outpacing revenue growth. The MHP continues to explore alternative service models to leverage additional funding and improve efficiencies to mitigate fiscal impact of continued rising IMD service demands.

FY 2019-20 Recommendations

PIP Status

1. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. (*This is a carry-over recommendation from FY 2018-19 and FY 2017-18.*)
2. Begin two new projects, with data that clearly substantiate a specific beneficiary problem in the county and with plans for prospective data collection.

Access to Care

3. Monitor psychiatry turnover rates in the upcoming year and determine an acceptable rate, then decrease the rate if necessary. (*This is a follow-up recommendation from FY 2018-19.*)
4. Monitor and document the contribution of out-of-network providers to augmenting timely access to psychiatric services for children in the upcoming year. (*This is a follow-up recommendation from FY 2018-19.*)

Timeliness of Services

5. Include time to services for contract providers in future submissions of the MHP Assessment of Timely Access. (*This recommendation is a follow-up from FY 2017-18 and FY 2018-19.*)
6. Improve the timeliness of response to urgent conditions for children and for youth in foster care (FC). Document the efforts to improve timeliness.
7. Improve the access to psychiatry for children and for youth in FC.

Quality of Care

8. Revise the quality improvement (QI) work plan and the evaluation to include measurable goals, supported by data, and with specific individuals responsible for overseeing the objective.
9. Conducted a time-limited audit of medication reconciliation. Depending on the findings, mandate procedures for reconciling and correcting these discrepancies.

Beneficiary Outcomes

10. Develop relevant indicators and track the outcomes of the Forensic Program.

Foster Care

11. Incorporate the review of data from California Child Welfare Indicators Project and the EPSDT Performance Outcome System (POS) (i.e., regarding medication utilization of children in FC) in QIC meetings and other relevant forums (e.g., the Interagency Placement Committee or the medical practice committee. *(This is a carry-over recommendation from FY 2018-19.)*
12. Report timeliness for children in FC separately from other children receiving services in the QIC reports.

Information Systems

13. Capture and report time to service data for contract providers that deliver 47 percent of the MHP's services, without requiring additional direct data entry from the contract providers. *(This recommendation is a follow-up from FY 2017-18 and FY 2018-19.)*
14. Select and implement a software application for centralized appointment management that has features that enable reporting of time to services. *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*
15. Develop a business plan to acquire a comprehensive integrated behavioral health information system that serves the entire MHP, including directly-operated services and with the capability to integrate contract provider's EHR, eliminating the burden of additional data entry.
16. Strengthen the MHP's ability to extract, report, and communicate reliable data by restoring the two FTE reduction in data analytic employees.

Structure and Operations

17. Move the direct-report for IT to either the Director or the Chief Deputy Director.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible.
- This was a desk review of documents submitted by the MHP, without the opportunity of on-site observation and discussion with MHP employees, beneficiary and family members, and contract provider representatives.
- The diversion of MHP staff and resources to respond to COVID-19 curtailed opportunities for dialogue, particularly to get clarification on information that the MHP provided. For example:
 - Table A.7 of the FY 2019-20 ISCA, the Total Annual MHP Budgeted Amounts for the Following Funding Sources by Provider Types, the total dollar amount looks reasonable compared to FY 2018-19, but the rest of the table bears almost no resemblance to last year's report, suggesting a discrepancy in reporting.
 - Some Response to Recommendations entries did not directly address the recommendation or were sufficiently unclear that there was doubt the recommendation had been met.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - 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
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Ewurama Shaw-Taylor, PhD, Lead Quality Reviewer
Karen Baylor, Chief Operations Officer, 2nd Quality Reviewer
Robert Greenless, PhD, Information Systems Reviewer
Pamela Roach, Consumer/Family Member Consultant

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

Sites of MHP Review

None

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Anderson	Stacey	Quality Care Management (QCM) Coordinator	Behavioral Wellness
Huthsing	Jamie	QCM Manager	Behavioral Wellness
Khatapoush	Shereen	Research and Evaluation Epidemiologist Senior	Behavioral Wellness
Lepore	Caitlin	Research and Evaluation Epidemiologist	Behavioral Wellness
Winkler	John	Clinical Division Chief	Behavioral Wellness

Attachment C—Approved Claims Source Data

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

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB Santa Barbara MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	\$832,986,475	\$5,460
Medium	541,182	20,317	3.75%	\$121,508,029	\$5,981
MHP	36,655	1,320	3.60%	\$8,946,082	\$6,777

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

Table C2: CY 2018 Distribution of Beneficiaries by ACB Cost Band Santa Barbara MHP								
ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< \$20K	5,341	90.76%	93.16%	\$22,244,696	\$4,165	\$3,802	49.70%	54.88%
>\$20K - \$30K	241	4.10%	3.10%	\$5,899,856	\$24,481	\$24,272	13.18%	11.65%
>\$30K	303	5.15%	3.74%	\$16,609,158	\$54,816	\$57,725	37.11%	33.47%

Attachment D—List of Commonly Used Acronyms

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

Table D1—List of Commonly Used Acronyms

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

Table D1—List of Commonly Used Acronyms

WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Santa Barbara	
PIP Title: Polypharmacy	
Start Date : 07/01/17 Completion Date : 07/31/20 Projected Study Period: 24 Months Completed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date(s) of On-Site Review: 03/23-03/24/20 Name of Reviewer: Shaw-Taylor	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
	<input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP <input type="checkbox"/> No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): Per the MHP, the purpose of this project was to reduce polypharmacy (as appropriate) for the safety and well-being of their beneficiaries and to increase beneficiaries self-reported well-being and quality of life.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The project team includes psychiatric providers, pharmacists, and various analysts in the department. There is minimal participation of a peer employee towards the end of the project, to assist with survey distribution and data collection.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The team presented data from routine charts reviews and polypharmacy-specific review of a sample of charts from FY 2016-17 that rates of polypharmacy were 6.4 percent for children and 21.1 percent for adults. These rates are low and relatively within normal acceptable limits for polypharmacy. The rates do not suggest a problem with polypharmacy, given the literature that the MHP cited.</p> <p>The rate should have been combined, for adults and children. This rate would be 27.52 percent, and incidentally is how the team reported the polypharmacy rate for the remainder of the project.</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 checked="" type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions		<p><i>Non-clinical:</i></p> <input type="checkbox"/> Process of accessing or delivering care

<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 type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The project was related to other aspects of enrollee care and services (e.g., medication compliance, treatment efficacy, and beneficiary functioning), but the MHP did not address these in the project. The other areas that the project addressed were related to the psychiatric providers, including documentation of consent and appropriate rationale for prescriptions.</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)? <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>It appears that all enrolled populations on medications would be eligible for the project.</p>
Totals		<p>1 Met 1 Partially Met 2 Not Met 0 UTD</p>
STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> Do interventions to reduce polypharmacy result in: a) a reduction in prescribed medications b) improved rationale for prescribed medications c) better self-reported client outcomes</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Of the three parts of the study question, the MHP has only presented information to support part one. The study question has a direction for improvement, but no actual target. The MHP did not present any information that outcomes for their beneficiaries were adversely affected by polypharmacy. The second part of the study question relates to the psychiatric providers.</p>
Totals		<p>0 Met 1 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? <i>Demographics:</i></p> <p><input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The MHP included the entire beneficiary population from FY 2017-18, but the study is only specific to those who are taking medications.</p>
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i></p> <p><input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other:</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine</p>	<p>The team reported that a “random sample of charts” were pulled monthly for review. The team did not indicate if and how the random sample would represent the MHP’s population, which the team presented in detail. Additionally, these charts also included beneficiaries who were not taking medications, and therefore should not be included.</p>
Totals		0 Met 0 Partially Met 1 Not Met 1 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators? <i>List indicators:</i></p> <ol style="list-style-type: none"> 1. Percentage of polypharmacy 2. Reduction in polypharmacy prescriptions 3. Improved rationale for polypharmacy prescriptions 	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Indicator 1 and 2 are, in effect, the same; with fewer prescriptions for multiple medications, the percentage of polypharmacy would necessarily reduce. Indicator 3 relates to prescriber behavior and in and of itself would not reduce polypharmacy. The team presented a separate table of 12 beneficiary outcomes for which there was no baseline and no context for the outcomes. The team did not provide a goal, presented as a specific number, for improvement.</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 beneficiary focused.</p> <p><input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</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 one indicator that relates to beneficiary outcomes relates to a change in a process of care.</p>
Totals		0 Met 1 Partially Met 1 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? b) Confidence interval to be used? c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>The team reported that the sample of charts included 20 charts reviewed monthly by QCM and additional 40+ charts reviewed by the specifically designated polypharmacy reviewer. The team did not explain how they arrived at the number of charts to review and if/how this sample related to the estimated frequency of polypharmacy.</p>

<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i> None indicted.</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 team has used a random sampling technique based on the current month. No specific technique was identified.</p>
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> Unable to Determine	<p>As the team did not indicate the estimated frequency of polypharmacy and also included some charts that were likely from those not taking medications, it is difficult to determine if the numbers were sufficient.</p>
Totals 1 Met 0 Partially Met 1 Not Met 0 NA 1 UTD		
STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The team presented some of the data to be collected. They did not include the results of the notification sent to the prescribers, which is particularly important for determining if a change occurred.</p>
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met	<p>Charts and survey data were identified. The team also included MIS/EHR as a data source, but added that the report could not be used because the data were inaccurate and incongruent. Presumably, the</p>

<input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input type="checkbox"/> Other: Charts (i.e., medical record), survey, and MIS/EHR data	<input checked="" type="checkbox"/> Unable to Determine	charts were some of the same that were included in the EHR, but the team did not speak to the accuracy of the information in the charts. How many of the charts reflected actual polypharmacy versus lack of corresponding documentation regarding deprescribing of medications?
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?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The team did not provide methodology after the initial selection and review of charts. The following were not addressed: <ul style="list-style-type: none"> • How soon after polypharmacy was identified was change supposed to be implemented? • How soon after polypharmacy was identified were charts re-reviewed? • How soon after the intervention would the survey take place?
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other: Charts and survey	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	The team makes references to lack of sufficient documentation and rationale for medications, suggesting that polypharmacy, itself, may not be the issue. The survey, which depended on the beneficiaries' recall (e.g., of change to medications, functioning) was given almost two years after the intervention was first applied.

<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 <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Neither a prospective data analysis plan nor contingencies for untoward outcomes were presented.</p>
<p>6.6 Were qualified staff and personnel used to collect the data? <i>Project leader:</i> Name: Shereen Khatapoush Title: Research & Program Evaluation Role: QI <i>Other team members:</i> Names: Several psychiatrists, staff from Research & Program Evaluation, and a few program leaders</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 staff involved in data collection included a psychiatrist, a Research and Evaluation program staff member, and a peer employee. Each was familiar with gathering data from the various sources.</p>
Totals		<p>1 Met 1 Partially Met 1 Not Met 3 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> <ol style="list-style-type: none"> 1. Polypharmacy notice to psychiatrists 2. Development of training for onboarding psychiatrists 3. Routine polypharmacy chart review 	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The team’s interventions were indirect. None of them actually decrease polypharmacy (i.e., the prescription of multiple antipsychotic medications). Part of the issue is that the team does not address the reasons for polypharmacy in their system of care. The team provided a detailed table of types of polypharmacy but failed to make the connection to their own MHP. The team added the third intervention, additional chart review, which was similar to grand rounds, in March 2019; however, the need for this additional indirect intervention was not clear, given that the polypharmacy rates at that time were already decreasing.</p>
Totals		0 Met 0 Partially Met 1 Not Met 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>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The team did not have an analysis plan.</p>

<p>8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Are they labeled clearly and accurately? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</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>The team presented data on polypharmacy rates, medication consents, and rationale for medications. The team did not provide sufficient explanation for the inclusion of medication consents in this project on polypharmacy. The team presented multiple tables related to the survey and its outcomes, but there was nothing to which the survey results could be compared. It is important to note that over 65 percent of the participants reported that either there was no decrease in their medications or that they did not recall if their medications had decreased or not.</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? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine</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>The team presented quarterly results of polypharmacy, medication consents, and rationale. The survey results were not repeated. Statistical analyses were not 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? <i>Limitations described:</i> None <i>Conclusions regarding the success of the interpretation:</i> According to the MHP “from chart review, rechecking charts and client survey data – that the PIP is successfully impacting Polypharmacy.” <i>Recommendations for follow-up:</i> None</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>The team speculated on the degree to which the project was successful. The team did not discuss limitations. The survey data were presented, but it is unclear how the survey questions related specifically to medication change versus participants perception of their mental health services in general.</p>
<p>Totals 0 Met 3 Partially Met 1 Not Met 0 NA 0 UTD</p>		
<p>STEP 9: Assess Whether Improvement is “Real” Improvement</p>		
<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>	<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 study appears to have been conducted the same throughout the 2.5 years of the project.</p>

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration Statistical significance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>The baseline for polypharmacy at the start of the project was 42.6 percent. At the end of the second quarter of FY 2019-20, the polypharmacy rate was 26.0 percent. The polypharmacy rate began declining after the third quarter of the first year of the project.</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 checked="" type="checkbox"/> Small <input type="checkbox"/> Fair <input type="checkbox"/> High</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>The interventions were successful in increasing prescriber’s attention to documenting the rationale for medications and, by extension, to polypharmacy. It was entirely possible for the notification to be sent out and for the prescriber to provide more justification for the medications, but not decrease polypharmacy, which the team’s data showed.</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>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>No statistical analyses were performed.</p>

<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</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 polypharmacy rate began declining after the third quarter of the first year of the project and continued to decline for six consecutive quarters.</p>
Totals		3 Met 1 Partially Met 0 Not Met 1 NA 0 UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
<p><i>Conclusions:</i> The impetus for this project was a sample of beneficiary records that showed a polypharmacy rate of 27.52 percent. By the conclusion of this project or the time of this review, the MHP had a polypharmacy rate of 26.0 percent, which is close to where the MHP originally was in FY 2016-17. The project also focused on improving prescriber’s rationale for medications and appears to have had a more lasting impact in this areas.</p>

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

Recommendations:

- Conclude this project (i.e., do not present this topic for a subsequent PIP).
- Use current, extant data as the basis for a future clinical project.
- Ensure that the data (above) support the need for improvement.
- Set concrete and specific numbers as targets for improvement.

Check one:

- High confidence in reported Plan PIP results Low confidence in reported Plan PIP results
 Confidence in reported Plan PIP results Reported Plan PIP results not credible
 Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Santa Barbara	
PIP Title: Crisis System Continuum of Care	
Start Date : 05/01/17 Completion Date: 04/31/20 Projected Study Period: 42 Months Completed: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Date(s) of On-Site Review: 03/23-03/24/20 Name of Reviewer: Shaw-Taylor	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input type="checkbox"/> Active and ongoing (baseline established and interventions started)
	<input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
	<input type="checkbox"/> Concept only, not yet active (interventions not started) <input checked="" type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP <input type="checkbox"/> No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The team stated different, but interrelated aims for this project. Per the MHP, the PIP aims to enhance crisis services and to expand the continuum of care by providing more treatment options, levels of care, and prevention strategies, with the ultimate goal of decreasing inpatient hospitalization and rehospitalization. Elsewhere, the MHP also stated that the goal of the project was to prevent “unnecessary inpatient hospitalizations and reduce re-hospitalization.” Lastly, the goal was to improve client care in the crisis system.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	After over two and a half years, the MHP has not been able to include beneficiaries or family members into this project, which very much would benefit from their input. The team reported that beneficiaries and family member involvement was “unspecified at this time”. The team included psychiatric providers, staff of crisis services, outpatient clinics, and staff of Research and Program Evaluation.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data and information that served as the basis to begin the current project were not provided. In its place, the team discussed the interventions.
<p>Select the category for each PIP:</p> <p><i>Non-clinical:</i></p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> Care for an acute or chronic condition <input checked="" type="checkbox"/> Process of accessing or delivering care </div> <div> <input type="checkbox"/> High volume services <input type="checkbox"/> High risk conditions </div> </div>		

<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 type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The project related to how beneficiaries access crisis. It also appears to relate to hospitalizations. The focus of the project has shifted from last year to this year, with more focus on systems improvements rather than beneficiary improvements.</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)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Information on the MHP's entire population were provided, as well as crisis utilization and hospitalizations.</p>
Totals		<p>Met Partially Met Not Met 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 administrative interventions improve client care in the crisis system in the following areas:</p> <ol style="list-style-type: none"> 1. LPS utilization and care, as measured by admission rate to LPS from a crisis service and PHF re-hospitalization rate 2. Care coordination and timeliness to psychiatry, as measured by reduced wait time to psychiatry following a crisis service 3. Use of lower levels of crisis care, as measured by increased stability in services for clients at the CRT, and increased CSU occupancy rates 4. Law enforcement involvement, as measured by increased mental health outcomes for clients initially contacted by law enforcement 	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>This year's study is quite different from last year's, which puts more emphasis on beneficiary access to services.</p>	
Totals		Met	Partially Met Not Met 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 type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The MHP presented data on their entire population and numbers of beneficiaries who had used crisis services and the numbers who had been hospitalized from FY 2016-17 and FY 2017-18.</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 type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other: <Text if checked></p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The team did not articulate why certain crisis services were measured and not others, for example, the utilization of the CRT versus the CSU.</p>				
Totals		<table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Met</td> <td style="width: 25%;">Partially Met</td> <td style="width: 25%;">Not Met</td> <td style="width: 25%;">UTD</td> </tr> </table>	Met	Partially Met	Not Met	UTD
Met	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> <ol style="list-style-type: none"> 1. Admission Rate to LPS from crisis services 2. PHF Re-Hospitalization Rate within 30 days 3. Transition from crisis service to psychiatry appointment: - Avg. Wait time 4. Transition from crisis service to psychiatry appointment: - % within 7 Days 5. CRT → increased stability (fewer crises) 6. CRT → increased stability (more outpatient) 7. CSU Occupancy Rate 8. Rate of calls responded to by mental health co-response that led to crisis system response 	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The team has presented different indicators, some of which were meant to address deficiencies from the previous year others related to the MHP's revised focus on "a broad evaluation of [its] crisis system".</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 beneficiary focused.</p> <p><input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The team changed the indicators in an attempt to address some concerns raised in last year's PIP. The indicators seem to reinforce a focus on a system problem rather than a beneficiary problem. For example, in regard to CSU occupancy, the team wrote that "low CSU occupancy rate has been an identified problem within our system..."</p>
Totals		Met Partially Met Not Met 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? b) Confidence interval to be used? c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>The project did not involve sampling.</p>

<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The project did not involve sampling.</p>						
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The project did not involve sampling.</p>						
<table border="1"> <tr> <td style="width: 45%;">Totals</td> <td>Met</td> <td>Partially Met</td> <td>Not Met</td> <td>NA</td> <td>UTD</td> </tr> </table>			Totals	Met	Partially Met	Not Met	NA	UTD
Totals	Met	Partially Met	Not Met	NA	UTD			
<p>STEP 6: Review Data Collection Procedures</p>								
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The team provided a table of sources of data, but not the specific data elements to be captured.</p>						
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met	<p>The sources of data were indicated.</p>						

<input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input type="checkbox"/> Other:	<input type="checkbox"/> Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	Data appeared to be collected monthly with quarterly and annual reviews.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other:	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The team explained how the data were reliable and valid.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	A basic analysis plan was presented, indicating quarterly and annual review. Percent change would be calculated, but no statistical analysis was indicated.

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Caitlin Lepore Title: Research and Program Evaluation Role: Facilitator <i>Other team members:</i> Names: various MHP staff and CBO staff</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Staff involved in analysis and evaluation were part of the PIP team. The team did not indicate specifically how these individuals could ensure accuracy and reliability of data collection (e.g., including that from the hospital).</p>
Totals		Met Partially Met Not Met UTD
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> 1. Psychiatrist 16-hour shifts at PHF 2. Crisis Services Hub 3. Law Enforcement Drop Offs to Crisis Hub 4. Law Enforcement Co-Response</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>The team provided a conceptual map of the relationship between the interventions and the objectives of the project.</p>
Totals		Met Partially Met Not Met 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>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The team collected data quarterly and included a trend line showing change over time.</p>
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The team presented a number of figures showing change in the indicators. There were no labels on the x axis of the figures.</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? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent ____Unable to determine</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>Monthly data collection and quarterly reviews were planned and executed.</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? <i>Limitations described:</i> The scope of the project was too big/broad. <i>Conclusions regarding the success of the interpretation:</i> “Our mental health crisis system has experienced many positive successes as a result of the systemic changes over the past five years. <i>Recommendations for follow-up:</i> “We are still working on starting a system to allow for data sharing with the jail...”</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>The team addressed outcomes and success of the project. The team mentioned a plan to capture data from law enforcement from the jails and a potential new indicator.</p> <p>The team discussed success in terms of a system effort to improve crisis. The team added that the “PIP has experienced a bit of a “tip of the iceberg” problem whereby capturing the real change through particular chosen indicators has been imperfect.”</p>
Totals		<p>Met Partially Met Not Met NA 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? <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>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>The PIP has undergone a conceptual change, but no change in actual methodology. However, the team did not have all of the corresponding and relevant data for the conceptual changes made.</p>
<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: <input type="checkbox"/> Improvement <input type="checkbox"/> Deterioration Statistical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No Clinical significance: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>There were improvements in the utilization of various crisis services. There were reductions in the rehospitalization rate and crisis service utilization.</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>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>Some of the changes have not been sustained.</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 type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>Statistical analyses were not preformed.</p>
<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 type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The team has been conducting this project for 33 months, over which time improvements have maintained for some indicators.</p>
Totals		Met Partially Met Not Met NA UTD

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

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

Conclusions:

The project is best viewed in the context of the MHP’s ongoing efforts to improve crisis services. The MHP has continued to expand crisis and facilitate beneficiaries’ access to ongoing services post-crisis. The project changed conceptually, on paper, from last year to this year, with no changes to the interventions. The team also cited three changes in the project lead, which affected the continuity and execution of this project.

Recommendations:

- Begin a new project, with data that clearly establishes a beneficiary problem.
- Maintain a circumscribed focus on the scope of the project.
- Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Check one:

- High confidence in reported Plan PIP results Low confidence in reported Plan PIP results
 Confidence in reported Plan PIP results Reported Plan PIP results not credible
 Confidence in PIP results cannot be determined at this time