FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

Mendocino

Conducted on

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INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Beneficiaries served in CY14—1,462
  - MHP Size—Small
  - MHP Region—Superior
  - MHP Threshold Languages—Spanish
  - MHP Location—Ukiah

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the Mendocino mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

[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.

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Mendocino MHP submitted two PIPs for validation through the EQRO review. The PIP(s) are discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

[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 serve to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY14-15

In this section we first discuss the status of last year's (FY14-15) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

In the FY14-15 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY15-16 site visit, CalEQRO and MHP staff discussed the status of those FY14-15 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY14-15

- Recommendation #1: Utilize consumer and staff input on the development of a survey to assist the MHP in obtaining feedback on the strengths and challenges of the new dual Administrative Services Organization (ASO) model of care.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - Mendocino County Mental Health Plan (MHP) has created two surveys; one for staff to complete and one for consumers to complete to obtain feedback on the strengths and challenges of the new dual ASO model of care.
  - The MHP providers will be disseminating surveys in early October to all MHP staff and consumers. The surveys will be analyzed and the results will be provided to the Mental Health Director, MHP Providers, and Quality Improvement Committee.

- The MHP provided a copy of the survey questions to the review team.

- Recommendation #2: Broaden access tracking data, which already follows numbers of Spanish speakers, to include timeliness for Spanish speakers.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has added to the Quality Improvement Work Plan for Fiscal Year 15-16 the following additional items to track timeliness for Latino consumers:
    - Monitor timeliness of routine (initial) mental health appointments from the date of first request to the date of first billable clinical assessment for Latino beneficiaries and
    - Monitor timeliness of routine (initial) medication appointments for Latino beneficiaries.
  - The data will be reviewed and analyzed at the monthly Utilization Management meetings and reported at the bi-monthly Quality Improvement Committee Meetings.
  - The MHP had begun to report this indicator at the time of the review.
- Recommendation #3: Prioritize the implementation of an electronic EHR/Practice Management system within the OMG Adult ASO (Avatar or other selected option), and online integration of outcome instruments.
  - ☐ Fully addressed ☐ Partially addressed ☒ Not addressed
  - The MHP continues to work in partnership with Ortner Management Group (OMG), Redwood Quality Management Group (RQMG), NetSmart, Xpio, and Redwood Mednet to get all Mental Health Plan providers online with an electronic health records system, with the Adult System of Care prioritized.
  - The MHP has worked with Redwood Quality Management Group to integrate the CANS and ANSA fully into their electronic health record system.
  - The next phase the MHP intends to focus on with the Ortner Management Group will be to integrate the CANS and ANSA into the NetSmart system.

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

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

- Access to Care
  -
  - Acquisition of and service implementation at the Mendocino Coast Hospitality Center to provide integrated specialty mental health services.
  - Implementation of the SB 82 Triage Grant as a mobile outreach and engagement team targeting specific high need communities – South Coast, Anderson Valley and North County.
  -
  - Expansion of the Behavioral Health Court to the coast (Fort Bragg).
- Timeliness of Services
  - Implementation of Telehealth for medication support for improved timely access.
- Quality of Care
  -
  - The MHP was awarded $500,000 through the SB82 funding. The MHP is exploring local Crisis Residential Services, extending regional care which does not otherwise have any 24 hour care
  - Development of Regional Drug Medi-Cal services in collaboration with 7 other small Northern Counties and Partnership Health Plan.
- Consumer Outcomes
  - Implemented suicide prevention services (including, but not limited to county wide trainings and suicide hotline), potentially contributing to recognition of suicide ideation and promotion of destigmatization. Early intervention potentially contributes to decreased fatal outcomes.
  -
  - Laura's Law – Implementation date January 1, 2016, to provide assisted outpatient treatment for individuals who cannot access community mental health services voluntarily due to the severity of their mental illness.
  - MHSA Permanent Housing Project, providing a first step towards housing security, potentially leading to increased functioning and consumer independence.
  - The MHP's clinical PIP is focused on improving the process of using the CANS to improve treatment appropriateness, consumer satisfaction and clinical outcomes.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark (not included in MHP reports; a separate report will be submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
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- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2016.

TOTAL BENEFICIARIES SERVED

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

Table 1—Mendocino MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity

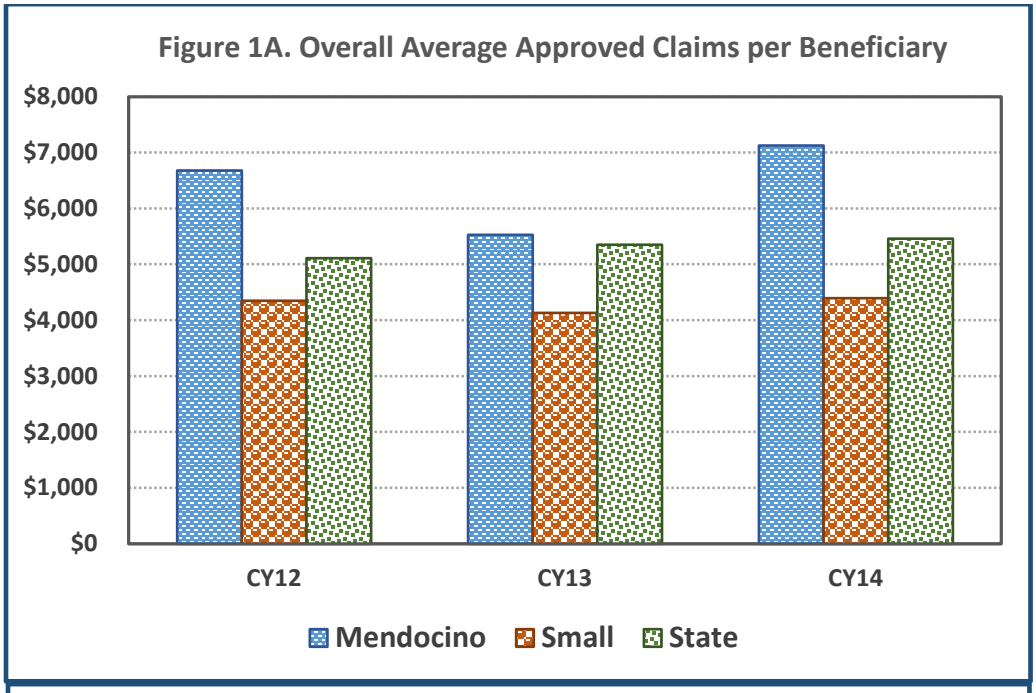
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	14,460	893
Hispanic	9,519	292
African-American	267	33
Asian/Pacific Islander	425	15
Native American	1,829	86
Other	2,541	143
Total	29,039	1,462

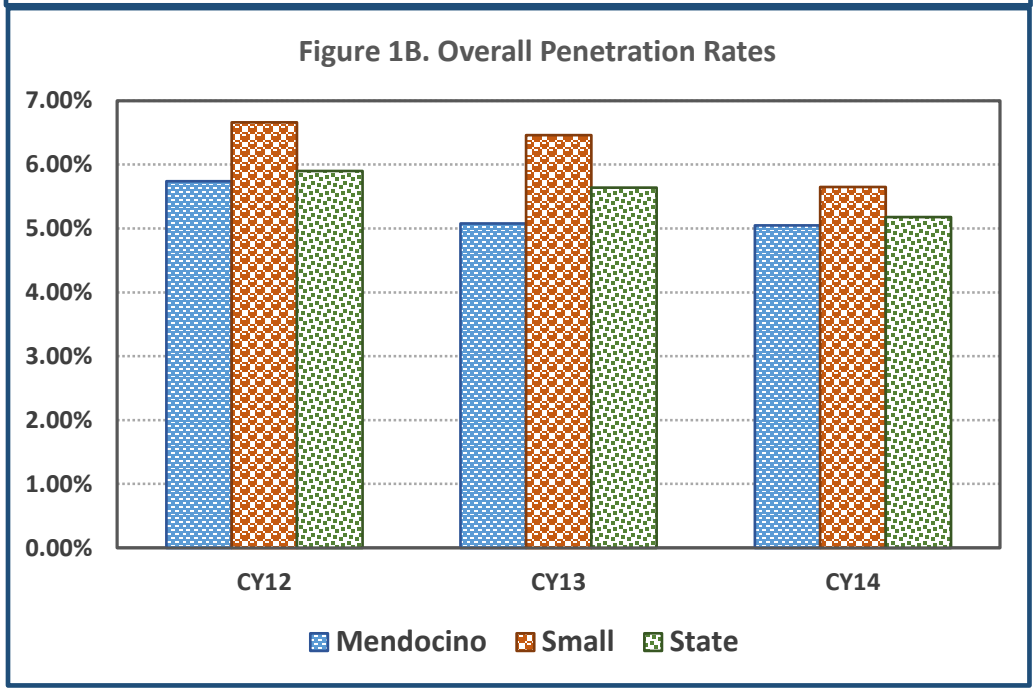
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

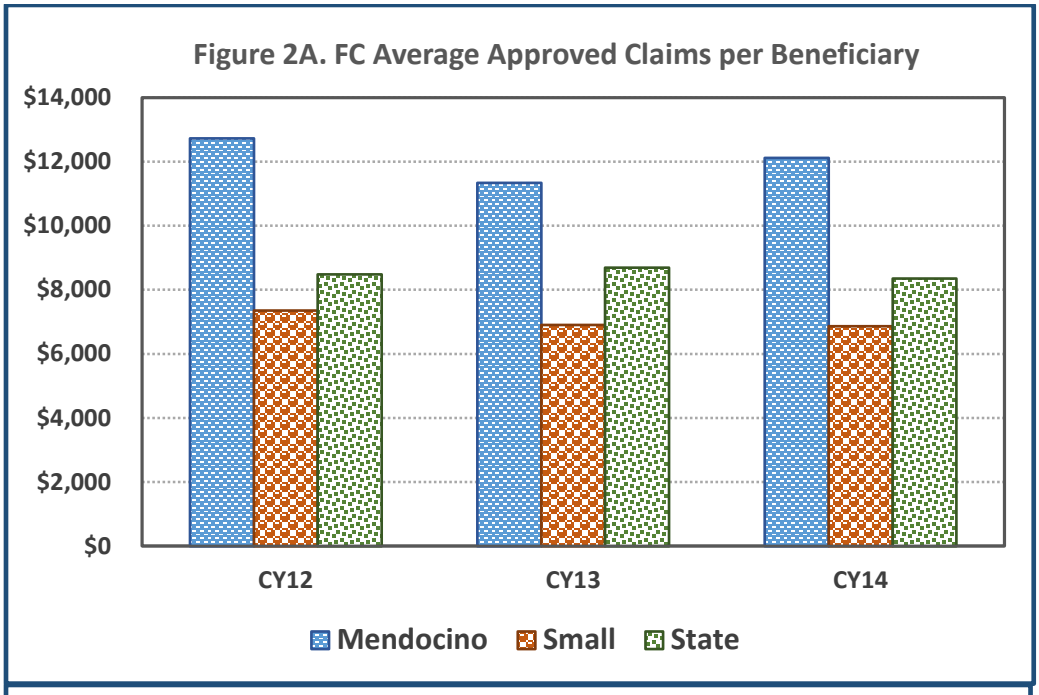
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

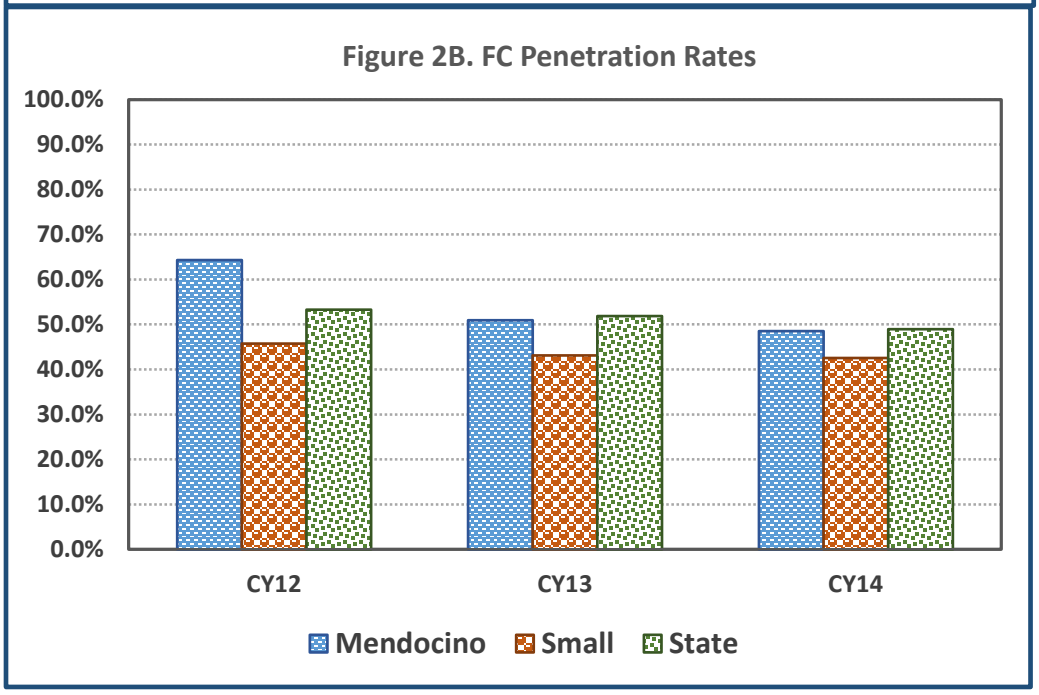
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.



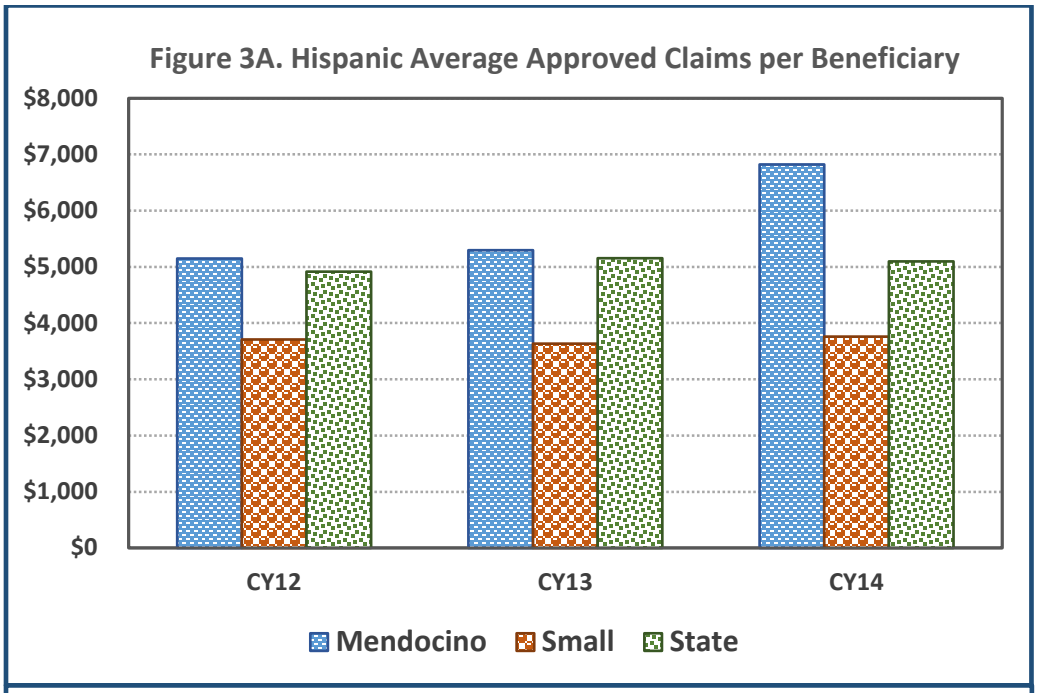


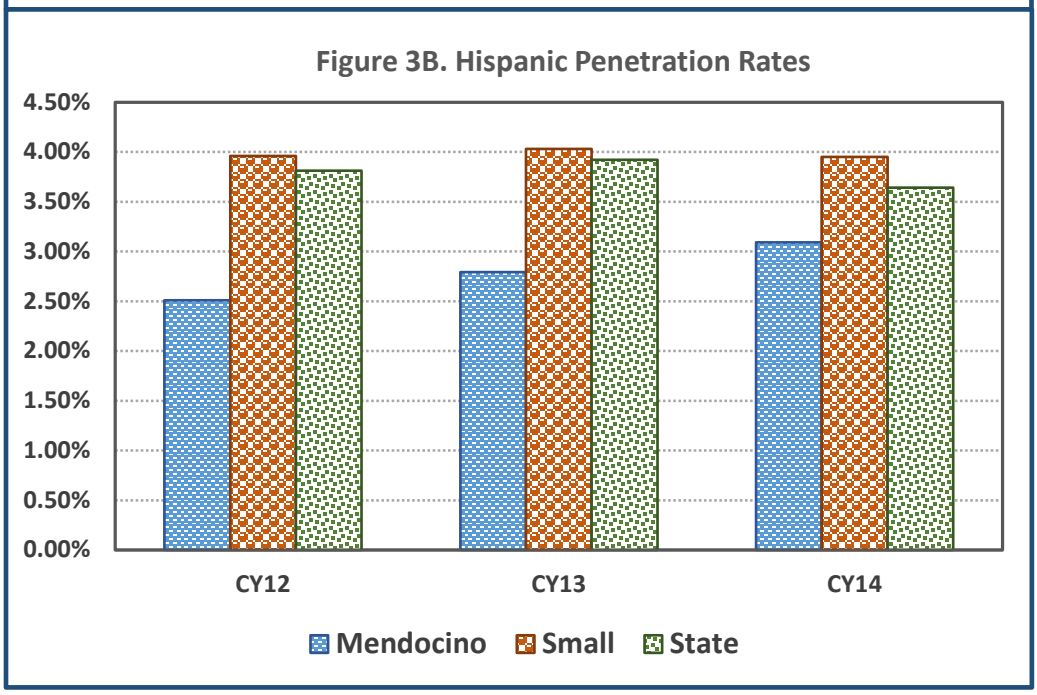
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Small MHPs.





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





HIGH-COST BENEFICIARIES

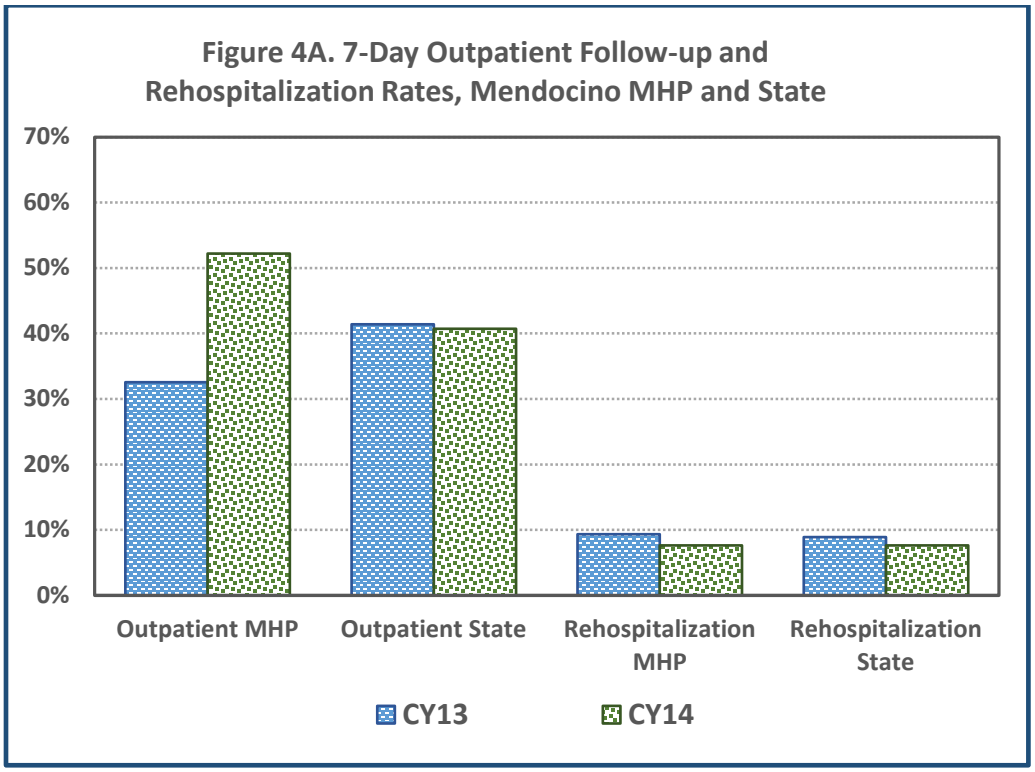
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

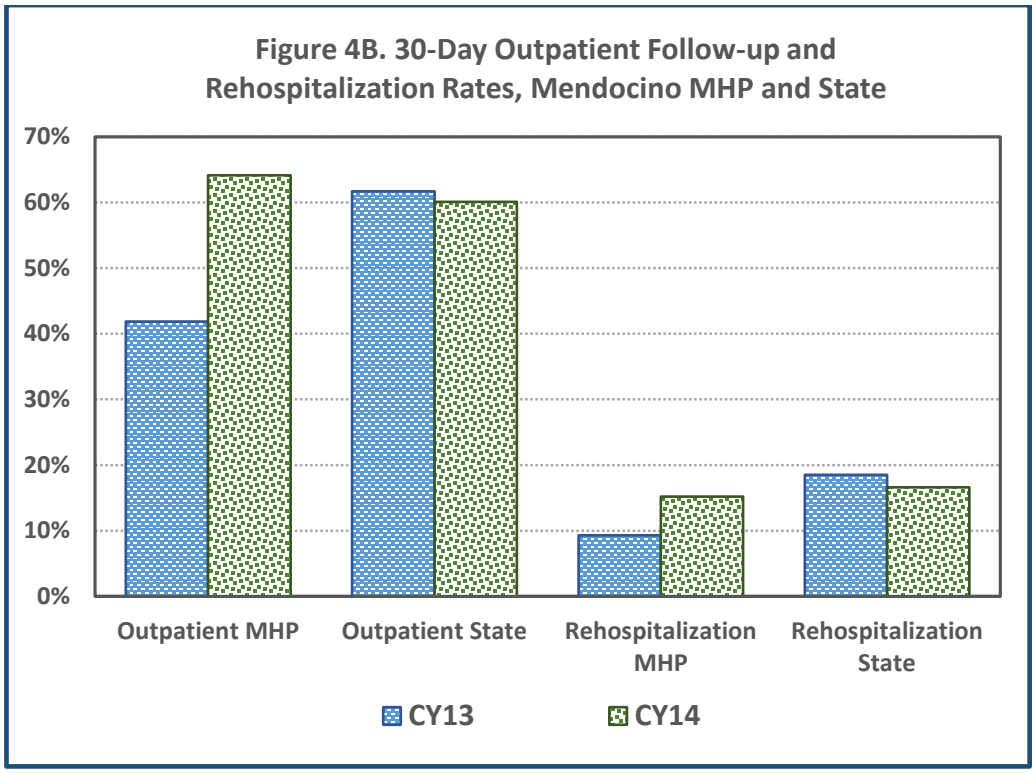
Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	$50,358	$617,293,169	24.41%
Mendocino	CY14	64	1,462	4.38%	$40,744	$2,607,602	26.83%
	CY13	43	1,332	3.23%	$39,536	$1,700,029	23.09%
	CY12	75	1,434	5.23%	$42,332	$3,174,933	33.16%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

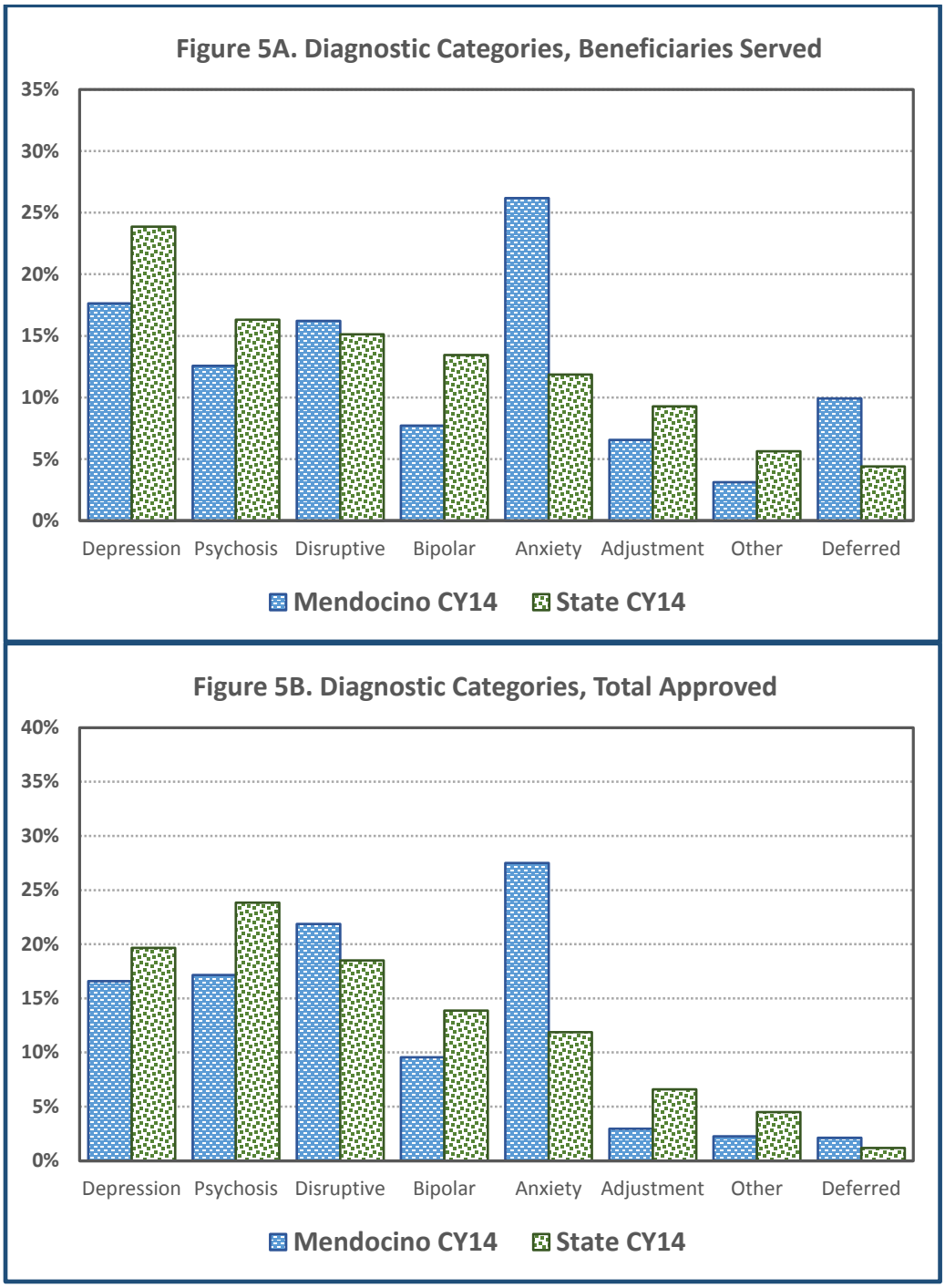
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY13 and CY14.





DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY14.



PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall penetration rate has declined each year between CY12 and CY14 similar to the trend experienced overall statewide and across small MHPs. Its penetration rate has been lower than that statewide during the same period.
  - The MHP's foster care penetration rate is slightly higher than the small MHP average and comparable to statewide. There has been a small downward trend in foster care rate statewide and for the MHP.
  - The MHP's Hispanic penetration rate remains lower than both the small MHP average and the statewide average.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after discharge from psychiatric inpatient was significantly higher in CY14 compared to its CY13 rates and higher than statewide rates in CY14.
- Quality of Care
  - The MHP's percentage of CY14 high-cost beneficiaries increased from its CY13 percentage and higher than the statewide percentage. Its total HCB claims dollars and total number served increased from CY14 but remains lower than the average approved claims statewide.
  - The MHP's average approved claims per beneficiary served for both foster care and Hispanic beneficiaries have been consistently significantly higher when compared to small MHPs and the statewide averages for the three years between CY12 and CY14.
  - The MHP had a significantly higher percentage of beneficiaries with a primary diagnosis of Anxiety Disorders and those with Deferred Diagnoses, and a slightly higher percentage with a diagnosis of Disruptive Disorders.
  - The MHP had a lower percentage with a primary diagnosis of Bipolar Disorders, Depression, Psychosis and Adjustment Disorders than statewide figures.
  - The total approved claims for the MHP for individuals with Anxiety Disorders were higher than that for any other diagnostic category and significantly higher than the statewide figures.
- Consumer Outcomes
  - The MHP's 7 day psychiatric rehospitalization rate was lower in CY14 compared to its corresponding rate in CY13.

- The MHP's 30 day psychiatric rehospitalization rate was higher in CY14 compared to its corresponding rate in CY13 and lower than the statewide rate for the same timeframes.
- The MHP appears to use Deferred Diagnoses for a slightly higher percentage of its beneficiaries compared to statewide.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2014.

MENDOCINO MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Mendocino MHP submitted two PIP(s) for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	CANS Assessment Improvement Tool
Non-Clinical PIP	Katie A. Screening Process Improvement

Table 3A lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[4]

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

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	M	M
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	M	M
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	PM	M
		6.6	Qualified data collection personnel	M	M
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	PM	M
		7.2	Interim data triggering modifications as needed	M	M
		7.3	Data presented in adherence to the plan	M	M
		7.4	Initial and repeat measurements, statistical significance, threats to validity	M	M
		7.5	Interpretation of results and follow-up	M	M

Table 3A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	M	M
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	M	M
		8.3	Threats to comparability, internal and external validity	M	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	M
		9.3	Improvement in performance linked to the PIP	M	M
		9.4	Statistical evidence of true improvement	M	M
		9.5	Sustained improvement demonstrated through repeated measures.	NA	NA

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 3B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	27	29
Number Partially Met	2	0
Number Not Met	0	0
Number Applicable (AP) (Maximum = 30)	29	29
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	96.55%	100%

CLINICAL PIP—CANS ASSESSMENT IMPROVEMENT TOOL

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

"Do consumers whose providers regularly review their CANS sub scores, urgent needs, and progress on treatment goals have better outcomes than those consumers/families who did not receive a regular review?"

- Date PIP began: July, 2014
- Status of PIP:

  ☒ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☐ Submission determined not to be a PIP

  ☐ No PIP submitted

The Mental Health Plan implemented the Children's Assessment Needs Survey (CANS) and Adult Needs Survey Assessment (ANSA) system-wide outcome measurement tools over a year ago. With the implementation of the CANS and ANSA, the Administrative Service Organizations (ASOs) and the MHP began tracking outcome data and comparing it with utilization review. The reviews showed a range of CANS scores that did not correlate with the intensity of treatment services received by clients. The review also found that the CANS and GAF scores did not correlate.

This study proposes that if clinical supervisors and clinicians regularly review the CANS results with consumers and if progress is shown in treatment with the consumer and family then consumers will show an improvement in outcomes and be more satisfied with services than those in the control group which had not received regular reviews. The MHP determined its first cohort of the study would focus on the Children's System of Care beneficiaries of services.

Implementing a system of care in which providers regularly review with the client/family their CANS sub score, urgent needs, and progress on their treatment goals, will result in providers doing a better job of "Treating to Target". Clients will more likely receive the right level of services for the right amount of time, improving outcomes for all beneficiaries within the Children's System of Care.

Additionally, improving the consistency between the CANS sub score, the intensity of services, and the length of treatment, will positively impact the availability of limited treatment resources within Mendocino County, thus improving the county's penetration rates.

The MHP will compare the CANS sub scores, the length of time in treatment, and the average hours of services per month, between the control group and the study group to evaluate the benefits of the PIP interventions.

The MHP developed and instituted a CANS Scoring Guide that helps inform providers about recommended levels of services and when a client is ready to step down to community providers or to terminate services (CANS sub score below 15 and GAF score above 63). Clients in this range generally no longer need Specialty Mental Health Services and can be either referred to a community Medi-Cal managed care provider for lower level services or exited from treatment.

This study proposes that this intervention will result in:

- an increase in the percentage of consumers who show improvement in their CANS sub-scores,
- a reduction in the intensity of services, and
- a reduction in the length of service episodes when compared to a baseline group of consumers who did not receive this review.

The control group consists of 242 consumers, who are MHP Redwood Children's Services (RCS) consumers and two CANS scores during July 1, 2014 through December 31, 2014.

The first study group consists of 254 consumers who are MHP RCS consumers and had two CANS scores during January 1, 2015 through June 30, 2015.

The data was collected and discussed in monthly reviews with the analysis distributed at the end of the six month cycle. The analysis of the data shows an improvement in both process and consumer outcomes as demonstrated by a higher rate of congruency between the CANS sub score and the GAF score in the study group. The process component includes providing a regular CANS Data Report which is reviewed by supervisors and clinicians. When a clinician shows a pattern of discrepancies and/or problems in their assessments, the supervisor initiates a "training and coaching" process. The consumer outcome component is demonstrated by both the improved average CANS sub scores and the reduction in intensity of services in the study group, as compared to the control group.

The PIP results showed improved client outcomes and better protocols and procedures. The analysis of this measure found that 56.5% (n=244) of clients in the control group showed an improved CANS sub score. The study group, who benefitted from the PIP intervention, had 64.9% (n=271) of clients showing an improvement in their CANS sub score. The study group had a 14.8% increase in the percentage of clients who showed an improvement in their CANS sub scores over the control group.

The data shows that the length of treatment for the control group had an average of 6 hours of service per month, per client. This was compared to the average hours of service per client, per month, for the study period. The data shows that the study group had an average of 4 hours of

service per month. This is a 33% reduction in average hours of service per month, per client, from the control group to the study group.

During the control period 22% (n-271) of the CANS assessments were incongruent with the GAF score; this dropped to 9% (n=272) for the study period. The improvement in congruent CANS assessments and GAF scores appear to be due to several factors, for example, clinicians were regularly getting data, supervisors were providing feedback and trainings to clinicians, and clinicians were getting additional CANS trainings through the Praed training website.

The MHP attributes the improvements to clinicians being more focused on "Treating to Target" as a result of regular reports on clients' progress and frequent reviews with clients/families about their CANS sub scores, urgent needs, and progress in treatment. These reviews allowed for more timely reduction and/or termination of services when a client's level of functioning improved. Clinicians report that it is easier to ensure that clients are getting the "right amount of services at the right time" when they have access to current, reliable data regarding a client's progress.

Although the initial phase of the PIP has been implemented, the MHP will continue to roll out to other providers and ultimately continue this as a business practice. Another year of data will allow the MHP to determine if the PIP is the causal link for real improvement. The MHP added new indicators in August, 2015 which include the monitoring the frequency of the CANS reviews with clients and the client/family's response to the review of progress.

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

The technical assistance provided to the MHP by CalEQRO consisted of advising the MHP team that CalEQRO staff remain available to discuss its future activities as the MHP continues to address the goals of this PIP. As the MHP determines its next venture it may benefit to consult for its effectiveness at reaching the intention of the parameters of a PIP.

NON-CLINICAL PIP—KATIE A. SCREENING PROCESS IMPROVEMENT

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

- "Can Mendocino County Behavioral Health & Recovery Services and Child Welfare Services improve the percentage of screenings and number of eligible subclass members receiving Intensive Care Coordination (ICC) services by changing the screening process?"
- Date PIP began: August , 2014
- Status of PIP:

  ☐ Active and ongoing

☒ Completed

☐ Inactive, developed in a prior year

☐ Concept only, not yet active

☐ Submission determined not to be a PIP

☐ No PIP submitted

The MHP identified potentially eligible Katie A. subclass members were not receiving screenings and subclass members were not receiving ICC services at a rate that met its goals within 30 days. Improving the screening process for all open Child Welfare cases, and annually thereafter, is relevant to the consumer population as the existing process was not meeting the needs of the consumers. The existing process was not allowing potential subclass members to be screened and offered services in a timely manner. Approximately half or less than half of the children with open CWS cases determined to be eligible for subclass services were being provided ICC services: 27% (96 out of 355 eligible) in the 10/17/2013 Progress report and 51% (44 out of 86 eligible) in the 4/29/14 Progress Report.

By changing the screening processes, the Mental Health clinicians are more available for ICC coordination and direct work with children, youth, and families. In addition, more Katie A. subclass members would be identified and provided services. Changing the screening processes will allow subclass members to start receiving services earlier, which will impact their overall mental health, could reduce the need to be placed in a group or reduce the amount of time a member is in a group home.

Through various interventions, the MHP introduced process changes which focused on its goal to provide timely screening and provision of ICC services to the Katie A. subclass population. It began with a series of staffing changes starting with a social worker initiating the screening tool with the final change resulting in a Mental Health Rehabilitation Specialist (MHRS) completing the screening. An additional process change was to create a new screening tool for the age group of 6-21 year old foster youth. The goal was to not only identify Katie A. subclass eligible members but to identity youth with mental health issues.

Data was collected every six months which included the number of children/youth eligible to receive subclass services, the number and percentage of screenings, and the number and percentage of children receiving ICC services.

The improvements are significant in the percentage of screenings completed (75%). The percentage of eligible subclass children receiving ICC services (85%). There are indications that the improvements are the result of the changes to the screening process and the interventions identified. By prioritizing staff duties and refining processes the MHP was able to make better use of mental health clinician time to the improvement of direct client services in spite of no new hires.

The MHP indicated its formal work on the PIP is concluded. Future improvement ideas are to track beneficiary satisfaction surveys, to learn if improved Mental Health clinician services are having a

positive effect on satisfaction scores. Additionally, increased Mental Health clinician contact may have an improved effect on Child Adolescent Needs and Strengths (CANS) assessment scores. Finally, with being able to maintain target staffing levels, the MHP may be able to reduce the time frame from screening to referral for ICC services to less than 30 days, as the overall goal of the Katie A. Wraparound program is to ensure all subclass eligible children who are not in-home placements have an identified ICC coordinator as soon as possible.

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

The technical assistance provided to the MHP by CalEQRO consisted of encouraging the PIP team to discuss future ideas with CalEQRO staff early into its PIP process to ensure meeting the spirit of a PIP and to address any deficiencies prior to implementing its work.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Improved accessibility to services which addresses a target population.
  - Restructuring of processes of care can lead to efficiencies which allow increased time for staff to deliver services.
  - Improved access to services supports the foundation to wellness and recovery.
- Timeliness of Services
  - Streamlining screening processes can lead to earlier identification of needs for the Katie A. subclass population.
- Quality of Care
  - Regular review of consumer progress can lead to improved self-sufficiency and consumer ownership of care.
  - Focusing on continuity of care through reducing needs regarding intensity and length of service demonstrates recovery principles.
- Consumer Outcomes
  - Provision of level of care outcomes can support consumer growth with concrete identification of increased progress in treatment.
  - Service delivery to an identified target group demonstrates potential improved outcomes of care.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

As shown in Table 4, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 4—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	A wide variety of stakeholder presence and involvement is evidenced at the monthly Cultural Competency Committee meetings held regionally. The MHP was awarded a $500,000 grant through SB82 to establish a Crisis Residential Unit. The MHP indicated it has expanded its QI goals to track language, ethnicity and timeliness for Latinos. Additionally, it reached out to local natural healers within the Nuestra Alianza group and various Native American leaders. The MHP has provided and annually expanded multiple points of access and increased outreach into the community.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The inclusion of consumers locally is encouraged and feedback is solicited at these meetings. The MHP has developed strong collaborative ties with its CWS partners to address the needs of its Katie A. subclass members. The MHP creatively builds its delivery via acquisition of vacated community buildings, often of historical significance, to refurbish and establish regional MH service campuses. The TAY population is served as a subsystem of the RQMC with a focus on empowerment of youth through employability, education and transitional housing as needed.
1C	Integration and/or collaboration with community based services to improve access	FC	Comprehensive use of community and agency partners has enhanced the MHP's service delivery throughout a vast geographic area. The MHP collaborates closely with multiple community agencies, schools, police and justice system.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 5, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	FC	The MHP has an overall standard of 14 days and reports an average of 10 days meeting the standard at 100% of the time. For adult services it reports an average of 11 days and children's services of 10 days and meets the standard at 100% for both Children's and Adult systems of care.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	The MHP has an overall standard of 30 days and reports an average of 12 days meeting this at 100% of the time. For adult services it reports an average of 11 days and children's services of 12 days and meet both at 100% of the time. The MHP intends to expand medications support via telepsychiatry and service extenders at the Federally Qualified Health Centers (FQHCs).
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	The MHP has a standard of one hour during regular business hours and a standard of two hours for after hours. It reports an overall average of 26 minutes and meets the one hour standard at 95% and the two hour standard at 98% of the time. For adult services it reports an average of 34 minutes and meets the one hour at 90% and the two hour at 97%. For children's services it reports an average of 18 minutes and meets both the regular and after hour standards at 98% of the time.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP has a standard of 7 days and reports an average of 2 days meeting the standard for 94% of the discharges. For adult services it reports meeting this the same day at 100% and for children's services an average of 3 days meeting this at 87% of the time.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2E	Tracks and trends data on rehospitalizations	FC	The MHP has a standard of no more than 10% readmission rate and reports an overall average of 13%. For adult services it reports a 15% rate and for children's services it reports a 10% readmission rate. The MHP was advised to consider setting its expectation even higher with goals of zero readmission.
2F	Tracks and trends No Shows	FC	The MHP has a standard of 10% for clinicians and a 15% standard for psychiatrists and reports an overall average of 6% for both categories. Average No Shows is well under the goal at 6% for all services.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 6, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	Improvements within the structural operation of the QIC continue with enhanced and consistent stakeholder and consumer involvement. The QIC meeting is conducted on a rotating basis throughout various geographic community locations, providing stakeholders with opportunities to easily participate regionally. The MHP has a strong and comprehensive QI plan and timeline.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3B	Data are used to inform management and guide decisions	FC	It is apparent that data is used widely for a variety of decisions within this MHP and distributed to stakeholders. The primary area to address remains the decision to implement and collaborate with its ASO providers to determine an EHR system with interoperability to confidently collect its data. Mendocino County Mental Health has been working in partnership with Ortner Management Group, Redwood Quality Management Group, NetSmart, Xpio, and Redwood Mednet to get all Mental Health Plan Providers online with an electronic health records system. The Adult System of Care has been prioritized in the implementation phase.
3C	Evidence of effective communication from MHP administration	PC	Feedback from stakeholders verifies interchange and collaboration among various media methodologies. The MHP utilizes its natural community venues such as the Farmers Market, story board presentations, PSAs, radio and newspapers. It creatively advertises with wrist bands which were inspired by local high school youth establishing ones stating: Speak against Silence (suicide prevention) and the Power of Recovery. Also a pen inscribed with Speak against Silence and the county access number is available. Evidence of a remaining challenge lies with the ASO providers which could benefit from a deadline for an EHR decision in order to move forward.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Overall, staff and consumer stakeholders stated there was two way communication and that the MHP valued their input. However, without a conclusive EHR decision, ASO providers remain unable to impact quality data driven systems, leaving a perception of perhaps unintentional limited involvement.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP has strong interaction with multiple agencies including schools, police, and the justice system.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP has been using the CANS and ANSA since July 1, 2013. The CANS has also been used since the inception of Katie A in Mendocino County. The PIP focused on ways to enhance outcome measurement tools. CANS and ANSA outcome tools are an integral component of the assessment process and continue throughout the treatment process.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	Both consumer and staff surveys are newly created and will be distributed in October 2015 to survey its new ASO provider system of care. The MHP distributes the bi-annual required statewide consumer perception survey for results. The MHP presented evidence of using consumer feedback for change in the use of data, making it available geographically and user-friendly informative.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	Consumers and family members are employed at all levels throughout the system. Some of these positions include: Executive Director, managers, supervisors, care managers, parent partners, and peer specialist. An informal system of acquiring a progression of job skills and responsibilities is present, however a formal classification system is absent.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP continues with its consumer run Manzanita site and the Mendocino Coast Hospitality Center, has developed the peer run Arbor on Main for TAY youth, with its CITY one stop campus approach and provides employment readiness skills.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP is looking at expanding its service array with the possibility of a crisis residential unit.
  - The MHP initiated a PIP to focus on improving the screening process and subsequent timely provision of service to its Katie A. subclass population.
  - Three service sites have recently received Drug Medi-cal certification, thereby expanding access to this priority service. Three sites were certified, two county and one provider.
  - There have been significant, steady, positive changes within the last year impacting consumers' ability to receive services. The MHP system of care has provided extensive outreach and multiple points of access.
  - Two grants have been received which provided funding for Mobile Outreach.
  - ICMS and Redwood Community Crisis Center have improved crisis management. In addition, crisis assessments are conducted in the field, at the ER, and at the access centers.

-
- The number of consumers going through the Behavioral Health court has increased due to the addition of the behavioral health court on the coast.

- Timeliness of Services
  - The MHP boasts impressive metrics for its timeliness indicators.
  - Timeliness, although corroborated by stakeholders may be impacted secondary to its ASO adult providers utilizing manual spreadsheet methodologies for tracking.
  - The MHP intends to provide increased timely access to medications support with its telepsychiatry expansion.
  - Consumers initially access services within two weeks. Appointments are made within two days. More urgent appointments are given before two weeks. Crisis teams respond within the hour during the day and within two hours after clinic hours.
  - The MHP has provisions for immediate access for children if needed. With Katie A. collaboration and receipt of screening forms, any child exposed to trauma are connected immediately to a Public Health nurse.
- Quality of Care
  - The MHP utilizes multiple community partners to provide its service delivery to a broad geographic base.
  - The MHP has established routine QIC meetings with rotating geographic meeting sites to accommodate its complex and vastly different consumer needs.
  - Data distribution is provided and discussed consistently with each geographic service area.
  - Integration among its stakeholders, organizational providers and community groups resulted in the MHP establishing a full multi use campus, with a wellness center, supportive housing, gardens, and environmental learning at its newly established Mendocino Coast Hospitality Center site in Fort Bragg.
  - Hospital discharge clients receive immediate attention. Exit interviews are scheduled routinely, dependent on consumer need. Medication, clothes, food and return appointments are given. This support is considered another component of the continuum of care model.
- Consumer Outcomes
  - The MHP has demonstrated active and timely use of outcome tools to support consumer progress in treatment.

- Through intentional planning, the MHP continues to develop a broad spectrum of services throughout its regions thereby providing local service areas for consumers in this geographically challenged MHP.
- Collaboration with the local community college resulted in internships throughout the Health and Human Services Agency.

CONSUMER AND FAMILY MEMBER FOCUS GROUP

CalEQRO conducted one 90-minute focus group with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group which included the following participant demographics or criteria:

- A culturally diverse group of adult beneficiaries including both high and low utilizers of MHP services which have initiated services within the prior 12 month period.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This group consisted of nine adult consumers of mental health services and was conducted at the MHP Administrative Offices at 1120 S. Dora St in Ukiah. Group participants reported receiving services over the course of several years with two members initiating services within the past year. Access to service was readily obtained. Overall, the majority of group participants received medications support, case management, or therapy. Some members reported improved symptoms once services were in place. Group participants indicated staff were encouraging, sensitive and knowledgeable and gave them hope for recovery. Overall, they were knowledgeable of what to do in a crisis, often stating individual provider staff were available. Group members indicated supportive services included housing, transportation to appointments, and referrals to physical health.

Group participants were aware of the wellness and recovery centers as well as pro-social activities through the college learning centers. Activities comprised of both consumer run and staff run presentations. Socialization, recovery, and recreational groups were encouraged as a component of healthy recovery. The majority of the group reported a sense of improved health and had benefitted from the services.

The community networking system provides information about the MHP activities from staff, newspapers, verbal exchanges, and the various wellness center sites.

Volunteer opportunities were known by group members and many had known other consumers who participated.

Recommendations arising from this group include:

- Increase outreach to youth over eighteen years old to increase awareness regarding services.
- Consider additional transportation vehicles for case managers in order to link to services.

Table 7A displays demographic information for the participants in group 1:

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	7 2
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 5 3 1
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	9
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	5 1 1 1 1
Gender	Male Female Transgender Other Decline to state	3 6

**Number of sub-categories may not add up to total number of participants due to the fact that some participants may not have completed a Demographic Information Form.*

Interpreter used for focus group 1: ☒ No ☐ Yes

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 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	7.32%
Contract providers	92.67%
Network providers	.0008%
Total	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☒ Monthly ☐ More than 1x month ☐ Weekly ☐ More than 1x weekly

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

9.98%

- MHP self-reported average monthly percent of missed appointments:

6%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- The MHP's billing lag time is averaging 60 days from date of service to date claimed. The MHP is attempting to shorten that lag to 45 days,
- The MHP's percent of co-occurring diagnoses (9.98%) has decreased by 6.55% from last year (16.53%), yet the MHP reports there is a high incidence of co-occurring diagnoses in teen and youth populations. The MHP will be researching their methodology and verifying the data.

CURRENT OPERATIONS

- The MHP continues to use NetSmart/Avatar technology and Exym.
- The MHP reports that 92.67% of services are provided by contracted providers, 79.75% of services are claimed to Short Doyle/Medi-Cal (SD/MC).
- Seventy to eighty clinicians are online.
- The MHP submits monthly CSI reports. Substance Abuse Treatment submits monthly Cal OMS reports.
- The MHP trains new and existing employees on an as needed basis. Two internal IS staff train, maintain dictionaries and provide technical assistance. There is a paper EHR manual.
- Routine reporting consists of service delivery reports, demographic reports and Katie A. reports. The MHP is developing dashboard reports.

MAJOR CHANGES SINCE LAST YEAR

- The MHP's Avatar system was upgraded with an ICD 10 patch. Testing occurred successfully in July 2015.
- In 2015 MHP received state licensing and Medi-Cal billing code for 16 bed facility in Willits. The MHP did not have licensed beds in Mendocino County prior to 2014.
- MCMHP contracted with Dimension in July 2015 to create a report off of the County's 837's and 835's to assist with aid codes. The MHP has noted significant improvement in their billing reporting going retro to 2008-2009.

- A consultant from XPIO was hired to lead a multi-faceted analysis of IS area needs including HIPAA, Meaningful Use, and state DHCS SD/MC claiming requirements.

PRIORITIES FOR THE COMING YEAR

- The MHP has had significant inoperability challenges and has not made much progress in implementing the Practice Management/Electronic Health Record System (PM/EHR) within the Ortner Management Group (OMG) adult ASO. The MHP states that both clinical staff access and billing will be implemented by January 2016.
- Assessments, progress notes and treatment plans are not fully integrated into the system; only portions are currently available.
- Training for the Scheduler will begin at the end of October 2015 and the MHP is working towards implementation by January 2016.
- MCMHP has identified a provider for telepsychiatry, primarily for adults. There is a collaborative agreement and services have been contracted with OMG. The MHP is working on technical security issues. Telepsychiatry is projected to be implemented by December 2015.
- The MHP states there are challenges with aid codes and repopulating the data; they are attempting to have the data fully automated for October 2015 billing.
- The MHP is continuing to download universal forms into the Avatar system (i.e., BPSA and Client Plans).
- The MHP is meeting with Redwood Mednet on a funded project for Health Information Exchange (HIE).
- The MHP is collaborating with XPIO to have a work plan and risk analysis by January 2016. They are hoping to do a security analysis by August 2016. The MHP has begun to update policies and procedures in preparation.

OTHER SIGNIFICANT ISSUES

- In the future, when the MHP's system is operational, the MHP's EHR will not be longitudinal, but all records will be accessible.
- The MHP stopped billing Medicare in 2006. They have not enrolled their providers and estimate that 25% of their consumers have Medi-Medi coverage. There is no internal staff dedicated to the certification process.

Table 9 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 9—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
MyAvatar	Cal Practice Management	NetSmart, Exym	12	
MyAvatar	Client Work Station	NetSmart, Exym	7	

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans to replace Avatar.

ELECTRONIC HEALTH RECORD STATUS

Table 10 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 10—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Netsmart/Avatar		X		
Clinical decision support	Netsmart/Avatar		X		
Document imaging			X		
Electronic signature—consumer			X		
Electronic signature—provider			X		
Laboratory results (eLab)					
Outcomes			X		
Prescriptions (eRx)			X		
Progress notes	Netsmart/Avatar		x		
Treatment plans	Netsmart/Avatar		x		
Summary Totals for EHR Functionality			3	7	

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

- The MHP is in contract with XPIO, Redwood Net and NetSmart to analyze and make recommendations on operability in the Avatar system and how best to integrate the ASO's information into the Avatar system.
- Assessments, progress notes and treatment plans are not fully integrated into the system; only portions are currently available. The MHP states that all three functions will be fully integrated by March 2016. The Children and Youth System of Care has all the listed categories within their EHR.
- Training for Scheduler will begin the end of October and the MHP is working towards implementation in January 2016.
- Ultimately in the future when the system is operational the MHP's EHR will not be longitudinal, but all records will be accessible.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP has identified a provider for telepsychiatry, primarily for adults projected to be implemented by December 2015. The MHP is working on the technical security issues.
  - In 2014MHP received state licensing and Medi-Cal billing code for 16 bed facility in Willits. The MHP did not have licensed beds in Mendocino County prior to this year.
  - The Quality Improvement Committee meets monthly to closely examine statistical data on timeliness.
- Quality of Care
  - The MHP developed a PIP on the CANS Assessment Improvement Tool. See Clinical PIP for details.
- Consumer Outcomes
  - The county does a beneficiary satisfaction survey at least annually. The MHP also has several other surveys that are conducted throughout the year.
  - Two surveys have been created – one for staff and one for consumers regarding satisfaction with the new system of care via ASO providers. These are scheduled for distribution in early October 2015.

SITE REVIEW PROCESS BARRIERS

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

- There were no barriers to conducting this review.

CONCLUSIONS

During the FY15-16 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
  - The MHP has developed multiple initiatives in a relatively short duration addressing a full spectrum of services for its varied populations.
  - The MHP's recently concluded non-clinical PIP resulted in significant increase in timely screenings of Katie A. beneficiaries and sub-class members receiving ICC services.
  - The MHP appears to address community wide concerns when it delivers its new services with stakeholder meetings held geographically.
  - The MHP announced multiple sites recently received Drug Medi-Cal certification.
- Opportunities:
  - With plans to enhance SUD services, it would benefit the MHP to capture confident data collection of its co-occurring disorder population.

Timeliness of Services

- Strengths:
  - The MHP indicated significant progress in meeting its timeliness indicators well within its standards.
- Opportunities:
  - In spite of the standards being met, adult providers continue to submit data manually to the MHP.
  - The MHP indicated its co-occurring disorder data for FY15-16 was 9.98%, down from FY1415 at 16.53%.

Quality of Care

- Strengths:
  - The QI leadership has laid a solid foundation to monitor and analysis its goals and future endeavors.
  - A true spirit of embracing recovery and consumer wellness appears to be prevalent among a wide variety of stakeholders.
  - The MHP appears to have demonstrated a smooth transition to utilizing ASO providers to deliver over 90% of its services.
- Opportunities:
  - The MHP has significant inoperability challenges with limited progress in implementing the Practice Management/Electronic Health Record System (PM/EHR) within the Ortner Medical Group (OMG) adult ASO.
  - There is no written IS strategic plan and no committee dedicated to IS issues.
  - The MHP has nominal use of its EHR capability with limited portions of the assessments, progress notes and treatment plans integrated into the system.
  - The MHP has yet to enroll its organizational providers and site into Medicare through Noridian, the Medicare plan administrator. The MHP estimates that 25% of their consumers have Medi-Medi coverage. There is no internal staff dedicated to the certification process, therefore, outsourcing may be a feasible option.

Consumer Outcomes

- Strengths:

  The MHP appears to consistently embrace recovery values and extends consumer participation in its initiatives.
  - The MHP's clinical PIP using the CANS tool was beneficial in addressing both individual and aggregate data by providing quantitative and qualitative insight in consumer outcomes.
- Opportunities:
  - The MHP can continue to examine their aggregate data with the CANS tool and ANSA tools to modify and enhance treatment options and consumer progress.
  - A formal career ladder to enhance consumer employability is lacking within the MHP

RECOMMENDATIONS

- Initiate a committee and create a written Information Systems (IS) strategic plan with organizational provider involvement adhering to dedicated implementation timelines for immediate action.
- Prioritize resolution of inoperability issues in implementing the Practice Management (PM)/EHR system within the Ortner Management Group (OMG) adult Administrative Services Organization (ASO) to enhance functionality of the IS system and full integration of EHR.
- Examine protocols and establish a formal system of progressive job skills and responsibilities for consumer employees.
- Evaluate the methodology for collection of co-occurring disorder data and standardize data collection.
- Continue to track timeliness indicators for adherence to the established standards, emphasizing the impact of the anticipated telepsychiatry appointments.
- Enroll organizational providers into Medicare through Noridian, the Medicare plan administrator. Consider outsourcing this as a feasible option.

ATTACHMENTS

Attachment A: Review Agenda

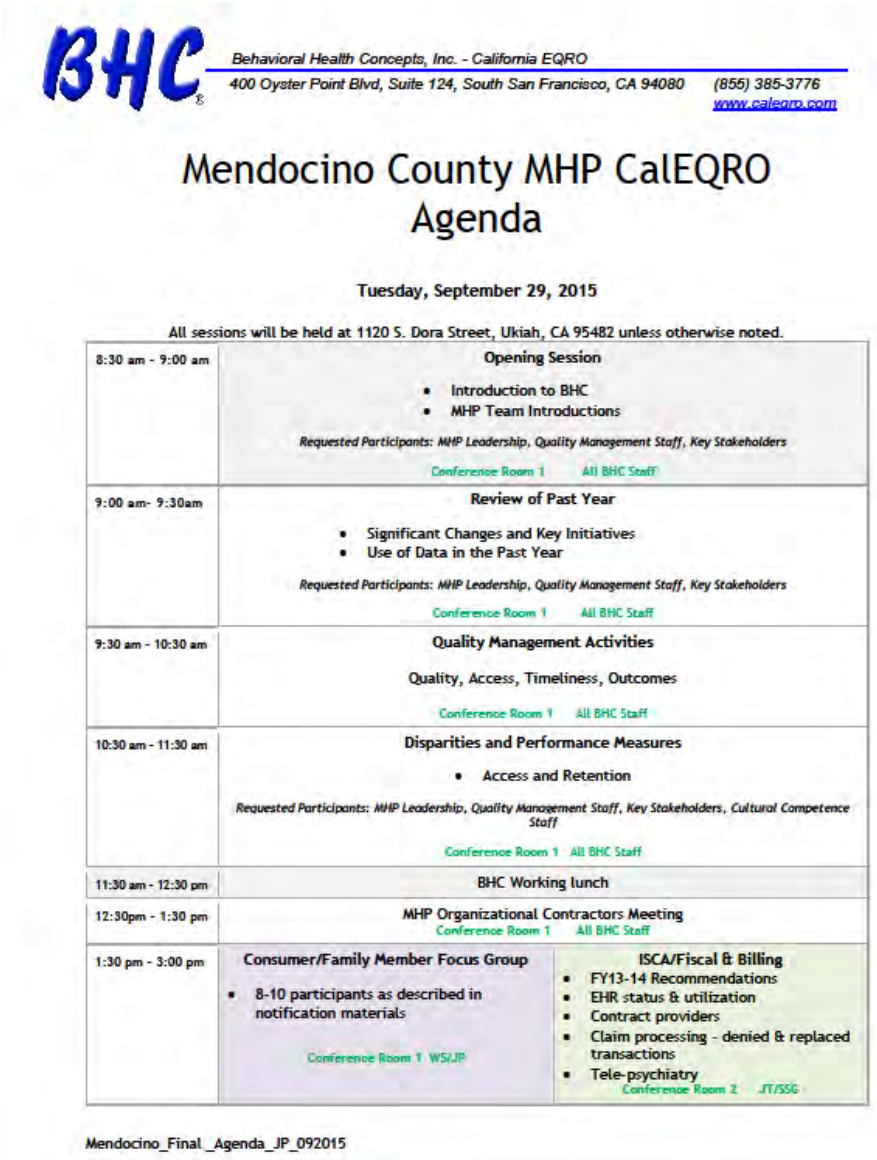
Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:



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Mendocino County MHP CalEQRO Agenda

Tuesday, September 29, 2015

All sessions will be held at 1120 S. Dora Street, Ukiah, CA 95482 unless otherwise noted.

8:30 am - 9:00 am	**Opening Session** • Introduction to BHC • MHP Team Introductions *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Conference Room 1 All BHC Staff	
9:00 am- 9:30am	**Review of Past Year** • Significant Changes and Key Initiatives • Use of Data in the Past Year *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders* Conference Room 1 All BHC Staff	
9:30 am - 10:30 am	**Quality Management Activities** Quality, Access, Timeliness, Outcomes Conference Room 1 All BHC Staff	
10:30 am - 11:30 am	**Disparities and Performance Measures** • Access and Retention *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff* Conference Room 1 All BHC Staff	
11:30 am - 12:30 pm	**BHC Working lunch**	
12:30pm - 1:30 pm	**MHP Organizational Contractors Meeting** Conference Room 1 All BHC Staff	
1:30 pm - 3:00 pm	**Consumer/Family Member Focus Group** • 8-10 participants as described in notification materials Conference Room 1 WS/JP	**ISCA/Fiscal & Billing** • FY13-14 Recommendations • EHR status & utilization • Contract providers • Claim processing - denied & replaced transactions • Tele-psychiatry Conference Room 2 JT/SSG

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ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, Quality Reviewer Consultant
Saumitra SenGupta, Executive Director
Judith Toomasson, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP SITES

Mendocino County Behavioral Health
1120 S. Dora St.
Ukiah, CA

Participants Representing the MHP

Name	Position	Agency
Connie Drago	Compliance Officer	Ortner Management Group
Camille Schraeder	Chief Systems Officer	Redwood Quality Management Company
Lois LaDelle-Daly	QA/Compliance	Redwood Quality Management Company
Barbie Svendsen	MH/QA, Program Administrator HHSA	
Tom Pinizzotto	Assistant Director HHSA	
Larry Ainbinder	Compliance Manager	
Todd A. Harris	Clinical Director	Ortner Management Group
Jena Conner	CWS Deputy Director	
John Riley, MD.	Chief Medical Officer	Ortner Management Group
Todd Storti	Fiscal Manager	
Chandra Gonsales	Crisis Program Manager	Redwood Community Services

Name	Position	Agency
Tim Schraeder	CEO	Redwood Quality Management Company
Karen Lovato	Program Manager	
Venus Hoaglen	Staff Service Administrator	
Mark Montgomery	Vice President, Operations	Ortner Management Group
Dan Anderson	Chief Operations Officer	Redwood Quality Management Company.
Jenine Miller	Deputy Director	
Carol Vokoun	Department Application Specialist	
Andrea Turchin	Department Analyst II	
Danielle Lower	Special Projects Manager	Redwood Quality Management Company
Will Ross	Project Manager	Redwood MedNet
Tina Simms	Clinician	Redwood Community Services
Hallie Davrill	Therapist	Tapestry Family Services
Linda Wootton	MH Rehabilitation Specialist	ICMS
C. Joy Kinion	MOPS	
Patricia Messner	Clinician	
Debra Rogers	Case Manager III	Manzanita Center
Victoria Schmidt	Therapist	Mendocino County Youth Project.
Sue Stever	Case Manager III	Hospitality Center

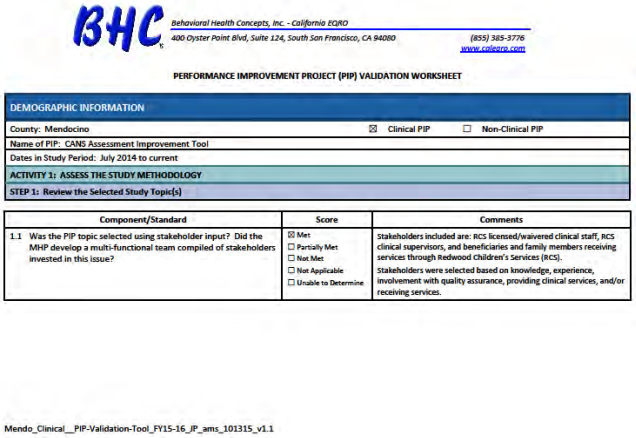
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:



Behavioral Health Concepts, Inc. - California EQRO
400 Oyster Point Blvd, Suite 124, South San Francisco, CA 94080 (855) 385-3776
www.caleqro.com

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Mendocino	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: CANS Assessment Improvement Tool		
Dates in Study Period: July 2014 to current		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Stakeholders included are: RCS licensed/waivered clinical staff, RCS clinical supervisors, and beneficiaries and family members receiving services through Redwood Children's Services (RCS). Stakeholders were selected based on knowledge, experience, involvement with quality assurance, providing clinical services, and/or receiving services.

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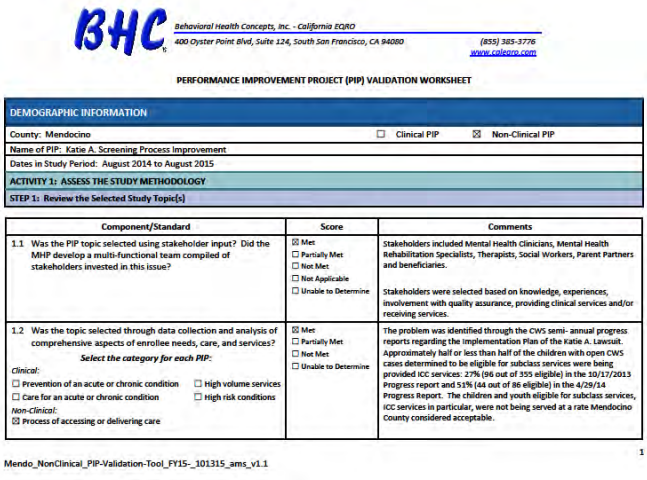
Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Mendocino	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Katie A. Screening Process Improvement		
Dates in Study Period: August 2014 to August 2015		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Stakeholders included Mental Health Clinicians, Mental Health Rehabilitation Specialists, Therapists, Social Workers, Parent Partners and beneficiaries. Stakeholders were selected based on knowledge, experiences, involvement with quality assurance, providing clinical services and/or receiving services.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The problem was identified through the CWS semi- annual progress reports regarding the implementation Plan of the Katie A. Lawsuit. Approximately half or less than half of the children with open CWS cases determined to be eligible for subclass services were being provided ICC services: 27% (96 out of 355 eligible) in the 10/17/2013 Progress report and 51% (44 out of 86 eligible) in the 4/29/14 Progress Report. The children and youth eligible for subclass services, ICC services in particular, were not being served at a rate Mendocino County considered acceptable.

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