FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

County MHP Final Report

San Diego

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 CY13—34,248
  - MHP Size—Large
  - MHP Region—Southern
  - MHP Threshold Languages—Spanish, Arabic, Vietnamese, Tagalog
  - MHP Location—San Diego

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the San Diego County 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.
- 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; San Diego MHP submitted two PIPs for validation through the EQRO review. The PIPs 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:

- 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.

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[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.

- 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, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 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 FY13-14

- Recommendation #1: Standardize timeliness goals across age demographics and regions. Continue to refine data collection methodologies to insure data accuracy as well as collection of data elements that capture differential access by racial/ethnic/linguistic groups.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - Since the last review, an extensive improvement project was completed to revise data collection tools to standardize and to allow tracking of access times for urgent and routine appointments, as well as by racial/ethnic/linguistic groups. All providers were trained to utilize the standardized tool and a Handbook/User Guide was created as a resource as well. The new tool was implemented effective October, 2014.MHP polled its providers regarding how client information is recorded in

service logs, and the results differed from provider to provider. A new tool was developed and implemented Fall 2014.

- The MHP added race/ethnicity and language characteristics to their monthly access time log in the fall of 2014. Providers are using the MHP's timeliness tracking concepts in the form of supplying raw data and entering into MHP designed reporting instruments, which then performs the appropriate calculations. . The revised timeliness process is applied to Children, Youth and Families, Adult and Older Adults, improving accuracy across all served populations.

- Recommendation #2: Enhance access to consumer run clubhouses and parent partner/peer support specialists to populations in all the relevant threshold languages.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- Since the last review, the MHP completed a Workforce Survey to review data related to number of partner/peer staff and languages spoken by these staff within their Systems of Care. The MHP plans to use this information to assist in determining gaps to be addressed in an operational plan.
- Currently, the MHP has placed language appropriate resources in each of the areas where specific populations reside. In the Central Region, the consumer run Clubhouses have resources in English, Spanish, Ethiopian, French, German, Tagalog, and American Sign Language. In the North Central Region, resource languages include English, Spanish, French, ASL, Cambodian, Vietnamese, and Hmong; South Region includes English, Spanish and Tagalog; North Coastal Region includes English and Spanish; and North Inland Region includes English, Spanish and Mandarin.
- Regarding transportation, discounted bus passes are available.

- Recommendation #3: Provide for consistent processes, messaging and training of Contracting Officer's Technical Representatives (COR) to enhance this valuable liaison role between the MHP and its contractors.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP developed a work group for monitoring and making processes consistent across system. All CORS were mandated to complete economy and efficiency training and attend monthly meetings. The MHP developed and implemented policies for monitoring medical records, fiscal claims, and accounting.
- The MHP showed evidence of additional training of COR staff in the past year, but providers indicated that information provided by different CORs is not always consistent even within a single agency.
- Providers also indicated that CORs were not always prepared to provide guidance and answer questions about changes to policies and procedures (for example: the implementation of "Article 14" security rules.) Providers are required to complete

monthly/quarterly outcome reports to meet objectives. If programs do not meet minimum objectives, they are put on a plan of correction.

- Recommendation #4: Assign sufficient subject matter experts to complete the Cerner Remote Hosting solution as planned.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has utilized IT representatives from Cerner, Hewlett-Packard, Optum Health, and County IT staff to develop and implement Remote Hosting. The team is currently meeting weekly to oversee the process.
- The MHP is in phase I of testing the pilot system and is scheduled to fully go-live in May 2015.

- Recommendation #5: Investigate the feasibility of using interoperability functionality between Cerner system and contract providers with their IS systems and contracted hospitals to automate data exchange and eliminate double data entry and transaction reconciliation by providers. Similarly, automate hospital patient's admission and discharge data acquisition.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP has established a Technical Interoperability subcommittee and has been holding monthly meetings with contract providers to plan a data exchange process which would allow interoperability. They have identified needs, but at the present time there is no proposed solution or plan.
- Optum Health is currently entering hospital admission and discharge data in the Cerner system based on data collected from their daily concurrent review authorization process. Hospitals have direct access to Cerner, but are not using it for data entry. Outpatient providers continue to report delays in admitted individuals appearing on the daily hospital report, which results in lack of confidence in the accuracy of this management report.

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

- To assist with implementation of ACA, the MHP developed specific documents including a one page screening tool to assist with initial referrals and promote appropriate access, as well as severity analysis tools for both the Adult/Older Adult

system and the Children, Youth and Families (CYF) system to assist with clinical determination of mild to moderate vs. severe functioning to determine appropriate treatment options. This work also advanced the behavioral health and health care integration efforts.

- The MHP created a Joint Mental Health and Alcohol and Drug (AOD) Board. The MHP identified the need to align policy with service delivery to ensure parity and equity to address Welfare and Institution Code 5604 and insure that AOD perspective there. In past years, both the Alcohol and Drug Advisory Board (ADAB) and the Mental Health Board (MHB) advised the Director of Behavioral Health Services regarding prevention, treatment and recovery services. Beginning 2015, Behavioral Health Services integrated the boards for Mental Health services and Alcohol and Drug services into a single board with the desire to more effectively provide services to both communities. There are 5 family members and 5 consumers on the joint board which are prioritizing communities of color and beginning to address their struggle for representation.

- Timeliness of Services

- Welfare & Institution Code Section 5270 – The MHP hosted a series of strategic stakeholder meetings and focus groups studying the clinical, legal/ethical, operational and fiscal impacts of implementing W&I Code Sect. 5270 (Involuntary Psychiatric hold for up to 14 days, after a 72-hour 5150 involuntary hold). Input was actively sought from community hospitals, the local chapter of the California Hospital Association, the San Diego County Psychiatric Society, hospital and community-based psychiatrists and licensed mental health providers, professional peer groups, patient advocacy groups, legal/court professionals and members of the San Diego County National Alliance for Mental Illness (NAMI). After considering all input, W&I Code Sect. 5270 was adopted for implementation in May, 2014.
- Treatment Authorization Request (TAR) Policy – The MHP hosted a Tele Town Hall meeting on October 29, 2014 to address questions from local providers on the newly implemented DHCS Treatment Authorization Request (TAR) requirement for minors with Medi-Cal who are prescribed antipsychotic medication. An FAQ document was generated for local providers, and the MHP also issued memos to educate local prescribers and local pharmacies about this new regulation and the 72 hour emergency supply expectation to support the MHP's local providers and their clients.

- Quality of Care

- For the MHP's continued quality improvement of its Katie A. implementation processes, the MHP's training of Child Welfare Service, Children Youth Services County staff, and contracted staff has been intensified during FY 14-15. Eighteen one-day in-person trainings are taking place. These training sessions were taught in

a triad with representatives/trainers from Child Welfare Services, the Behavioral Health Services and the family/youth sector.

- Beginning in 2014, Crestwood Behavioral Health, Inc., contracted with the County to operate a new Mental Health Rehabilitation Center (IMD) in San Diego. The program has 40 beds and treatment services include evidence-based practices focusing on recovery, empowerment, hope and meaningful roles. The contract includes 40 beds with different levels of acuity. The MHP reduced beds at Alpine and contracted for the same amount of beds with Crestwood (75 beds at Alpine, 40 beds at Crestwood). This shift provided a gain not in total, but in diversity of type of beds available. (3 levels with different terms of stay, increased level of care). The MHP is assembling a task force to assess the effectiveness of the shift.

- Consumer Outcomes

- None noted based on the performance measures.

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
- 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

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, 2015.

TOTAL BENEFICIARIES SERVED

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

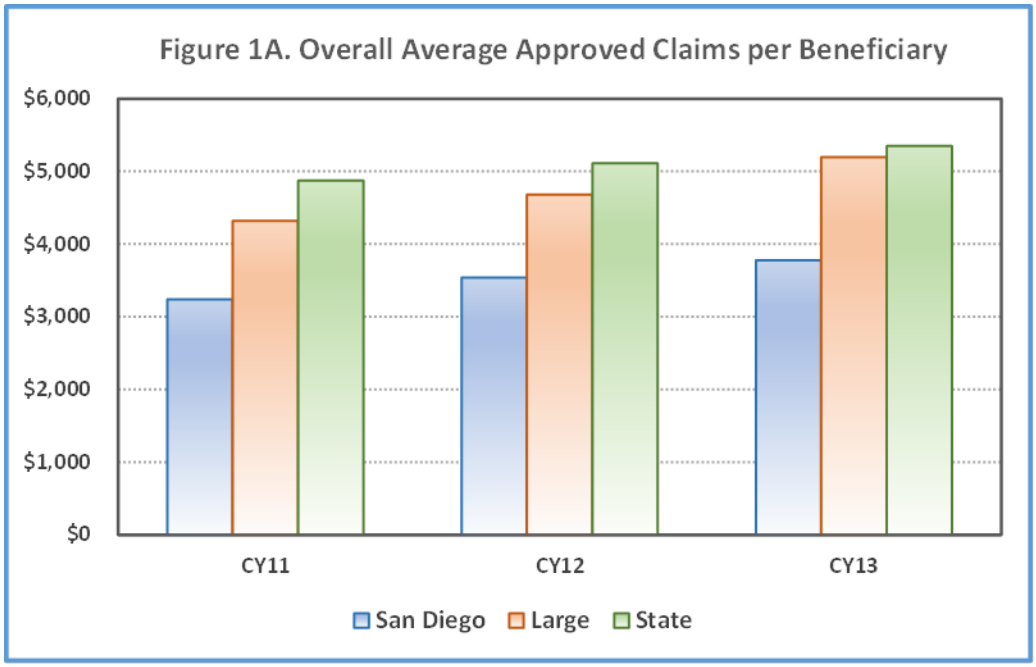
Table 1—San Diego MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

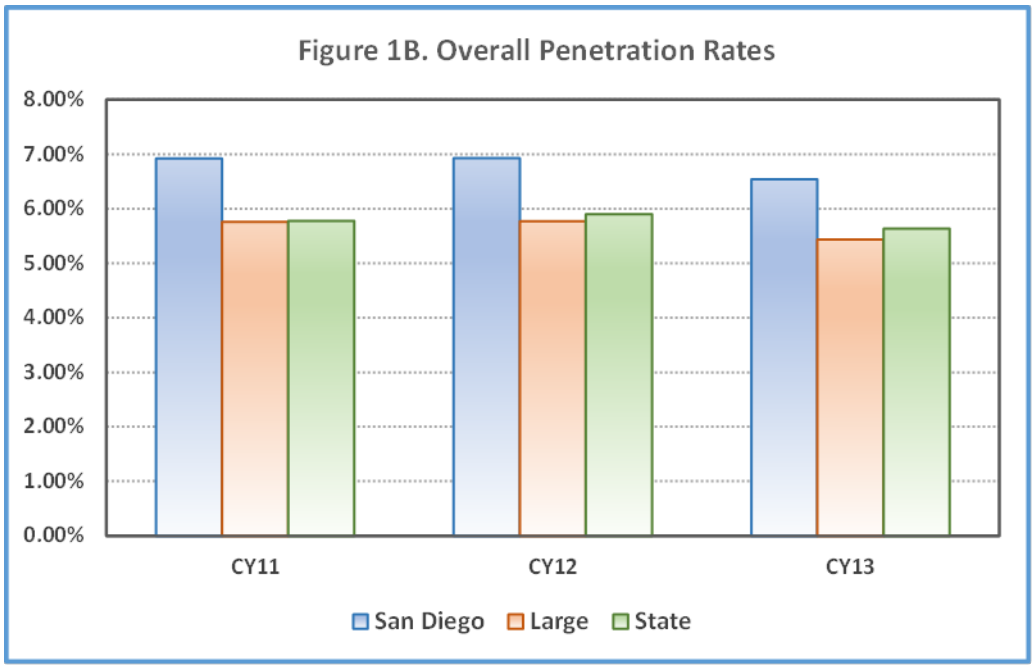
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	100,308	11,488
Hispanic	254,151	12,104
African-American	38,936	3,712
Asian/Pacific Islander	44,767	1,841
Native American	2,115	246
Other	8,303	4,857
Total	523,577	34,248

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

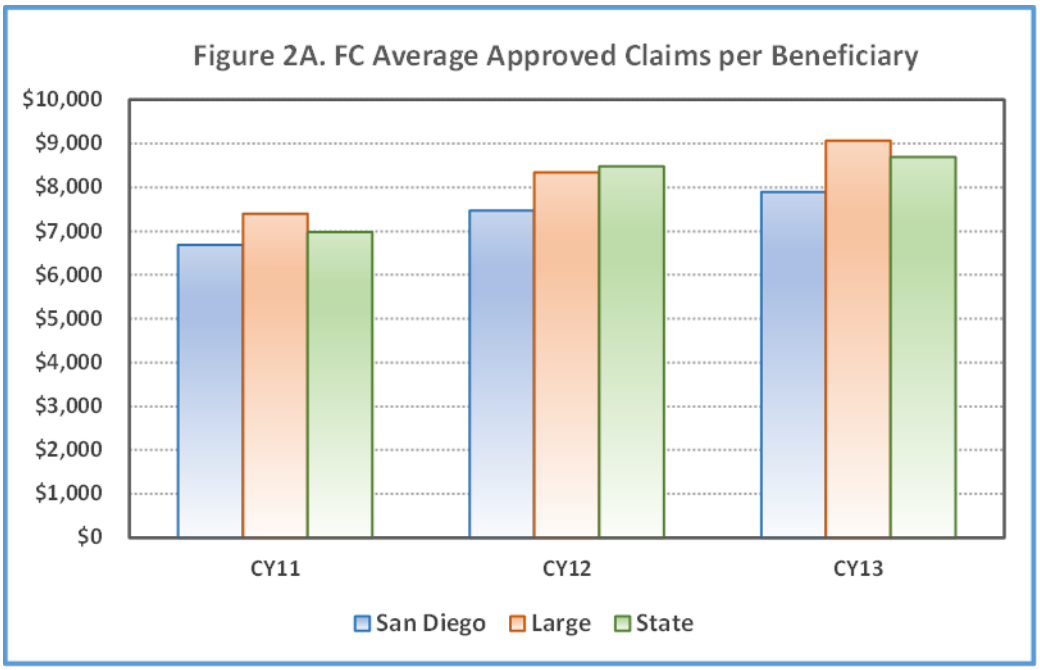
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

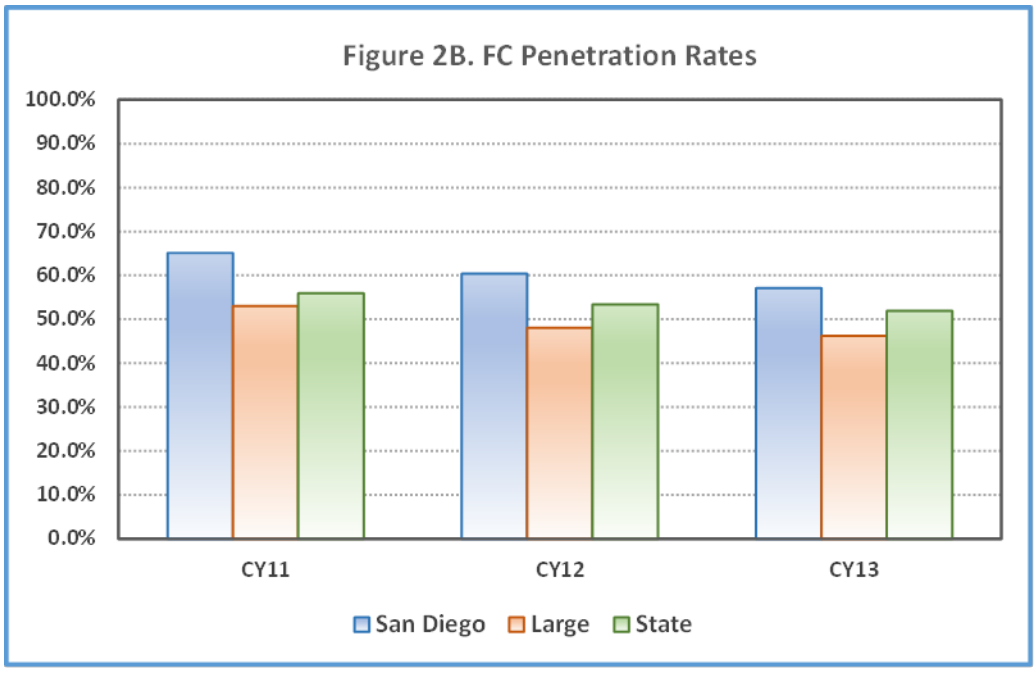
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



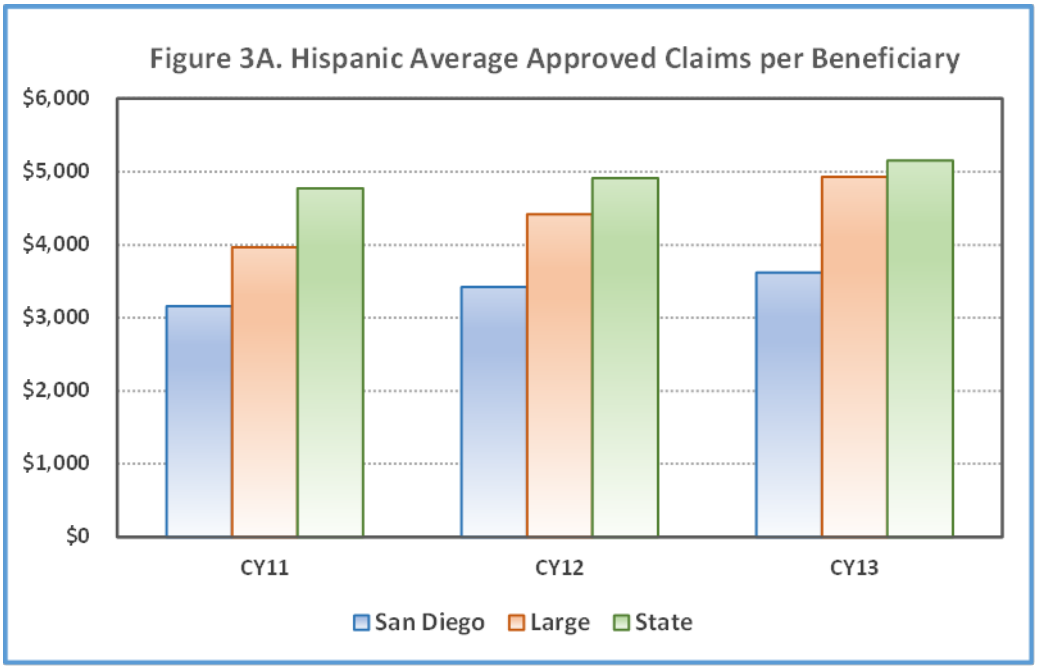


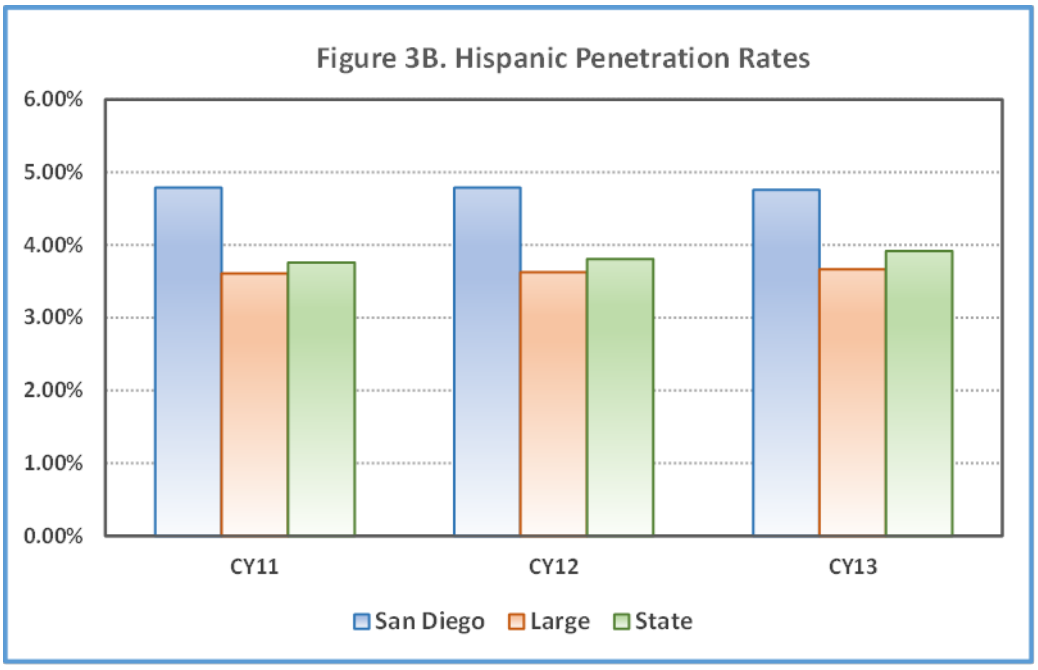
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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 large MHPs.





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, 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 Number	Total Beneficiaries	% of Total	Average per HCB	HCB Total Claims	% of Total Claims
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
San Diego	CY13	635	34,248	1.85%	$44,301	$28,131,393	21.75%
	CY12	534	31,842	1.68%	$45,015	$24,037,885	21.33%
	CY11	459	31,427	1.46%	$44,064	$20,225,398	19.73%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

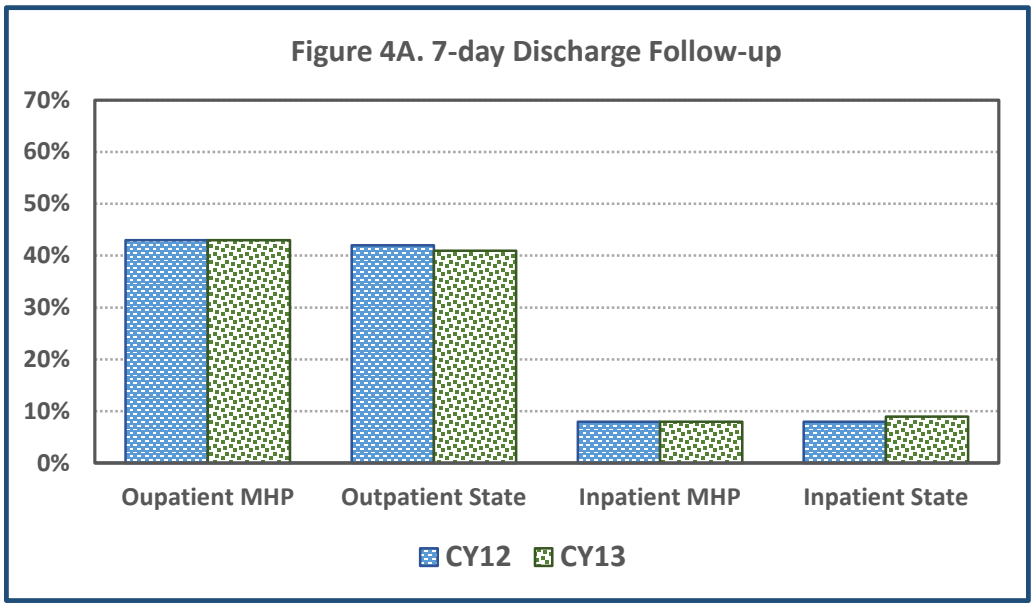
Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

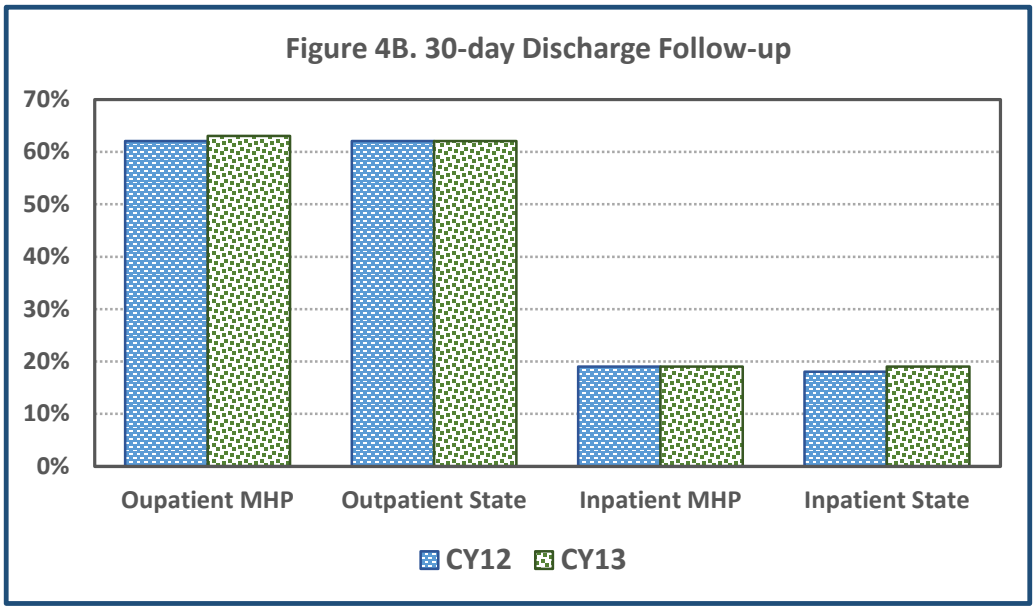
Table 3—TBS Client Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Client Count	TBS Client Count	TBS Penetration Rate
San Diego	Yes	15,384	780	5.07%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

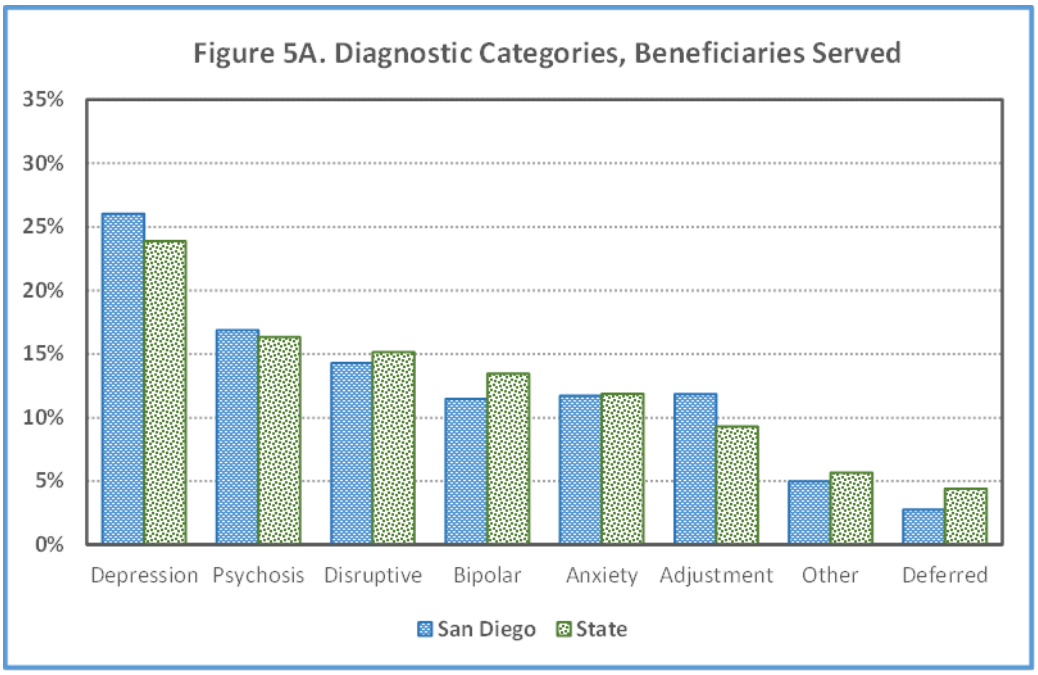
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

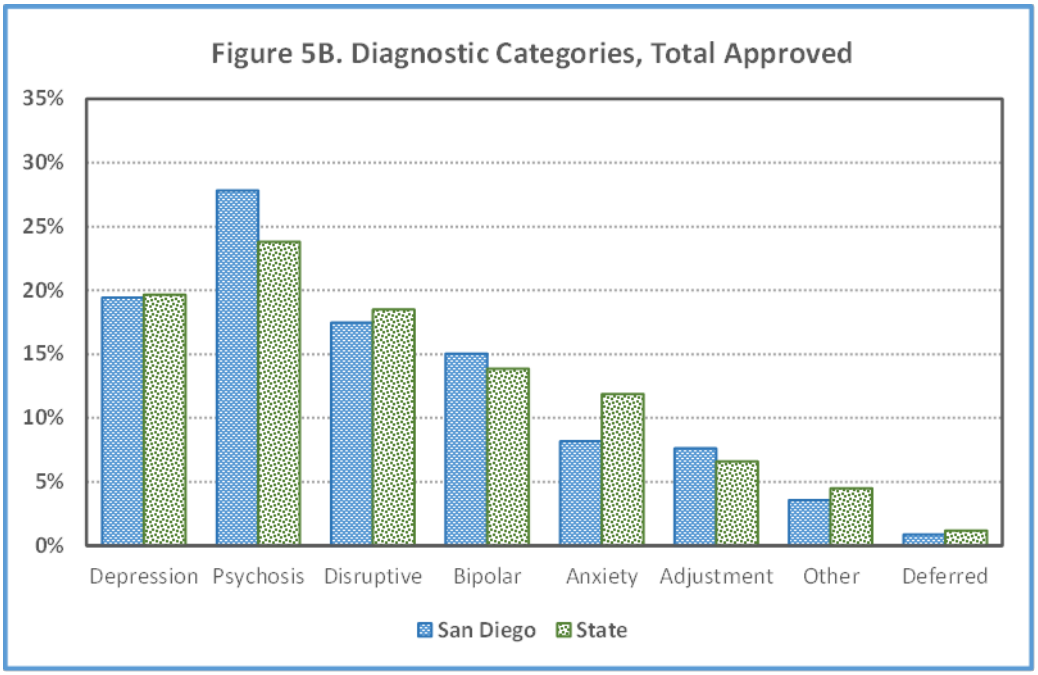




DIAGNOSTIC CATEGORIES

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 CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

o The MHP's overall penetration rate is higher than both the large county MHP average and the statewide penetration rate. However, the overall penetration rate is slightly lower than CY12 overall penetration rate.

o The MHP's foster care penetration rate is higher than the large MHP average and slightly higher than the statewide average.

o The MHP's Hispanic penetration rate is significantly higher than both the large county MHP average and the statewide average.

o The MHP's TBS Level II penetration rate is significantly higher than the statewide average TBS Level II penetration rate.

- Timeliness of Services

o The MHP's 7 and 30-day outpatient follow-up rates after psychiatric inpatient discharge are very similar to the statewide average.

o The MHP's 7 and 30-day inpatient recidivism rates are very similar to the statewide average.

- Quality of Care

o The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are both significantly lower than the statewide percentages.

o The MHP's overall and Hispanic average approved claims per beneficiary are significantly lower than the averages for both large MHP's and statewide averages. The foster care average approved claims per beneficiary are lower than large MHP's and statewide averages, but not significantly lower.

o The MHP's distribution of diagnostic categories is fairly similar to statewide distribution. The MHP has a slightly higher percentage of depression and adjustment diagnoses and slightly lower percentage of bipolar disorder and deferred diagnoses than statewide.

o The MHP has a very low total approved claims for deferred diagnosis in comparison statewide figures.

- Consumer Outcomes

o None noted.

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 2013.

SAN DIEGO MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	Prevention/Reduction of Suicides Occurring 0-90 Days After Last Services. Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	Impact of Peer and Family Support Specialists on Client Recovery Engagement and Advancement. Onsite technical assistance was provided to identify future PIP topics.

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

Table 4A—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	NA	NA
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NA	NA
		8.3	Threats to comparability, internal and external validity	NA	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	NA
		9.3	Improvement in performance linked to the PIP	NA	NA
		9.4	Statistical evidence of true improvement	NA	NA
		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 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	9	3
Number Partially Met	5	7
Number Not Met	2	6
Number Applicable	16	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	71.88%	40.63%

CLINICAL PIP—PREVENTION/REDUCTION OF SUICIDES OCCURRING 0-90 DAYS AFTER LAST SERVICES

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

- "How will SDCBHS prevent or reduce completed suicides that occur within 90 days after the last date of service?"
- Date PIP began: August 2014
- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☒ Concept only, not yet active

  ☐ No PIP submitted

The MHP's clinical PIP is focused on reducing the high percentage of San Diego County BHS client suicides that occur within 90 days of the last service received in the BHS Systems of Care. Specifically, there were 89 suicides in Fiscal Year 2013-14 for Behavioral Health clients (including both Mental Health and Alcohol and Drug Services), with 45% of the suicides occurring within 90 days of the last date of service. The goal of this Performance Improvement Project is to identify best practices that prevent or reduce suicides occurring within 90 days after a last date of service by enhancing efforts to provide effective identification of and follow-up with at-risk clients.

The MHP's clinical PIP should be revised. It is unclear what the MHP is trying to measure, i.e., prevent all suicides or prevent suicides within 90 days of treatment. Further, PIP focus on suicide prevention seems redundant as it should be an everyday practice to work to prevent suicides. It is unclear how the MHP will know that their interventions decreased suicides, i.e., if the suicide rate decreases? Further baseline data would be required regarding rate of suicides in the prior year. Additionally, is the rate of suicides outside the norm even for those who received a service within 90 days, when compared to other counties that size, the state average and even the national average?

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 recommendations that the MHP needs to explain/establish the case regarding why they are addressing it now and what has changed to target this issue. The PIP should be expanded to include more details on what they plan to measure and how, who will enter the data, who will pull the data, how often will the data be

pulled, what do they expect the data to show, and if it doesn't show that, what would the next steps be.

NON-CLINICAL PIP—IMPACT OF PEER AND FAMILY SUPPORT SPECIALISTS ON CLIENT RECOVERY ENGAGEMENT AND ADVANCEMENT

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

- "How will SDCBHS improve client recovery and client health management through:
  - Training and retention of Support Specialists;
  - Recruitment of clients in recovery into Support Specialist roles; and
  - Specific strategies to enhance understanding of the roles that Support Specialists play in the behavioral health system?"
- Date PIP began: 2014
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☒ Concept only, not yet active

☐ No PIP submitted

The MHP's non-clinical PIP was focused on Peer Support services. The PIP focused on what the MHP determined to be a "great need for Support Specialists in the behavioral health systems of care" and that evidence is needed to demonstrate tangible outcomes among clients, career support for successfully recovered clients to become PSSs; and advancement opportunities for PSSs and FSSs to grow into leadership roles and pursue clinical degrees. Based on literature, the MHP asserts that a plan on professional development for new and current support specialists will improve recovery, engagement, and the overall quality of care.

However, the MHP did not adequately articulate a problem for its consumers and why there was a great need for support specialists in their county. Further, the study question is not measurable and does not identify the focus of the PIP. A possible study question would be: Will an enhanced Support Specialists program at SDCBHS improve the rate of recovery for consumers by X% (or factor)? Then a), b), c) of the stated question become indicators of the progress of the study question.

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 recommendations on establishing that scope and impact of the lack of peer specialists on consumer outcomes and providing evidence that San Diego consumers are experiencing a negative impact, followed by the focus on interventions related to consumer outcomes.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's clinical PIP on reducing suicide rates among clients who received service within 90 days could potentially impact access to care if, during additional data gathering an access problem is identified as a potential contributor to the problem.
- Timeliness of Services
  - The MHP's clinical PIP on reducing suicide rates among clients who received service within 90 days could potentially impact timeliness, if during additional data gathering a timeliness problem is identified as a potential contributor to the problem.
- Quality of Care
  - The MHP's clinical PIP on reducing suicide rates among clients who received service within 90 days could potentially impact quality of care if, during additional data gathering a quality problem is identified as a potential contributor to the problem.
  - The MHP's non-clinical PIP related to utilizing peer specialist to improve quality of care could potentially impact quality of care if, during additional data gathering and analysis demonstrate that quality/outcome access problem is identified as a potential contributor to the problem.
- Consumer Outcomes
  - Not addressed.

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 5, 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 5—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP attends to the cultural and linguistic needs that present within its region of responsibility. In addition to the threshold languages of Spanish, Vietnamese, Tagalog and Arabic, the MHP seeks to meet Farsi linguistic needs through direct or contract agency programs and through the use of interpreters. The MHP's survey of consumers indicates that 75% received written information about services and/or received services in their preferred language. The MHP's cultural competence activities are aimed at ensuring staff have sufficient training and testing to reach diverse populations effectively. It may benefit the MHP if geographic analysis of the preferred language of eligibles would periodically occur from the MMEF download, providing greater granularity of information used in its planning efforts, in addition to the MHP's regular analysis of served consumers.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	It is clear that evaluation of providers and services is done regularly. The MHP would benefit from using its provider clinical directors to provide input on their sense of utility/face validity of the results of data runs and conclusions. Programs have a strong sense that the slots and pay for psychiatry is a problem, and the provider network psychiatrists are often rather providers of marginal quality services.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP utilizes contract agencies for 79% of service delivery, and has a partnership with Optum Health in which the Medi-Cal population is divided between the mild to moderate and severely ill. Both sides of this partnership has a no wrong door policy. The process for case assignment determination continues to evolve. Recently there was a renewed effort to provide greater inclusion of faith-based providers in the array of services.

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

Timeliness of Services

As shown in Table 6, 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 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	This tracking item is displayed as time to assessment but is really a time to screening, according to the program supervisors. These staff acknowledge continued use of the Access Log data collection process, however this is not time to an assessment. Programs believe the actual time to assessment is weeks to months. Despite improvements in tracking, providers feel that the data does not accurately reflect reality despite the development of a Service Log/Access Times Manual.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	A standard or goal has not been established and providers report wait times for psychiatry appointment greater than those reported. The MHP is collecting data on initial psychiatry visit timeliness and presented 3.5 days for adults and 8.6 for children and youth. However, there is not a clear standard presented and the MHP cannot present percentages of consumers meeting the standard; MHP plans on rolling out regular reporting on this item during this coming year. The MHP identifies processes for psychiatry access that have consumers triaged for level of need and making expedited appointments for those with high or urgent needs. This was confirmed by some consumers and by program supervisors.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP began collecting data in October 2014, but no data is available. The MHP has a three-day goal for urgent need response, and is planning to report out on this information for the fy14-15 end-of-year period. To date it has lacked a tracking mechanism for this data.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP utilizes a 3-day standard for post-hospitalization follow-up, which is met 46% in A/OA and 52% in CYF services. The MHP has also implemented a second post-hospital follow up program, NEXT Steps, to assist with timely follow-up.
2E	Tracks and trends data on rehospitalizations	FC	46% adults and 52% CYS, meet three day standard. The MHP has also implemented a second post-hospital follow up program, NEXT, which is in addition to the exiting program.
2F	Tracks and trends No Shows	NC	Although data is collected, the MHP does not distinguish between Psychiatrists and other clinicians. No standard or goal was provided. The MHP is able to report no-shows in general. Adults 7.5%; 3.6% for children/youth. There so far has not been a regular recurring reporting on this item. There are discussions of running this report measure on a regular basis.

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

Quality of Care

As shown in Table 7, 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 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	
3B	Data are used to inform management and guide decisions	FC	The MHP possesses an extensive capacity to perform data tracking and analysis, and posts an impressive array of reports and other documentation online for public access Examples include demographic analysis, penetration rates, and comprehensive analysis of services. The MHP has long partnered with UCSD for the analysis of systems data, and the development of data tracking strategies including outcomes. Contract organizational providers report that the MHP makes mid-year changes, based on data collected and reported, in resource allocations to programs. The MHP utilized some of this information to determine expansion of post-hospital follow-up (NEXT Steps) program to assure continuity of treatment and medications.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3C	Evidence of effective communication from MHP administration	PC	The MHP communicates with consumers and other stakeholders through emails, flyers at clubhouses, county facilities, and through posters. Staff reported that flyers are in the grocery stores, beauty shops and churches as well. Contract programs believe that efforts are made by the MHP and COR representatives to communicate in a strength-based approach but at times policy decisions have already been made. The "Up To The Minute" QI newsletter is viewed as a very effective and information mechanism. Providers would like to know about coming initiatives or changes early on, even before significant work has been done, so that they might help by formulating some programmatic recommendations. They also reported that it would be helpful to be updated on the status of issues that were identified in previous meetings.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	The MHP recently revamped its process of monitoring contract providers, simplifying the process and eliminating redundancy. Contract providers and MHP staff appreciated the collaborative efforts utilized by the leadership to obtain input on new initiatives or changing priorities. In some areas, such as the EHR changes, there is extensive collection of input from multiple venues that can only be implemented in a process dependent upon the system capability – and some of the changes may not be currently possible, such as reduction of redundancy in the treatment plan structure; and user-definable screen font size. Examples of stakeholder collaborations include: The W&I 5270 30-day involuntary hold process; and the Laura's Law AOT project. Contract providers stated that it would be helpful if their input was solicited in advance of setting provider meeting agendas.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP's array of services incorporate partnerships for 79% of services. Collaborations exists for all levels of care, including clinic services and specialty programs such as FSPs.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP utilizes a variety of outcome instruments throughout the system, including CYF instruments, the CANS, MORS, LOCUS, and others that tie back to evidence-based practices. Review respondents state this information is used individually to help determine progress in treatment and, for some measures, identify individuals who should be considered for transitioning to primary care. Review feedback indicates a need to identify an instrument that is effective for assessing three and four year-olds.
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP performed a consumer satisfaction survey in April 2014, and published an extensive evaluation of its findings in August 2014. The MHP highlighted both areas of strength and opportunity in that analysis, and also presented the data by age and ethnicity groupings. In addition, the MHP was able to track self-reports of law enforcement contact during that period, which indicated a reduction for those engaged in services.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	According to the MHP PIP data, there are a total of 163 positions in which peer or family lived experience was required in 2013. The PIP data also identify between 79 and 85 Peer Support Specialists employed in various programs. There was no evidence of consumers or family members in leadership or supervisory positions. There is no established career ladder for consumer employees. The MHP's Non-Clinical PIP includes an evaluation of Peer and Family Support Specialist roles, retention factors, and looks to potentially identify a career path for these individuals.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	San Diego refers to their Wellness Centers as Clubhouses. There are six clubhouses in the Central Region. Each clubhouse is structured to meet the needs of the locale. The combined languages spoken at the various clubhouses in the Central Region are: English, Spanish, Ethiopian, French, German, Tagalog and ASL. In the North Central Region there are two clubhouses with combined languages spoken of English, Spanish, Hmong, French, Cambodian, Vietnamese and ASL. In the South Region there are three with English, Spanish, and Tagalog. In addition there is a clubhouse in the North Coastal Region with English and Spanish and in the North Inland Region there is one with English, Spanish and Mandarin. Many consumers praised their clubhouses, but some had problems with transportation.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care

  - The MHP has focused on Health Care Integration, specifically, how these initiatives relate to better consumer access, quality of care and timeliness. They continue to utilize CalMediConnect to design systems to work together with medical health plans. The MHP set up systems and benefit designs, and provided training for providers on how to implement and work within the managed care plan.
  - The county also utilizes a paired partner model – where there is a relationship created with primary care for referrals for members who are ready for a lower level of service.
  - The county has also implemented the Next Steps program to facilitate consumers accessing the next level of care when discharged from psychiatric facilities.

- The MHP also provides the Smart Care Program – a psychiatric consultation program. The MHP provides behavioral health consultation to psychiatrists and providers who are unsure of taking on behavioral health clients. Additionally, the MHP has a parent line to act as brief case management to get parents connected to support services.

- Timeliness of Services

- Providers report long wait times for program admission and psychiatric assessments and appointments as a result of program underfunding and understaffing.

- Quality of Care

- The MHP has an executive QI team, a quality review council, a clinical standards committee and a cultural competence resource team. All meet regularly. However, communication is not optimal between MHP and its providers. Additionally, client and family members are not utilized through system in key roles, and despite technically being present to provide feedback, client/family members report feeling marginalized.

- Consumer Outcomes

- The MHP utilizes a variety of outcome measures. For the Adult System of Care, the outcome tools include the IMR (Illness Management & Recovery), RMQ (Recovery Markers Questionnaire), SATS-R (Substance Abuse Treatment Scale-Revised), as indicated, and the MORS (Milestones of Recovery) or the LOCUS (Level of Care Utilization System) depending on level of care program provides. The IMR, RMQ & MORS are completed at intake, every 6 months and at discharge. The LOCUS is completed at intake, every 12 months and at discharge. The SATS-R is completed at the initial development of a substance related goal on the client plan and every 6 months as long as there is a substance related goal on the client plan. In the Children, Youth & Families System the CAMS (Child Adolescent Measurement System: Caregiver and Youth separately) & CFARS (Children's Functional Assessment Rating Scale) are administered at intake, at utilization management/review and at discharge. The ECBI (Eyberg Child Behavior Inventory) is used with programs whose population is primarily very young clients. These instruments are contained in multiple databases: DES (Data Entry System) for the CYF System of Care outcomes tools and HOMS (Health Outcomes Management System) for the A/OA System of Care outcomes tools. Providers do enter the data into those systems at their program sites.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

- Consumer Focus Group
- Family Member Focus Group
- Consumer/Family Member Focus Group (Spanish)

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

Family Member Focus Group

For participants who entered services within the past year, the experience was described as:

- Focus group participant who began services within the last year waited six weeks to be assessed. This individual stated that it felt like a long time.
- The other three participants stated that they saw their counselors once every 2 weeks, sometimes monthly. Participants also reported that they see a psychiatrist about once every two months.
- When in crisis, focus group participants stated that they could call PERT (psychiatric emergency response team) but that they were not available Sundays and Mondays, and they don't begin services until 2:00 p.m. otherwise, members call 911 the crisis line, or they "go and bang on the door" to get services. Members said they could call their therapist/counselor but that it wouldn't get them in any sooner to see a psychiatrist. (Note: MHP clarified that PERT operates 7 days/week from 6am to midnight.)

Recommendations arising from this group include:

- Non-interrupted continued services for serious mental health behavioral health issues (not 13 sessions at a time)
- More resources for parents of children with serious mental health behavioral health issues.
- More psychiatrists.

- More counselors.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants		**4**
Number/Type of Participants	Consumer Only	0
	Consumer and Family Member	1
	Family Member	3
Ages of Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	3
	Older Adult (60+)	1
Preferred Languages	English	2
	Spanish	1
	Bilingual	0
	Other	1
Race/Ethnicity	Caucasian/White	1
	Hispanic/Latino	1
	Other	2
Gender	Male	0
	Female	4

Interpreter used for focus group 1: ☒ No ☐ Yes Language:

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

Consumer Focus Group

For participants who entered services within the past year, the experience was described as:

- Of the 13 participants, one inidividual began services within last year, citing that it took “about a day and a half” to be seen, and then to the Areta Crowell Center.
- Consumers stated that they see their counselors/therapists on average of every 2 weeks to once a month, with psychiatrist visits every 2 months.

- Consumers reported varied experiences when in crisis.
  - Most had knowledge of crisis phone numbers.
  - One person said they would call a nurse, and then a therapist, and that he received a call back within an hour. Another individual said that when he tried to reach his doctor, he had to call the behavioral health center to speak with a nurse, and the only appointment available was a week later. The person said he had to wait and be patient. The person said that to get ahold of the doctor immediately, it's almost impossible.
  - Another person said that he ended up hospitalized when speaking to a nurse on the phone about suicidal thoughts even though he felt he wasn't suicidal.

Recommendations arising from this group include:

- More programs for domestic violence – most programs require the person to pay and after payment or limited time, further supports or programming is not available.
- More outings, field trips, activities, i.e. a visit to the Lighthouse.
- Reduce the paperwork for enrollment.
- Clinic wait times – request to monitor for time in waiting room to appointment.
- First day, do triage, then if space, make appointment for whoever is in the most need. Ask people if they would volunteer to return in the future (Day 2 or 3). The next day, if one is on the list, go in for appointment. The second day everyone arrives at the same time, triaged appointments needed (Days 2 and 3)

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants		**13**
Number/Type of Participants	Consumer Only	5
	Consumer and Family Member	4
	Family Member	1
Ages of Participants	Under 18	0
	Young Adult (18-24)	3
	Adult (25–59)	8
	Older Adult (60+)	2

Table 8B—Consumer/Family Member Focus Group 2		
Category		Number
Preferred Languages	English	12
	Spanish	0
	Bilingual	0
	Other	1
Race/Ethnicity	Caucasian/White	6
	Hispanic/Latino	4
	Other	4
Gender	Male	7
	Female	6

Interpreter used for focus group 2: ☒ No ☐ Yes Language:

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

Consumer/Family Member Focus Group (Spanish)

For participants who entered services within the past year, the experience was described as

- The consumers and family members in this focus group were not new to services in the last year. They reported that on average, they see their counselors/therapists every 2 weeks, and their psychiatry appointments are every two months.
- Focus group members reported that their options when they are in crisis are to call the crisis line (3) or 911 (3). One person said he would call his therapist, another would leave a voicemail for the psychiatrist, and one person said he would go to the clubhouse. When asked how soon they would be seen if they were in crisis, one person reported that they would have to wait, while two reported they could walk in and by seen by a counselor.

Recommendations arising from this group include:

- Increase housing and shelter services, i.e., showers, shoes, etc.
- Club house on the hospital property is profited, others are non-profit and receive more donations for tickets, events, etc. Consumers would like to see more activities at hospital club house. For example, field trips for free.
- At club house, would like more ongoing physical activity (soccer, basketball, teams).

- Clubhouses could have healthier food (veggies, fruits, no red meat, fish, chicken, turkey).
- More psychiatrist, esp. south San Diego (2) need more that take insurance

Table 8C displays demographic information for the participants in group 3:

Table 8C—Consumer/Family Member Focus Group 3		
Category		Number
Total Number of Participants		**8**
Number/Type of Participants	Consumer Only	5
	Consumer and Family Member	1
	Family Member	2
Ages of Participants	Under 18	0
	Young Adult (18-24)	2
	Adult (25–59)	3
	Older Adult (60+)	3
Preferred Languages	English	4
	Spanish	4
	Bilingual	0
	Other	0
Race/Ethnicity	Caucasian/White	1
	Hispanic/Latino	7
	Other	0
Gender	Male	2
	Female	6

Interpreter used for focus group 3: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
  - Focus group members spoke positively regarding PERT – psychiatric emergency response team, but expressed concern that PERT services limited to Tuesday through Saturday, starting at 2:00 p.m. PERT is not available Sunday/Monday. When PERT services are not available, consumers call 911.
- Timeliness of Services

- Overall, reported timeliness was consistent with participants seeing counselors every 2 weeks and psychiatrists every 2 months.

- Quality of Care

- Overall, Clients/Family members felt that they received quality care when they were able to be seen.

- Consumer Outcomes

- Focus group members did not provide information on outcomes.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	15.08%
Contract providers	79.28%
Network providers	5.64%
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:

32%

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

5.4%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☒ Yes ☐ No

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

- Co-occurring diagnosis is calculated separately for adults (44%) and children (5%)

CURRENT OPERATIONS

- The MHP utilizes the Cerner Community Behavioral Health (CCBH) information system for practice management and electronic health records.
- Data is extracted from CCBH is for use in external databases for research and authorization.

MAJOR CHANGES SINCE LAST YEAR

- Archiving of legacy data from prior IS was completed.
- Project for converting the Citrix servers to the Cerner Remote Host Option is in the testing phase with planned completion on in May 2015. This is expected to significantly improve user performance.

PRIORITIES FOR THE COMING YEAR

- Completion of Remote Hosting Option
- Resolution of performance issues
- Implementation of electronic client signature collection

OTHER SIGNIFICANT ISSUES

- Providers report delays of 2 months or longer for obtaining user accounts and IS training for new staff.
- Providers report that completion of client plan to be cumbersome taking excessive time.

- Providers also report that user accounts for departed/terminated staff remain open despite multiple notices to the MHP. This presents a possible security issue.

Table 10 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 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner CCBH	Practice management and EHR	Cerner	6	MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP has no plans for information systems change

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Cerner CCBH	X			
Clinical decision support	Cerner CCBH	X			
Document imaging				X	
Electronic signature—client				X	
Electronic signature—provider	Cerner CCBH	X			
Laboratory results (eLab)				X	
Outcomes	HOMS & DES	X			
Prescriptions (eRx)	Cerner CCBH	X			

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Progress notes	Cerner CCBH	X			
Treatment plans	Cerner CCBH	X			
Summary Totals for EHR Functionality		7		3	

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

- A solution for collecting client signatures is under development

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - The MHP has a robust process for collecting and analyzing client data used to evaluate possible service gaps and disparities.
  - Penetration data is analyzed on both an eligibility and prevalence basis.
- Timeliness of Services
  - Access tracking is not integrated into the IS which appears to have led to inconsistencies tracking and reporting of timeliness data.
- Quality of Care
  - The MHP makes extensive use of consumer satisfaction data in evaluating services.
- Consumer Outcomes
  - Authorization and extension of outpatient visits are not integrated into the IS making it difficult to analyze how well the current limited visit model is working.
  - The outcome instruments being utilized are integrated into the HOMS and DES databases which are external to the CCBH IS..

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 identified on this review.

CONCLUSIONS

During the FY14-15 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:

o The MHP's attention to streamlining and improving the contract monitoring process has had a positive effect. The CORs as the key link between the MHP and organizational providers having the authority to shift resources within an organizational provider's programs is viewed as a positive.

o The MHP has the ability to produce and widely communicate reports relevant to services within the MHP. The publishing of 5-year wait time trends enables stakeholders to participate in evaluating the MHP's performance.

Timeliness of Services

- Strengths:

o The MHP has strong tracking and follow-up mechanisms for psychiatric inpatient discharged beneficiaries.

o The MHP has a wait time reporting system which tracks mental health assessment and psychiatric assessment timeliness across all providers and generates monthly summaries.

- Opportunities:

o The timeliness of services beyond assessments is not systematically tracked which leaves the MHP without information regarding capacity to provide treatment.

o Clinical staff and contract providers reported that there may be significant delays in getting post-assessment treatment appointments.

Quality of Care

- Strengths:

- The MHP's Clubhouse programs are widely distributed geographically and have broad linguistic capabilities.
- The MHP demonstrated its commitment to implementing Katie A. services through its intensified training program – 18 training sessions provided to team members from Child Welfare Services and Behavioral Health services.
- The MHP's clinical PIP shows promise for improved monitoring and quality of care in treating suicidality.

- Opportunities:

- Individuals with lived experience do not occupy significant roles within the leadership team of the MHP at this time.
- Contract providers reported there is room for improvement in communication including more participatory discussions at meetings with the providers.

Consumer Outcomes

- Strengths:

- The MHP utilizes a variety of outcome measures for adults and children, and dedicates substantial fiscal and human resources to outcome functions. The consumer outcomes are being collected in multiple areas, and various databases are being utilized by the MHP to collect and track outcomes.

RECOMMENDATIONS

- Enhance understanding of timeliness of services and treatment capacity by tracking post-assessment treatment appointments for both Children's and Adult Systems of Care.
- Develop and implement a plan to authorize and train new EHR users in a timelier manner.
- Establish and maintain two active performance improvement projects (PIPs) – one clinical and one non-clinical.
- Establish a provider working group to:
  - Jointly develop the MHP and contract provider meeting agendas
  - Obtain early input on emerging challenges and changes.
  - Validate service timeliness findings.

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:

SAN DIEGO COUNTY
MHP CALEQRO AGENDA

DAY 1 WEDNESDAY, FEBRUARY 11, 2015

Time	Activity Unless otherwise noted, all sessions will be held at 3255 Camino Del Rio S., San Diego, CA
8:30 am – 9:00 am	Opening Session • Introduction to BHC • MHP Team Introductions Participants: Alfredo Aguirre, Patty Kay Danon, Piedad Garcia, Dr. Michael Krelstein, Yael Koenig, Dr. Laura Vleugels, Patti Groulx, Lavonne Lucas, Junida Bersabe, AnnLouise Conlow, Tabatha Lang, Liz Miles, Steve Jones, Danyte Mockus-Valenzuela, Virginia West, Debbie Malcarne, Cecily Thornton-Stearns, Anna Palid, Betsy Knight, John Oldenkamp, Alfie Gonzaga, Steve Tally (HSRC), Amy Chadwick (CASRC), Mitch Gluck, Judi Holder (Recovery Innovations), Donna Marto (FYRT), Shannon Jaccard (NAMI), Carol Neidenberg (CCHEA), Mike Phillips (JFS), Michelle Galvan (Optum) Location: 3255 Camino Del Rio S., San Diego, CA, La Jolla Room
9:00 am- 9:45am	Review of Past Year • Significant Changes and Key Initiatives • Response to Previous Year's Recommendations • Use of Data in the Past Year Participants: Alfredo Aguirre, Patty Kay Danon, Piedad Garcia, Dr. Michael Krelstein, Yael Koenig , Dr. Laura Vleugels, Patti Groulx, Lavonne Lucas, Junida Bersabe, AnnLouise Conlow, Tabatha Lang, Liz Miles, Steve Jones, Danyte Mockus-Valenzuela, Virginia West, Debbie Malcarne, Cecily Thornton-Stearns, Anna Palid, Betsy Knight, John Oldenkamp, Alfie Gonzaga, Steve Tally, Amy Chadwick, Mitch Gluck, Judi Holder (Recovery Innovations), Donna Marto (FYRT), Shannon Jaccard (NAMI), Carol Neidenberg (CCHEA), Mike Phillips (JFS), Michelle Galvan (Optum) Location:3255 Camino Del Rio S., San Diego, CA, La Jolla Room
10:00 am- 11:00am	Healthcare Integration • Cal Mediconnect • San Diego Paired Partner Model • ICARE

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Cyndi Eppler, LCSW, LPCC, Lead Quality Reviewer
Rob Walton, RN, MPA, Quality Reviewer
Jerry Marks, IS Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant
Saumitra SenGupta, Ph.D., CalEQRO Deputy Director

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

MHP Administration
3255 Camino Del Rio S.
San Diego, CA

Participants Representing the MHP

Name	Position	Agency
Abbe Crone	Administrative Assistant	Recovery Innovations
Adriana Olalla	Program Manager	Ally
Alfie Gonzaga	Principal Administrative Analyst	BHS - AOA
Alfredo Aguirre	BH Director	BHS
Amelia Guingab	PAA	BHS
Amy Chadwick	Project Coordinator	UCSD HSRC
Andrea Carlin	Patient Advocate Supporter	JFS Patient Advocacy
Andy Sarkin	Program Evaluator	UCSD HSRC
Anna Palid	Program Coordinator	BHS
Anne Fitzgerald	MHSA/WET Coordinator	BHS
AnnLouise Conlow	MIS	BHS
Anselma Danque	BHS Billing Supervisor	Fiscal/HHSA
Besty Knight	Behavioral Health Program Coordinator	BHS - AOA
Bevelyn Bravo	Community Engagement Liaison	FYRT
Bill Penfold	MIS Manager	Optum

Name	Position	Agency
Cara Murray	Regional Director	Providence Community Services
Cathi Palatella	Deputy Director	Child Welfare Services, HHSA
Cecily Thornton-Stearns	Behavioral Health Program Coordinator	BHS - AOA
Celeste Hunter	Family Partner/Certified Grief Recovery Specialist	UFAC - Alliance for Community Empowerment
Chona Penalba	Principal Accountant	Fiscal/HHSA
Chris Strows	QI PIT	HHSA
Cinthya Luis	Peer Recovery Program Coordinator	NAMI San Diego
Danyte Mockus-Valenzuela	Prevention and Planning Manager	BHS - HHSA
Dasha Dahdouh	Research Analyst	BHS QI PIT
David Weinberg	Peer Support Specialist	Mental Health Systems
Debbie Verduzco	Administrative Analyst II	BHS
Deborah Malcarne	Behavioral Health Program Coordinator	BHS
Deva Lipson	Volunteer	NAMI San Diego
Dixie Galapon	MH Director	VCAC
Donna Ewing Marto	CEO Family partner	Family & Youth Roundtable/Liaison
Edith Mohler	Administrative Analyst III	BHS - CYF
Elizabeth Locano	Health & Human Services Administration	BHS - CYF
Emilia Pine	Catalyst	Providence Community Services
Emily Trask	Psychologist/Consultant	CASRC/UCSD
George Scolari	BH Manager, Managed Care Plan	Healthy San Diego
Guy Nelson	QI PIT	HHSA
Hiwet Beyene	Peer Support Specialist	Recovery Innovations
Joe Mayer	Clinical Line Staff	South East Behavioral Health Center
Judi Holder	Recovery Service Administrator	Recovery Innovations
Klea Galasso	Sr. Program Manager	NAI
Kris Summit	QI PIT	HHSA
Kristi Shiao	QI PIT Research Analyst	HHSA
LaShaune McCottry	Clinical Line Staff	Telecare Corp. Gateway to Recovery
Laura Colligan	Pathways Manager	BHS - HHSA
Laura Vleugels, MD	Supervising Child & Adolescent Psychiatrist	BHS - CYF

Name	Position	Agency
Lauren Chin	Health Planning Specialist	BHS - HHSA
Lauretta Monise	Chief, Child and Adolescent Services	BHS - HHSA
LaVonne Lucas	BHS Claims Manager	Fiscal/HHSA
Leandra Holland	Case Manager	San Diego County
Linda Richardson	Program Manager	NAMI San Diego
Liz Miles	Principal Administrative Analyst	BHS/QI
Mary Obrien	Consumer Health Advocate	CCHEA
Mary Woods	Regional Administrator	Telecare Corp.
Meghan Maiya	Research Center Q1	HSRC
Mercedes Webber	Peer Liaison	Recovery Innovations
Michael Krelstein	Medical Director	San Diego County
Michael Miller	Program Director	CRF MAST
Michelle Galvan	Executive Director	Optum
Michelle Gregoire	Peer Liaison	Recovery Innovations
Michelle McDonald	In our Own Voice Coordinator	NAMI San Diego
Michelle Raby	QI Specialist	BHS - HHSA
Minerva Morales-Moreno	Program Manager	FHCSD
Nancy Johnson	Clinical Supervisor	SDCC - ECOP
Natalie Blair	Program Manager	County of San Diego
Nilsa Rubenstein	System Maintenance Analyst	Optum
Patricia Gilbert	Program Manager	YMCA
Patricia Madison	MIS IT Analyst	BHS
Peter Shih	Health Care Policy Administrator	HHSA
Piedad Garcia	Deputy Director	HHSA
Ranoy Little	CAO	Recovery Innovations
Rebecca Fischer	Team Lead	Telecare Corp. Gateway to Recovery
Sarah Pauter	Executive Youth Partner	Family & Youth Roundtable/Liaison
Sarah Welsh	Clinical Line Staff	Douglas Young Youth & Family Services
Shellie Raczok	Peer Advocate	Consumer Centre for Health Education & Advocacy (CCHEA)
Shelly Tregembo	Analyst, Int. Care	BHS - HHSA
Stephen Ingram	Peer Support Specialist	Recovery Innovations
Steve Jones	QM Program Manager	BHS

Name	Position	Agency
Steve Tally	Assistant Research Director	UCSD HSRC
Steven Wells	Supervisor - CWS Pathways to Wellbeing	Child Welfare Services
Sue Slauibe	COO - CDD	NAMI San Diego
Tabatha Lang	QI Chief	San Diego County
Tamara Stark	VP SD Programs	Exodus Recovery
Tesra Widmayer	QI PIT	HHSA
Thien Pham	Clinical Line Staff	UPAC
Valerie Porter	Clinical Line Staff	Family Health Centers of San Diego
Veronica Gallagher	Clinical Line Staff	MHS
Virginia West	Program Coordinator	BHS
Wendy Maramba	Chief	BHS/HHSA/CYF
Yael Koenig	BHS - CYF Regional Director	BHS
Zina Salem	CEO	CMSS

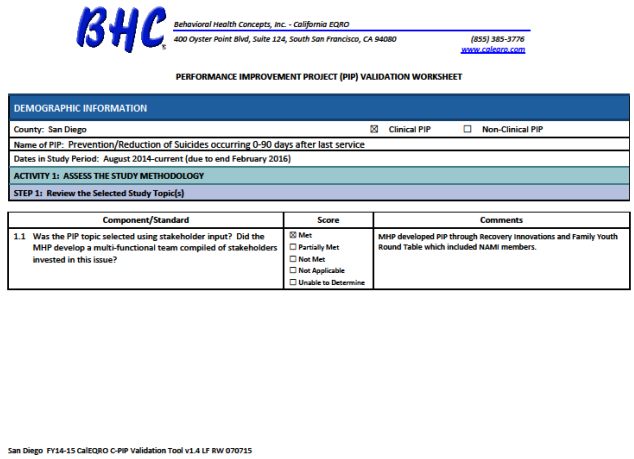
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP separately 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
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www.caleqro.com

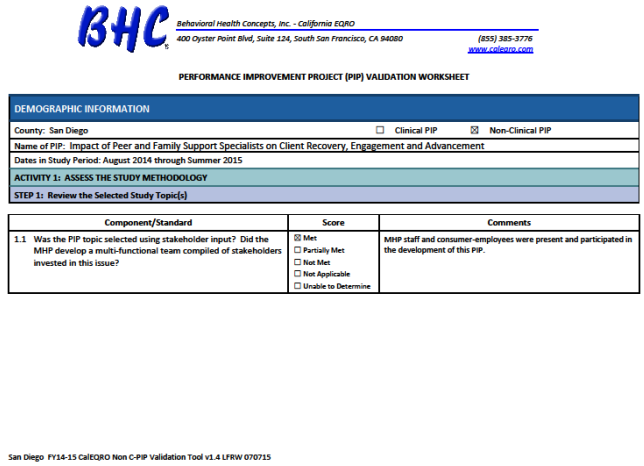
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: San Diego	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Prevention/Reduction of Suicides occurring 0-90 days after last service		
Dates in Study Period: August 2014-current (due to end February 2016)		
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	MHP developed PIP through Recovery Innovations and Family Youth Round Table which included NAMI members.

San Diego FY14-15 CalEQRO C-PIP Validation Tool v1.4 LF RW 070715

Non-Clinical PIP:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: San Diego	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: Impact of Peer and Family Support Specialists on Client Recovery, Engagement and Advancement		
Dates in Study Period: August 2014 through Summer 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	MHP staff and consumer-employees were present and participated in the development of this PIP.

San Diego FY14-15 CalEQRO Non C-PIP Validation Tool v1.4 LFRW 070715