FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

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 CY14—34,712
  - MHP Size—Large
  - MHP Region—Southern
  - MHP Threshold Languages—Spanish, Arabic, Vietnamese, Tagalog
  - MHP Location—San Diego

This report presents the fiscal year 2015-2016 (FY 15-16) findings of an external quality review of the San Diego 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; San Diego 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 three 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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

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

[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: Enhance understanding of timeliness of services and treatment capacity by tracking post-assessment treatment appointments for both Children's and Adult Systems of Care.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP's two Systems of Care referred to above are fully known as the Children, Youth and Families (CYF) System of Care and the Adult and Older Adult (A/OA) System of Care. The MHP has worked extensively with providers during the year to standardize timeliness information and scheduling processes. The MHP and contractors developed a methodology for data tables to be transmitted to the MHP in order for the MHP to monitor access and calculate timeliness measures.

- The MHP is in the process of implementing the "*services journal*" in the Cerner Community Behavioral Health (CCBH – formerly Anasazi) electronic health record (EHR) to capture all contact and scheduling information. However, the completion of the "*services journal*" is still pending.

- Recommendation #2: Develop and implement a plan to authorize and train new EHR users in a timelier manner.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP underwent a significant restructuring of its EHR platform. The product is now hosted at the vendor's (Cerner) main data facility and all operations have been migrated to this Application Service Provider (ASP).
  - The restructuring resulted in a new workflow that allows the MHP to train EHR users much faster resulting in improved time to authorization.
  - The migration to the ASP has provided an additional benefit to the MHP which is now better able to review and update both their Disaster Recovery and Business Continuity plans.

- Recommendation #3: Establish and maintain two active performance improvement projects (PIPs) - one clinical and one non-clinical.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP completed their Clinical PIP, "*Reduction of Suicides occurring 0 – 90 days after last Service*". The PIP results were mostly inconclusive, but the MHP did succeed in instituting the High Risk Assessment (HRA) throughout the outpatient system of care.
  - The MHP's Non-Clinical submission, entitled "*Impact of Peer and Family Support Specialists on Client Recovery*", was determined not to be a PIP because the approach was a retrospective research study. In a PIP, the question, interventions and outcomes must be prospective, with current interventions aimed at producing future results.

- Recommendation #4: 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.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP has implemented monthly meetings with the Mental Health Contractors Association (MHCA) in which MHCA develops the agenda. The purpose of these meetings is to facilitate input from contract providers on

emerging challenges and changes. Stakeholders recognized the value of these meetings. Other efforts like the Quality Review Council (QRC) are also directed at obtaining meaningful input from Systems of Care providers. However, it is unclear to what extent these meetings are able to address major issues such as clinical documentation requirements, increased consumer demand and acuity, continuing experience with the"13 session" authorization model rolled out in January 2010 and evaluated by the MHP's Child and Adolescent Services Research Center (CASRC) – with a report issued in February 2015 – and other issues.

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
  - Providers reported increased demands by the "No Wrong Door" protocols that require them to refer an increasing number of "mild" to "moderate" consumers to federally qualified health centers (FQHCs) and the five Medi-Cal Managed Care Plans (MCPs) comprising "Healthy San Diego".
  - At the time of the review, the MHP had 33 Psychiatric Emergency Response Teams (PERTs) which pair licensed mental health clinicians with trained law enforcement officers to respond to crises. The MHP plans to expand this to 40 in March 2016.
  - To address the need for additional service capacity the MHP has undertaken new or expanded contracts to include:
    - Negotiations to open two new hospital-based Crisis Stabilization Units (CSUs) at Tri-City Medical Center and Palomar Hospital.
    - Building a 15-bed Crisis Residential Facility in Escondido.
    - Expanded housing and corresponding Assertive Community Treatment (ACT) support services. The MHP has over 1,020 housing units. However, the county's 2015 Point-In-Time Homeless Count is 8,750.
- Timeliness of Services
  - Contract providers now submit data tables on consumer contacts and appointments so that the MHP can monitor scheduling and calculate timeliness measures.

- The MHP anticipates implementing the "*services journal*" in 2016 as the EHR scheduler.

- Quality of Care
  - The MHP has developed a strong relationship with Child Welfare Services (CWS) on *Katie A*., Accomplishments include: i) an MOU for *Katie A*.; ii) co-location of staff in all 6 Regions; iii) a Katie A. Provider Toolkit binder which includes pertinent forms, bulletins, tip sheets, and general information for providers; iv) establishment of a *Katie A*. website, accessible by the public, which serves as a comprehensive tool and includes all of the county's resources; v) jointly led and attended trainings; vi) inclusion of Family and Youth Partners in the creation of all materials that are used in the Child and Family Teams (CFT) meetings; and vii) use of the EHR to capture *Katie A.* services. The MHP served 820 sub-class members in the six month period March – August 2015.
  - The MHP is deciding whether to opt into DHCS's federal Social Security Act Section 1115 Organized Delivery System (ODS) waiver for DMC/Substance Use Disorder (SUD) services. Considerations include: i) financial "risk" of the rate per modality model; ii) how successfully the MHP can fill units and house high acuity consumers; iii) the availability of physical health care services for the target population; and other factors.
  - The MHP is jointly implementing the Commercially Sexually Exploited Children (CSEC) Protocol (SB 75) with CWS, Public Health, and Juvenile Justice at juvenile halls. This is slated to begin in February, 2016.
  - The MHP is actively participating with prescribers, pharmacies, the County Health and Human Services Agency (HHSA) and the county Medi-Cal fiscal intermediaries to implement the Antipsychotic Drugs for Minors Program and California Guidelines for Psychotropic Medications for Foster Care children.
  - The MHP implemented the Remote Hosting Option in the EHR which has significantly improved speed and effectiveness.
  - The MHP is moving to implement the Cerner HealtheIntent platform as an open-ended business architecture to aggregate data across the system of care from disparate electronic sources.

- Consumer Outcomes
  - Fiscal Year (FY) 2013-14 aggregate adult and children's outcome scores between intake and discharge showed improvement, per the Adult and Older Adult (A/OA) and Children, Youth and Families (CYF) System wide Reports.

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
- 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, 2016.

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 CY14 by Race/Ethnicity

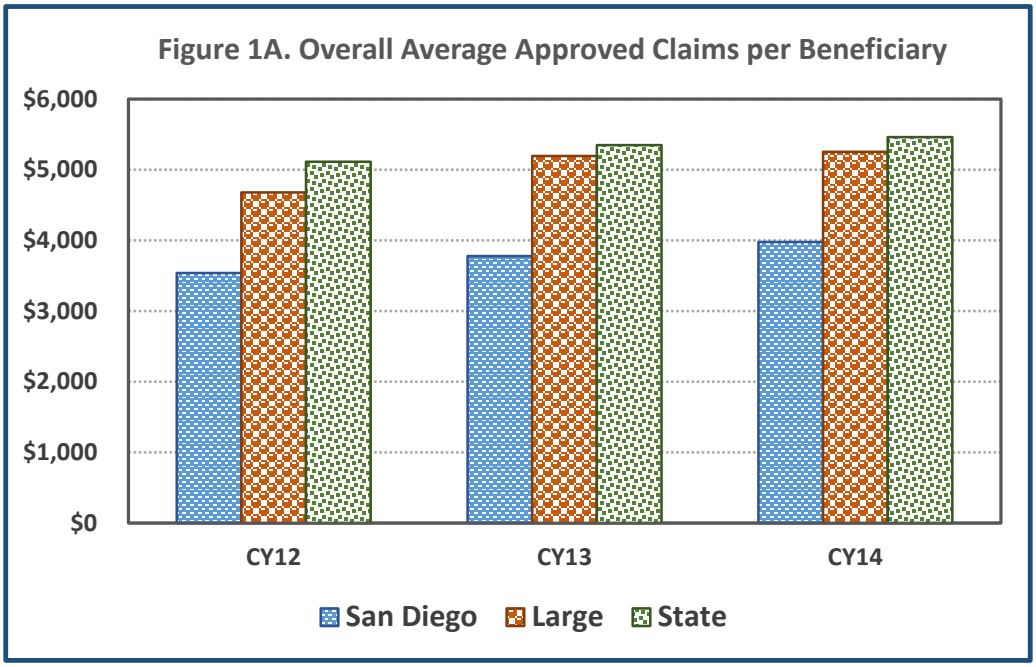
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	116,405	11,175
Hispanic	276,487	11,415
African-American	40,597	3,629
Asian/Pacific Islander	59,093	2,110
Native American	2,354	232
Other	104,608	6,151
Total	599,543	34,712

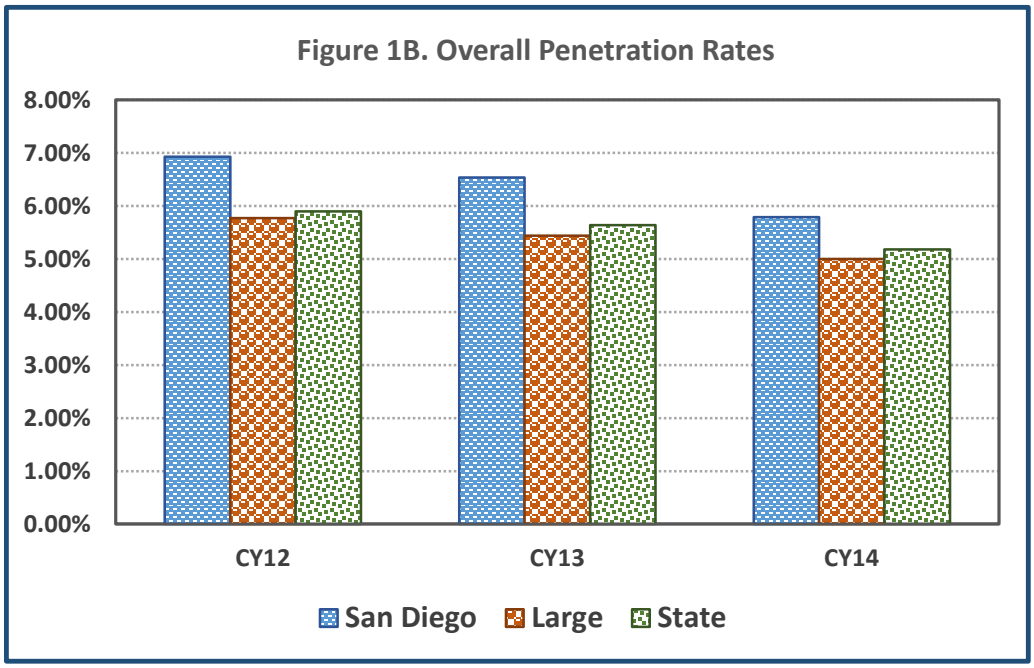
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

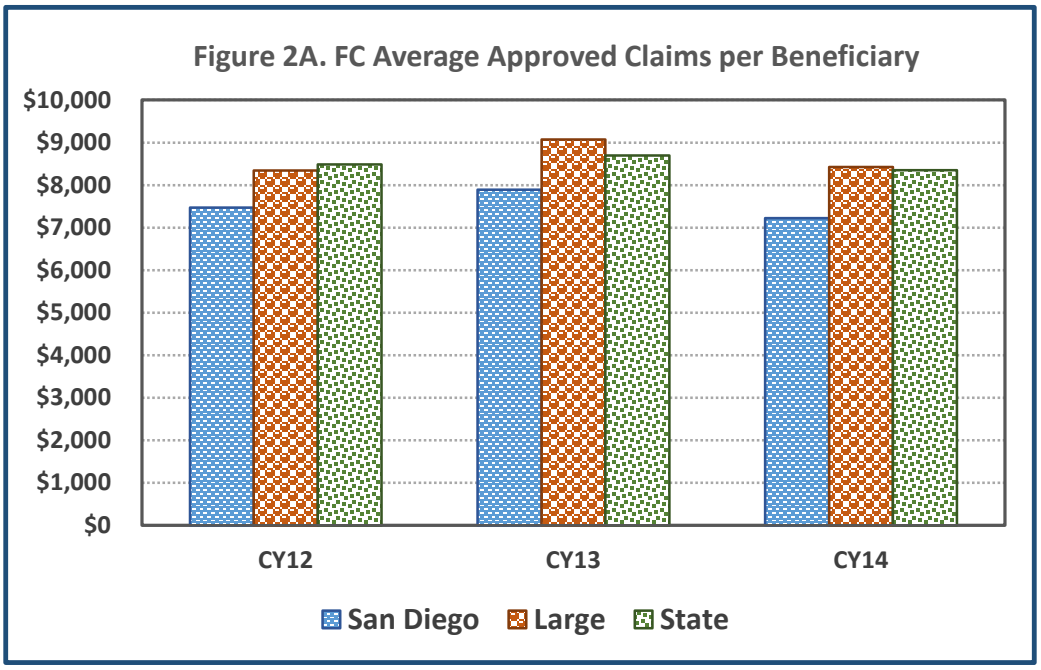
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

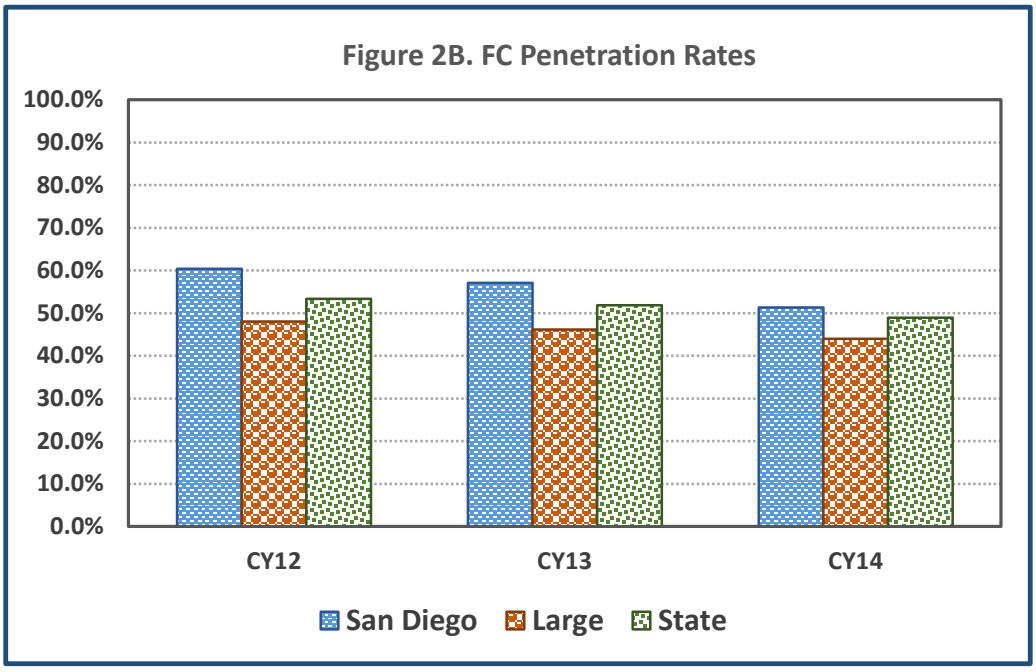
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.



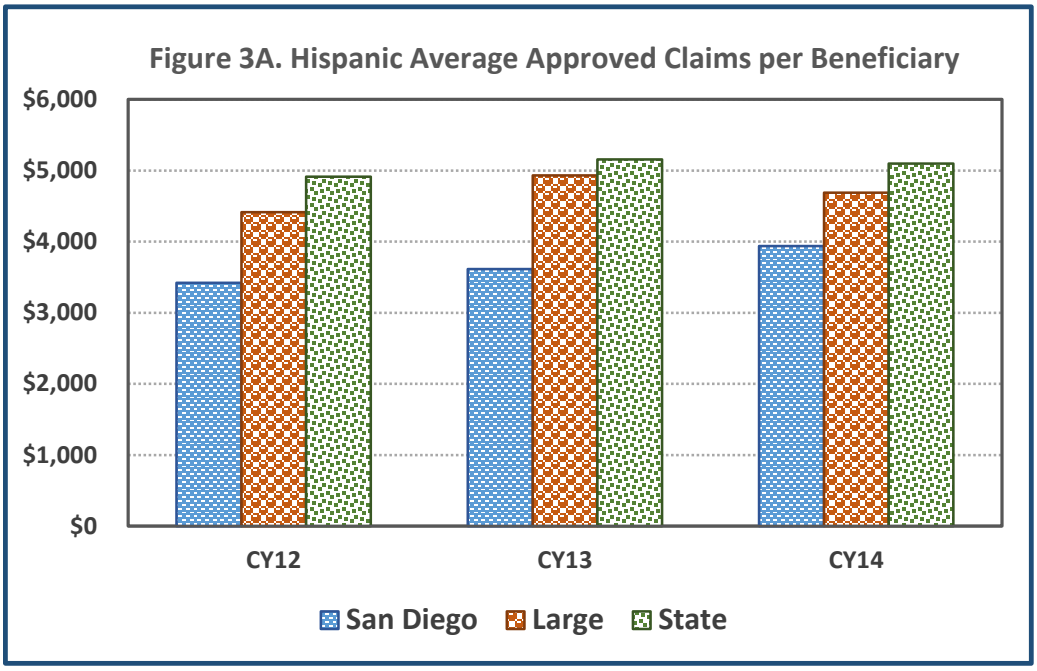


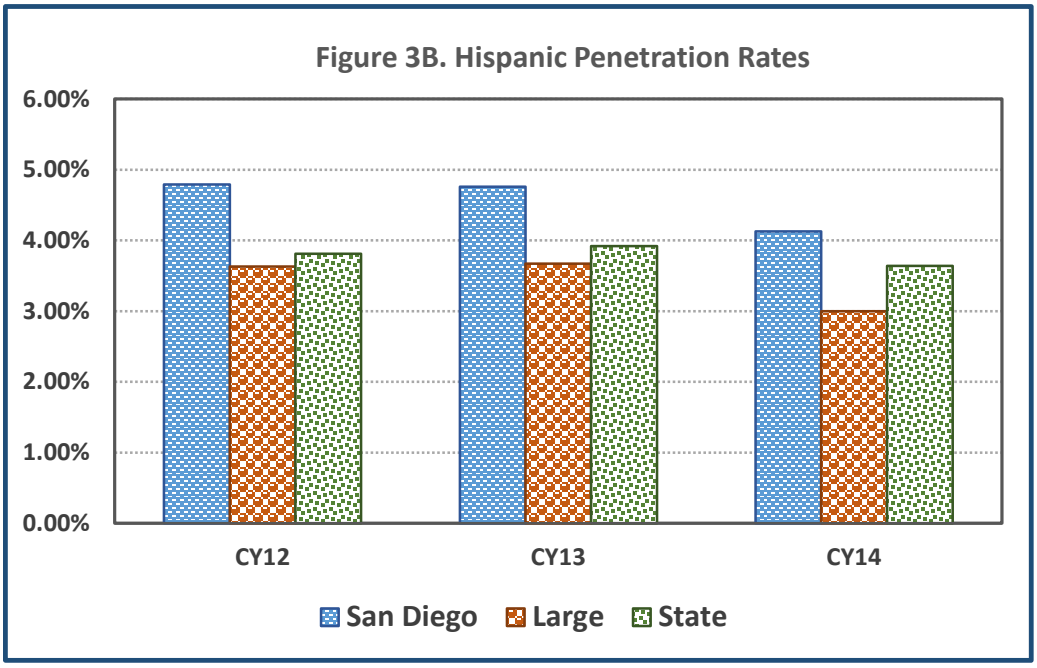
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large MHPs.





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

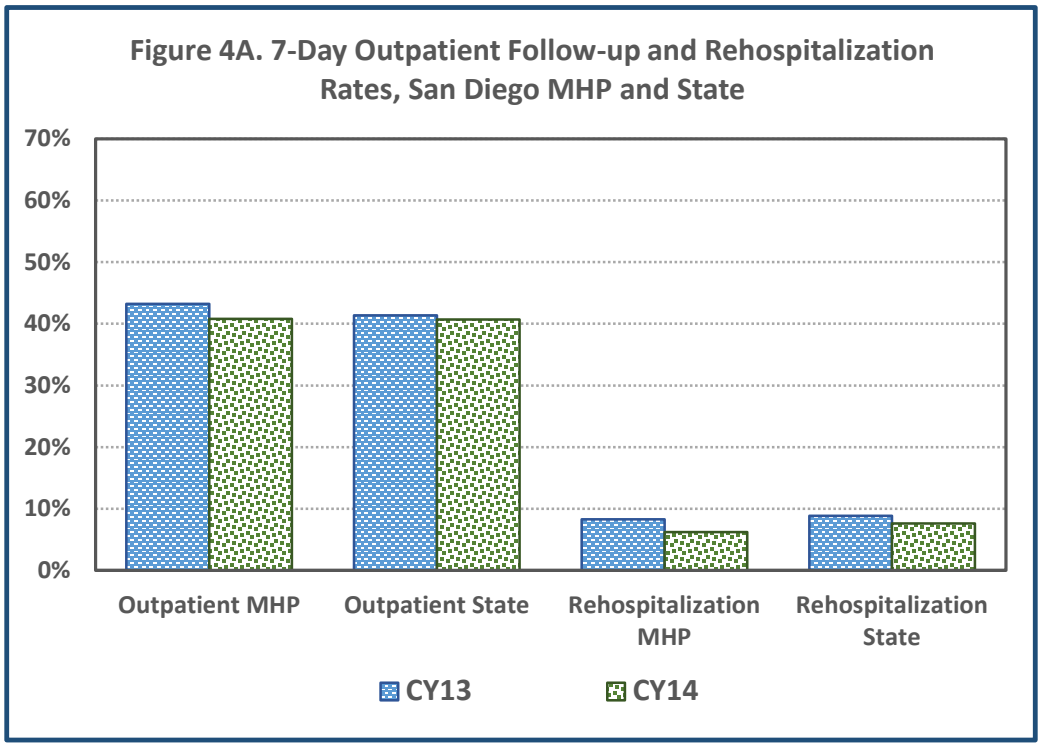
Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY14 with the MHP's data for CY14, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

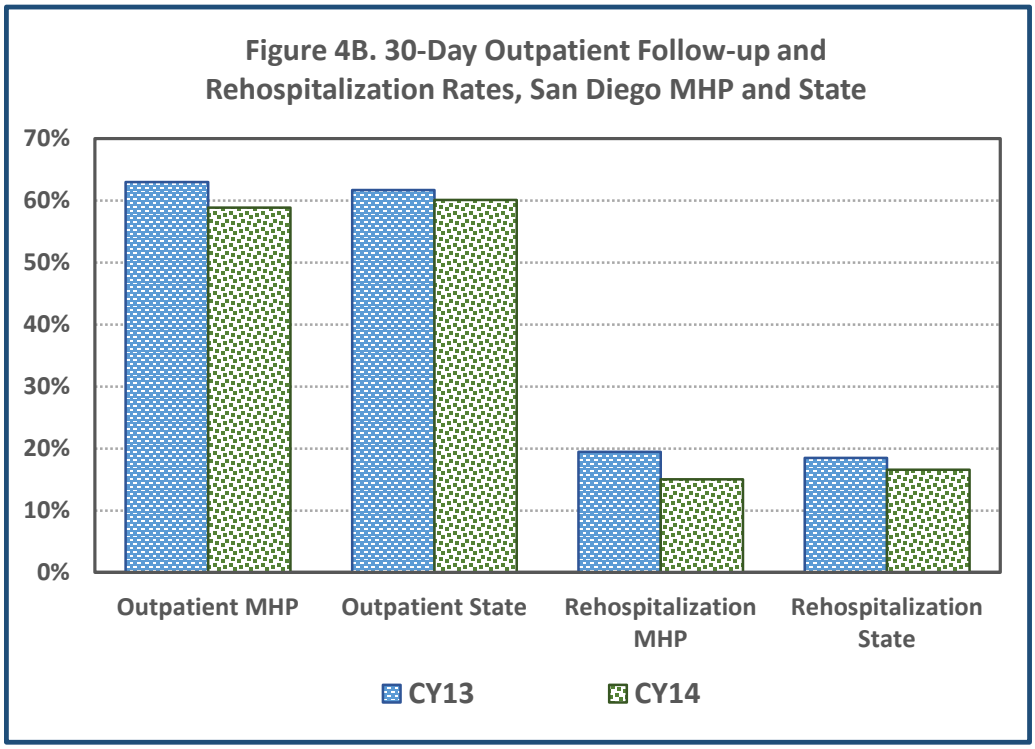
Table 2—High-Cost Beneficiaries

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%
San Diego	CY14	517	34,410	1.50%	$42,172	$21,802,775	18.12%
	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%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

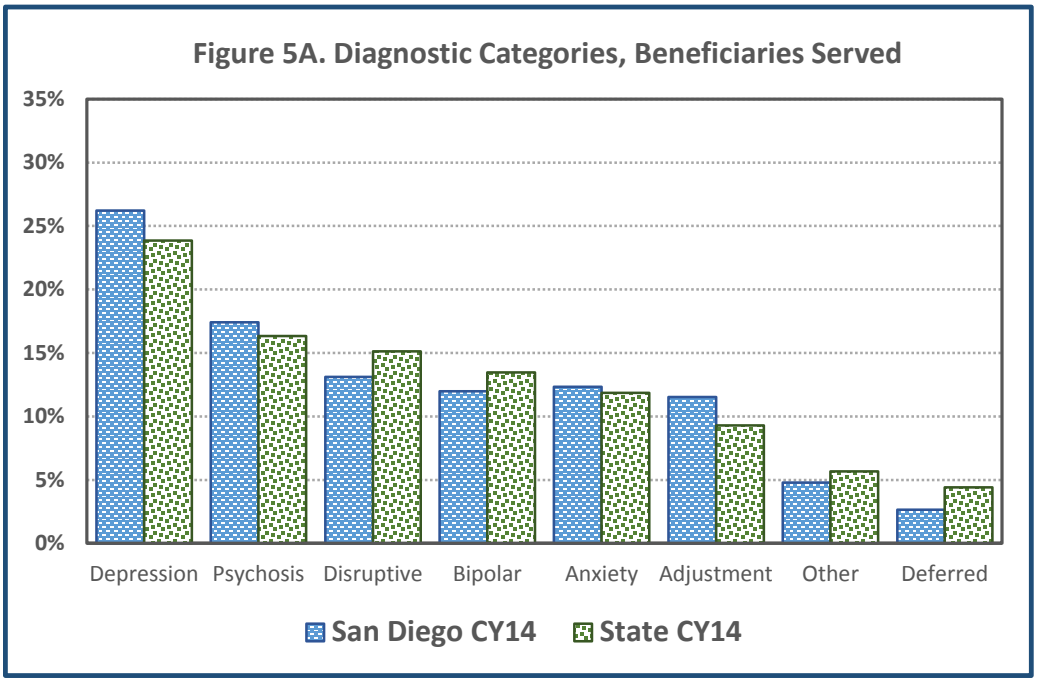
Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and re-hospitalization rates for CY13 and CY14.

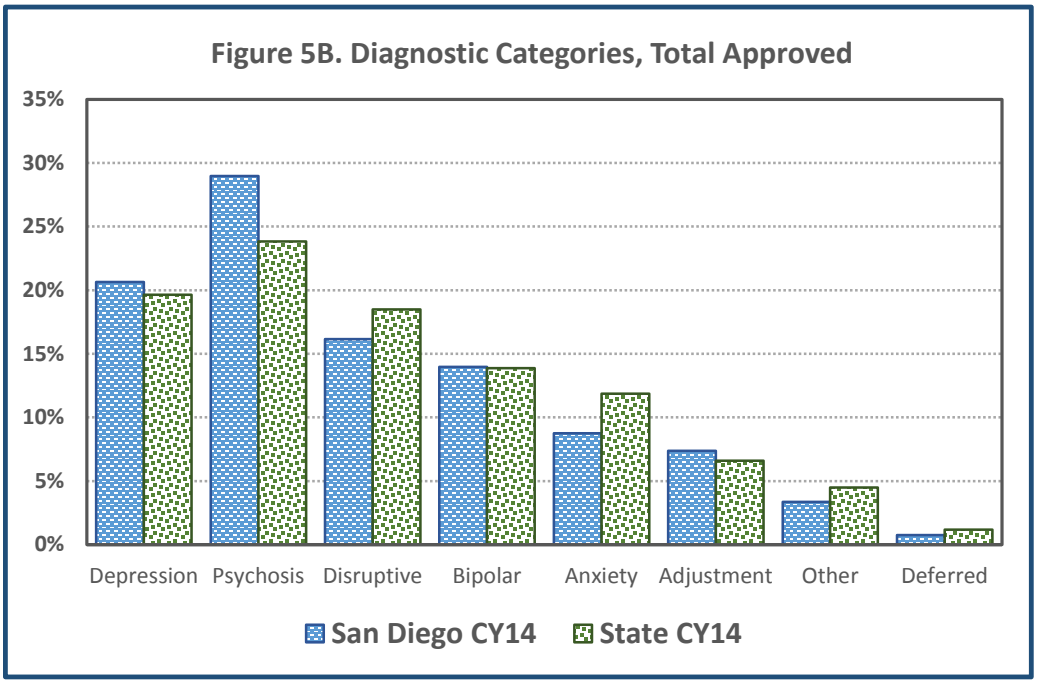




DIAGNOSTIC CATEGORIES

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 penetration rates for CY12-14 remain higher than both the other Large MHPs and the State although there is a downward trend during this period that is similar to other Large MHPs and statewide.
  - The MHP's penetration rates for foster care continue to be higher than other Large MHPs but appear about the same as the State average. Foster Care PR also appears to be declining.
  - The MHP's penetration rates for Hispanic beneficiaries are much above both Large MHP and statewide averages. As with the other PR categories a declining penetration rate also appears for Hispanic beneficiaries.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates are very similar to the Statewide averages.
- Quality of Care
  - The MHP's percentage of high cost beneficiaries (HCB) was significantly lower than the statewide averages (2.48% vs. 1.50%) in CY14 and lower than the previous two years. The Average Approved Claim per HCB was also significantly less than the statewide average.

- While the MHP's Average Approved Claim per Beneficiary Served was trending slightly higher during CY12-14, it remains significantly lower than both the Large MHP and statewide averages.
- The MHP's distribution of diagnoses follows that of the State as a whole, although it seems to use deferred diagnoses less often than statewide. The MHP's total approved claims in the Psychosis category is somewhat above the statewide average and lower in the Anxiety Disorder group.

- Consumer Outcomes
  - The MHP's 7 and 30-day re-hospitalization rates were similar to statewide during CY13-14.

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.

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 MHP submitted two PIPs for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	Reduction of Suicides of Suicides Occurring 0-90 Days After Last Service
Non-Clinical PIP	Impact of Peer and Family Support Specialists on Client Recovery

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

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	NM
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	M	NM
		8.3	Threats to comparability, internal and external validity	M	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	PM	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	NM
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	NM
		9.3	Improvement in performance linked to the PIP	M	NM
		9.4	Statistical evidence of true improvement	M	NM
		9.5	Sustained improvement demonstrated through repeated measures.	NM	NM

**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	23	0
Number Partially Met	6	0
Number Not Met	1	30
Number Applicable (AP) (Maximum = 30)	30	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	86.67%	0%

CLINICAL PIP—REDUCTION OF SUICIDES

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

- "Was San Diego County Behavioral Health Services' (SDCBHS's) implementation of a high risk assessment associated with a reduction of completed suicides that occur within 90 days after the last date of services?"
- 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

MHP data indicate that among MHP consumers who commit suicide, a high percentage occur within 90 days of the consumer's last date of service. The goal of the PIP was to determine if use of the "High Risk Assessment" (HRA), and training of clinicians in how to use the HRA, could prevent or reduce suicides occurring within 90 days of the last date of service.

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 to: i) utilize the questions raised by the PIP to institute a more appropriate suicide reduction screening mechanism(s); ii) consider tracking a wider range of indicators that capture self-injurious behaviors in general; iii) capture the full array of interventions within the MHP's sphere of influence that are needed to prevent suicides, such as preventing "No Shows" (as discussed), as well as other clinically meaningful interventions to reduce suicide risks; and iv) develop finer clinical and diagnostic profiles of at-risk beneficiaries.

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

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

- The MHP's submission, "Impact of Peer and Family Support Specialists on Client Recovery", was found to be a retrospective research study. This submission did not contain prospective study question(s), interventions and outcomes to meet the federal Centers for Medicare and Medicaid Services (CMS) guidelines to be a Medicaid PIP.
- 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

Brief summary of submitted PIP

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 utilizing the learning and conclusions from this retrospective research study in developing a PIP if considered as one of the top priorities for the system.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The Clinical PIP has implications for the importance of assuring that consumers have continued access to appropriate services.
- Timeliness of Services
  - The Clinical PIP underscores the importance of timely follow-up for high risk individuals.
- Quality of Care
  - The PIP results were mostly inconclusive in terms of suicide rate reduction, though results trended positive. The MHP wants to continue monitoring suicide

rates. The MHP recognized that: i) assessment tools besides the HRA may better measure suicide risk; ii) other factors and interventions need to be considered such as consumer demographics and type of services/changes in services provided to consumers based on risk assessment; and iii) the outcome indicator may need to be broadened to include all self-injurious behavior.

- Consumer Outcomes
  - The Clinical PIP has potential to reduce adverse outcomes for high risk individuals.

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	The MHP's penetration rates (PRs) exceed the Large MHP and statewide averages for Hispanics, Asian-Pacific Islanders, Native Americans, Whites, Disabled and Foster Care beneficiaries. The MHP's PR for African Americans exceeds the Large MHP average and is close to the statewide average. For African Americans, the MHP acknowledges that much of this is due to higher acuity Jail/Probation consumers while the MHP may not be serving other African American consumers with outpatient services needs in an equitable manner. The MHPs Mental Health Workforce Analysis shows increased percentages of racial/ethnic and threshold language-speaking MHP staff from 2008 through 2013.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	The MHP publishes data on the number of providers by region, program, race/ethnicity, and provider type/education. The MHP partners with FQHCs and Healthy San Diego in its service area to refer M2M consumers, but acknowledges that existing service capacity is insufficient. The MHP continues to experience difficulties in recruiting medical specialties, including psychiatrists and nurse practitioners. The MHP is experiencing more difficulties in recruiting and retaining clinicians due to demand from other health care employers. The MHP has higher PRs for many specialty mental health services than the Large MHP and statewide averages. 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.

Table 4—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP utilizes contract agencies for 79% of service capacity. DMC and federal Substance Abuse and Prevention Treatment (SAPT) Block Grant services are provided through the MHP and integrated with mental health. The MHP has a strong relationship with CWS on *Katie A*. The MHP has 40 PERTs which pair with law enforcement officers. The MHP has implemented Faith Based Councils and the CSEC Protocol. The MHP participates with prescribers, pharmacies, HHSA and County Medi-Cal fiscal intermediaries in the Antipsychotic Drugs for Minors program.

**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	PC	The MHP's standard is 8 days for adults and 5 days for children. Average wait times in the MHP's Self-Assessment of Timely Access (STA) was 5.15 days for FY 14/15 – 7.3 days for children and 3 days for adults. The children's time exceeded the MHP's 5 day goal. The MHP only included 6 months of data. The MHP did not describe either their previous or current methodology to calculate this measure. It is unclear if this measure only includes initial contacts through the MHP's Access and Crisis Line (ACL) or if it also includes consumers who are provided referrals from "walk-in"/other clinics and who schedule their own appointments. The MHP needs to clearly identify all consumers who "initially request" services.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	FC	Average wait times in the timeliness self-assessment (TSA) was 12.25 days for FY 14/15 – 18.6 days for children and 5.9 days for adults, which is well within the MHP's 30 day goal.
2C	Tracks and trends access data for timely appointments for urgent conditions	PC	The MHP sets a 3 day standard. Timeliness for adults (1.9 days) was significantly better than children (11 days). The MHP only recently began tracking this measure. It is unclear if this measure includes only emergency response (i.e. PERT) or includes other/"walk-in" appointments triaged as urgent. Per federal Medicaid regulations, a 1 day or less standard is required for emergency response.

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP's 7-day follow-up rate is slightly better than the statewide rate. The MHP's 30-day rate is slightly below the statewide rate. Both rates decreased from CY13. It is unclear how the MHP defines total hospital admissions (10,606) for this measure. The MHP lists only 2,698 total hospital admissions in the Readmissions measure below. CalEQRO's Approved Claims Data has 3,256 Medi-Cal hospital admissions for CY14.
2E	Tracks and trends data on rehospitalizations	FC	The MHP reports 12% hospital readmissions within 30 days in the TSA – including 11% for adults and 17% for children. This represents a reduction from 14.94% last year. This matches CalEQRO Approved Claims Data which shows a drop in re-hospitalization rate from CY13 to CY14.
2F	Tracks and trends No Shows	PC	MHP tracks "No Shows" through their EHR for consumers scheduled for appointments by the MHP's ACL. However, at this time, they cannot track "No Shows" from all access points and types of "No Shows" (i.e. consumer "No-Show", "Consumer Cancelled" and/or provider cancelled. The MHP has not included any performance improvement activities related to "No Shows"

**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	The MHP currently meets or exceeds all requirements of this Subcomponent. The MHP states that they will need more staffing as new data governance mandates become operational.
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. The MHP has long partnered with the University of California San Diego (UCSD) for analysis of systems data, and the development of data tracking strategies including outcomes.
3C	Evidence of effective communication from MHP administration	PC	The MHP communicates through emails, flyers at clubhouses, county facilities, and through posters. Stakeholders report that flyers can be seen in community settings. Contract providers believe efforts are made by the MHP to communicate and provide training and technical assistance. However, contractors still feel that policy decisions are sometimes not transparent and have already been made.
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Some stakeholders participate on the Quality Review Council (QRC), CCRT, the Family and Youth Roundtable and the Family Youth Advisory Committee. CFM and peer voices comes through Recovery Innovations and the Family Youth Roundtable. The CCRT has an advisory board, consisting of a Chairperson (also, the Ethnic Services Manager) and 20 voting members, four Subcommittees, and an Executive Committee. The CCRT meets monthly for 1.5 hours.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	Collaborations exist for all levels of care, including clinic services and specialty programs such as FSPs. Among other organizations, the MHP works with: i) the San Diego Task Force on the Homeless; ii) Council of Community Clinics (representing FQHCs/RHCs/IHCs); iii) San Diego Youth Services; iv) several Native American community based organizations (CBOs); v) Union of Pan Asian Communities (UPAC); vi) Survivors of Torture International (SOTI); vii) Southern Indian Health Council; viii) Elder Multicultural Access and Support Services (EMASS); ix) Chaldean Middle-Eastern Outpatient Services; x) NAMI; and xi) Deaf Community Services of San Diego, and others.
3F	Measures clinical and/or functional outcomes of beneficiaries served	FC	The MHP uses the Child and Adolescent Measurement System (CAMS), Eyberg Child Behavior Inventory (ECBI) and Children's Functional Assessment Rating Scale (CFARS) for all children. The MHP uses the Illness Management and Recovery Scale (IMR), Recovery Markers Questionnaire (RMQ) for all adults. The MHP screens all consumers for SUD, using the Substance Abuse Treatment Scale-Revised (SATS-R) and Adult Personal Experiences Screening Questionnaire (PESQ) for adults; and the Youth PESQ for children. The MHP uses other outcome instruments for special populations. Each program submits quarterly data to the MHP on their outcome tools.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP completes DHCS's bi-annual Performance Outcomes and Quality Improvement [POQI] surveys. The UCSD Health Services Research Center (HSRC) analyzes adult surveys. The UCSD Child and Adolescent Services Research Center (CASRC) analyzes youth surveys. The MHP publishes current annual findings compared to prior year. The MHP often adds county-specific questions or a sub-scale to the POQI.
3H	Evidence of consumer and family member employment in key roles throughout the system	PC	The MHP has 163.8 full-time equivalent (FTE) Family and Peer Support Specialists (F/PSS) hired through contract providers. The MHP's research study showed positive results for the effectiveness of F/PSS in consumer treatment. Family Youth Professional Partners (i.e. FSS) are intended to be included in all *Katie A.* CFTs. No self-identified consumers and/or family members hold leadership positions. There are no civil service positions which are explicitly designated for consumers.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	San Diego refers to their Wellness Centers as Clubhouses. By Region, there are: i) six in the Central Region; ii) two in the North Central Region; iii) three in the South Region; iv) one in the North Coastal Region; and one in the North Inland Region. Many include multiple threshold languages, and all include at least English and Spanish.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - Although the MHP tracks workforce diversity overall, the cultural competency/diversity of MHP Management/Executive staff is not specifically reported.
  - The MHP is unable to successfully refer many M2M consumers to FQHCs/Healthy San Diego due to insufficient service capacity.
  - The MHP is experiencing difficulties in recruiting medical and clinical staff as a result competition from other facilities that are recruiting to meet their own increased demands of ACA Expansion and Mental Health Parity.
- Timeliness of Services

  The "*services journal*" being implemented in the EHR should include the consumer's "initial request/contact" at any MHP program/site regardless of whether the site can schedule an appointment. It should be able to identify urgent, emergent, and emergency services, as well as "No Shows". The MHP states that the "*services journal*" will have the ability to distinguish between urgent, emergent and emergency requests for services, and that a report will be able to be run to identify urgent, emergent and emergency services, as well as "No Shows".
- Quality of Care
  - The MHP possesses an extensive capacity to perform data tracking and analysis.
  - The MHP has long partnered with UCSD for analysis of performance and outcomes data, and for further development of data tracking strategies including outcomes.
  - CFM/peer training and promotional opportunities may need to be increased, especially if the MHP intends to expand the use of F/PSS.
- Consumer Outcomes
  - The MHP utilizes the Adult IMR and RMQ and children's CAMS, ECBI and CFARS scores to show annual system-wide changes in outcomes from consumer intake to discharge.
  - The MHP uses SATS-R, PESQ and CRAFFT to screen and refer consumers to the MHP's SUD programs.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted 3 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 3 focus groups, which included the following participant demographics or criteria:

- Adult Consumer Focus Group
- Parent/Caregiver of Children/Youth Focus Group
- Consumer Focus Group

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

The first focus group was comprised of 15 adult consumers of varied ages, race, ethnicity and gender.

Of the three focus group participants who entered services within the past year, the experience was described as

- Being fairly easy to get services and information
- Therapy and psychiatry were relatively available as needed.
- Familiar about who to contact when in crisis. Most who needed help outside of regular appointments would go to their Clubhouse.

Recommendations arising from this group include:

- Provide more resources for jobs and job coaches.
- Reduce therapist turnover.
- Improve listening skills among staff.
- Allow more time in therapy so consumers don't feel "rushed" to complete treatment.

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*		15
Number/Type of Participants	Consumer Only	12
	Consumer and Family Member	2
	Family Member	-
Ages of Focus Group Participants	Under 18	-
	Young Adult (18-24)	2
	Adult (25–59)	10
	Older Adult (60+)	1
Preferred Languages	English	14
	Spanish	-
	Bilingual_____/_____	-
	Other(s) _____	-
Race/Ethnicity	Caucasian/White	3
	Hispanic/Latino	5
	African American/Black	5
	Asian American/Pacific Islander	-
	Native American	-
	Other(s)_____	-
Gender	Male	8
	Female	5
	Transgender	-
	Other	-
	Decline to state	-

**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

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

The second consumer focus group was comprised of six participants who represented, parents, caregivers and youth.

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

- Positive overall.

- Participants felt that services were beneficial for both their children and themselves.
- Services were timely in that intake assessments were within one week, and therapy was provided within a week to a month.
- All who desired/needed family therapy got it.

For the most part, participants in services more than one year were also satisfied with access, timeliness, and quality. One monolingual caretaker was not able to communicate directly regarding her child due to the lack of bilingual staff. Turnover in therapists was also mentioned as a barrier.

Recommendations arising from this group include:

- Authorize more than 13 sessions of therapy, if needed.
- Hire more bilingual staff.
- Implement more age-appropriate options for staff/providers to participate with youth.
- Continue to offer parent support and therapy.
- Expand access to mental health services in more community settings.
- Improve medication management.

Table 7B displays demographic information for the participants in group 2:

Table 7B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants*		6
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	- 6 -
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	- - 6 -
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	6 - - -

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Race/Ethnicity	Caucasian/White	-
	Hispanic/Latino	4
	African American/Black	1
	Asian American/Pacific Islander	1
	Native American	-
	Other(s)_____	-
Gender	Male	-
	Female	6
	Transgender	-
	Other	-
	Decline to state	-

**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 2: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The third consumer focus group was comprised of ten young adult consumers of varied race, ethnicity and gender.

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

- Liberating, useful, helpful and mind and habit changing.
- Most participants received services within two days and said information was readily available. The frequency of appointments is sufficient for most.
- Almost all receive therapy weekly or every other week.
- All agreed they are improving. Most had experienced positive changes to services in the last year.
- No participants were aware of behavioral health resources outside their regular therapy that they could access for extra help.
- Many were concerned about housing issues.

Recommendations arising from this group include:

- Allow more time in therapy so consumers do not feel "rushed" to complete treatment.

- Provide therapy in a more private space when provided at home.
- Increase access to consumer peers in the participants' age range.

Table 7C displays demographic information for the participants in group 3:

Table 7C—Consumer/Family Member Focus Group 3		
Category		Number
Total Number of Participants*		10
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	10 - -
Ages of Focus Group Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	- 10 - -
Preferred Languages	English Spanish Bilingual_____/_____ Other(s) _____	10 - - -
Race/Ethnicity	Caucasian/White Hispanic/Latino African American/Black Asian American/Pacific Islander Native American Other(s)_____	6 4 2 - 3 -
Gender	Male Female Transgender Other Decline to state	6 4 - - -

**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 3: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care

  - Perceived short therapy sessions as well as limits on the number of treatment sessions authorized translate to consumers feeling rushed.
  - Improve medication management.
- Timeliness of Services
  - Most consumers were satisfied with the frequency of visits.
  - Staff turnover has the potential for slowing timeliness.
- Quality of Care
  - Increasing the availability of peer supports would improve the experience of those participating in services.
  - Therapist turnover has implications for quality of care in that consumers are repeatedly experiencing changes in therapists.
  - The availability of more bilingual staff would improve the experience for those for whom English is not their first language.
- Consumer Outcomes
  - Respondents seemed to believe that services were beneficial for both their children and themselves.

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	15.32%
Contract providers	79.59%
Network providers	5.09%
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:

33%

- 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:

- The MHP breaks out its COD rates by Youth and Adult as well as providing the aggregate rate above.
- The MHP calculates penetration rates every three years for larger scale analyses but also does some targeted calculations more regularly for smaller targeted reports. The MHP does not appear to do system-wide PR analysis on a regular and timely basis.

CURRENT OPERATIONS

- The MHP uses the Cerner Community Behavioral Health (CCBH) software in remote hosted mode for its practice management and EHR needs. It also uses Cerner Millennium for its IP consumers. Adult outcomes data is collected via the UCSD Health Outcomes Management System (HOMS) platform which is web-based.
- Data is currently extracted from the CCBH platform for a variety of analyses and operational uses.
- The MHP's level of IT staffing remains stable at five and the ASO has increased IT staffing from four to five in the past year. Neither of these numbers reflects the number of data analyst staff currently working on the MHP's data store to extract information from the MIS.

MAJOR CHANGES SINCE LAST YEAR

- The MHP successfully migrated CCBH to Remote Hosting at Cerner's data center.
- Successfully implemented ICD-10 requirements.
- The MHP resolved CCBH performance issues.
- Implemented the ability to export data to .csv format for reporting efficiencies.
- Successful implementation of Diagnosis at Service.

PRIORITIES FOR THE COMING YEAR

- Begin implementation of HealtheIntent & Ultra-Sensitive Exchange modules for CCBH.

- Special Projects such as Data Integrity.
- Testing and implementation of client signature pads.
- Implementation of CCBH modules to do Meaningful Use.
- Complete change order for CCBH participation with ConnectWellSD.
- Access to Services Journal to facilitate timeliness and other reporting.

OTHER SIGNIFICANT ISSUES

- The MHP leadership encourages a culture of broad based data collection within its System of Care including a consistent adoption of the EHR by MHP staff and contract providers. However, the pervasiveness of the data culture sometimes leads to frustration among staff and contract providers about the burden on their time to meet the documentation requirements. There appear to be divergent perceptions of clinical utility of the data systems between MHP leadership and providers including line staff. The MHP may find it useful to investigate this discontinuity in order to align expectations.
- The MHP appears to utilize tele-psychiatry in a number of its direct service sites. Currently, this function appears to be primarily engaged in the redistribution of existing on-site psychiatrist capacity to maximize in-house utilization. Staff note that they are limited in the amount of tele-psychiatry service time they can use. The MHP does not acquire specialty tele-psychiatry from external providers. The MHP may want to assess the demand, supply and distribution of tele-psychiatry across the MHP.
- While the MHP does have a Data Governance protocol it admits that this effort has had to take a lower priority to some development projects mandated for the EHR such as ICD-10 and Remote Hosting. In spite of a very rich reporting and analysis function, few reports provided to the EQR included interpretational assistance for the wealth of non-clinical stakeholders who have access to reporting resources. Non-clinical staff are thereby forced to draw their own conclusions about reports, if they can, rather than rely on the expertise of the MHP's seasoned cadre of analysis staff. Inclusion of very brief interpretational summaries would heighten transparency to stakeholders and data consumers.

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
CCBH Client Data	Practice Management & Managed Care	Cerner	8	Vendor ASP
CCBH Scheduler	scheduling	Cerner	7	Vendor ASP
CCBH ATP	Assessments, progress notes, TX Plans	Cerner	6	Vendor ASP
CCBH Doctor's Homepage	Medical & eRx	Cerner	4	Vendor ASP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP currently utilizes the Cerner Community Behavioral Health (CCBH) software as its main MIS and has no plans for change.
- The MHP expects to begin implementation of the HealtheIntent and Ultra-Sensitive Exchange modules to facilitate data collection and HIE during the next year. These modules will provide a PHR/Portal function as well.

ELECTRONIC HEALTH RECORD STATUS

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

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Assessments	CCBH/Cerner	X			
Clinical decision support	CCBH/Cerner	X			
Document imaging	CCBH/Cerner	X			
Electronic signature—client	CCBH/Cerner			X	
Electronic signature—provider	CCBH/Cerner	X			
Laboratory results (eLab)				X	

Table 10—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Outcomes	CCBH/Cerner	X			
Prescriptions (eRx)	CCBH/Cerner	X			
Progress notes	CCBH/Cerner	X			
Treatment plans	CCBH/Cerner	X			
Summary Totals for EHR Functionality		8	0	2	0

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

- The move to the Remote Hosted ASP model for the EHR provided upgrades in reliability, performance and workflow around authorization and training. These improvements were confirmed by multiple focus groups.
- The MHP has been testing consumer signature pads but has yet to settle on a product or and implementation timeframe.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - While a variety of stakeholders described the added complexity of care access because of the ACA they also praised the ubiquitous nature of EHR documentation as a benefit to the intake process and care coordination in a complicated System of Care.
- Timeliness of Services
  - The System of Care is well aware of the shortages of psychiatrists but the MHP seems hesitant to bolster timeliness to psychiatric service with the use of targeted externally sourced supplemental tele-psychiatry provisioning.
  - The MHP needs to complete implementation and develop tracking and reporting capabilities for the "*services journal*" that can reliably identify and track: i) "initial request/contact" for all consumers; ii) first request/determination of need for medication evaluation; iii) urgent versus emergent and emergency services; and iv) defining and calculating "No Shows" – from any initial point of contact with the MHP, including, but not limited to, consumers who are provided referrals from "walk-in"/other clinics and schedule their own appointments.
- Quality of Care

- The MHP's current data collection paradigm for outcomes measures, while beneficial for large administrative and research projects, does not lend itself to seamless integration of these work tools within the front-line clinical workflow.
- The MHP does not, as yet, appear to be broadly exploiting its electronic prescribing data for harm reduction investigations such as national HEDIS measures.

- Consumer Outcomes
  - The MHP is able to successfully utilize longitudinal outcomes tool findings to right size service delivery to consumers thereby ensuring optimal recovery potential.

SITE REVIEW PROCESS BARRIERS

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

- None.

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 MHPs robust use of its EHR facilitates access and care coordination across the System of Care.
  - The MHP is continuing to increase youth and adult forensic services during and after incarceration.
  - Implementation of the "*services journa*l" should allow the MHP to more accurately monitor consumer access at all programs.
- Opportunities:
  - The MHP should assess the impact ACA has had on access, with special focus on contract providers.
  - FQHCs and Healthy San Diego currently appear limited in their ability to accept referrals of M2M consumers from the MHP.

Timeliness of Services

- Strengths:
  - The MHP continues to maintain tracking for consumers discharged from an inpatient setting.
- Opportunities:
  - The "services journal" should include all initial requests for services from all MHP programs, separately track urgent and emergency service requests, and calculate "No Shows" for all consumers, including those provided referrals.
  - The MHP needs to assess the broad use of tele-psychiatry to supplement service provision.

Quality of Care

- Strengths:
  - The MHP has successfully conducted research to validate the effectiveness of Peer Support to heighten consumer recovery.
  - The MHP has effectively implemented *Katie A.* The MHP anticipates implementing: i) a CFT Training module; ii) a CFT Meeting identifier in the EHR; iii) expansion of *Katie A.* services to TAY; and iv) linkage of *Katie A.* to the State's Continuous Care Reform (CCR) initiative for foster care group homes.
  - The MHP is trying to reduce hospital recidivism by increasing follow-up after hospital discharge through expanded "walk-in" clinics and F/PSS as navigators (e.g. the Next Steps program, NAMI "Friends in the Lobby", etc.).
- Opportunities:
  - Few reports provided by the MHP include brief interpretational summaries for non-clinical stakeholders. These should be included so that non-clinical stakeholders don't have to guess what reports should tell them.

Consumer Outcomes

- Strengths:
  - The MHP is regularly able to assess the effectiveness of its System of Care using its validated outcome tools. Activities like right sizing treatment are a regular part of MHP due diligence.
- Opportunities:
  - The MHP should consider ways in which to enhance use of tele-psychiatry for improving clinical outcomes.

RECOMMENDATIONS

- Maintain two active PIPs, one Clinical and one Non-Clinical. MHP should consult with EQRO early in the process for technical assistance on topic development and methodology.
- Implement the "*services journal*" to accurately track all "initial contacts", urgent versus emergency services, and "No Shows" to standardize timeliness measures. Publish the methodology (i.e. numerator, denominator and data elements used from the Health Record Layout for each timeliness measure) for each timeliness measure to support the proposed "1915(b) Data Dashboard".

- Investigate and remediate the differing perceptions between MHP administration and service providers concerning the clinical and administrative benefits and liabilities of the current level of clinical documentation, data collections and outcomes tools used.
- Investigate how to better use externally provided tele-psychiatry to supplement psychiatric capacity. As models, the MHP could consider ONC best practice recommendations and the experience of local peers like Kern to serve as guides.
- Move towards implementation of HeatheIntent (or ConnectWellSD if more appropriate) in collaboration with Optum, HHSA, Healthy San Diego and Cerner, to create interoperability for referral and scheduling of consumers between the MHP and Healthy San Diego/FQHCs.

ATTACHMENTS

Attachment A: Review Agenda

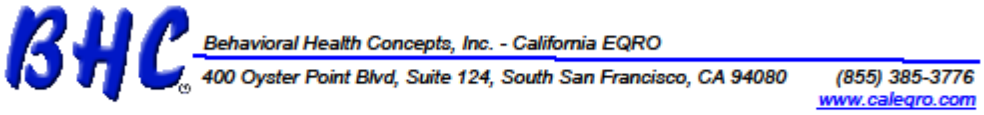
Attachment B: Review Participants

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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San Diego County
MHP CalEQRO Agenda

Day 1 Tuesday, January 12, 2016

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:** Tabatha Lang; Alfredo Aguirre; Holly Salazar; Piedad Garcia; Michael Krelstein; Yael Koenig; Laura Vleugels; Patti Groulx; Liz Miles; Dasha Dahdouh; Chris Strows; Katie Rule; Lavonne Lucas; Junida Bersabe; AnnLouise Conlow; Steve Jones; Danyte Mockus-Valenzuela; George Scolari (Healthy San Diego); Raul Loyo-Rodriguez; Judi Holder (Recovery Innovations); Donna Marto (Family and Youth Roundtable); Shannon Jaccard (NAMI); Carol Neidenberg (CCHEA); Mike Phillips (JFS); Michelle Galvan (Optum); Steve Tally (HSRC); Amy Chadwick (CASRC). EQRO Team: All 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 **Participants:** Tabatha Lang; Alfredo Aguirre; Holly Salazar; Piedad Garcia; Michael Krelstein; Yael Koenig; Laura Vleugels; Patti Groulx; Liz Miles; Dasha Dahdouh; Katie Rule; Lavonne Lucas; Junida Bersabe; AnnLouise Conlow; Steve Jones; Danyte Mockus-Valenzuela; Raul Loyo-Rodriguez; George Scolari; Steve Tally (HSRC); Amy Chadwick (CASRC); Judi Holder (Recovery Innovations); Donna Marto (FYRT); Shannon Jaccard (NAMI); Carol Neidenberg (CCHEA); Mike Phillips (JFS); Michelle Galvan (Optum). EQRO Team: All Location: 3255 Camino Del Rio S., San Diego, CA, La Jolla Room
9:45 am - 10:00 am	Break

Page 1 of 7 *Final Agenda*

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Gale Berkowitz, Quality Reviewer
Saumitra SenGupta, Quality Reviewer
Duane Henderson, Information Systems Reviewer
Richard Hildebrand, Information Systems Reviewer
Deb Strong, Consumer/Family Member Consultant
Nosente Uhuti, 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

San Diego County Behavioral Health Services
3255 Camino Del Rio South
San Diego, CA 92108

CONTRACT PROVIDER SITES

Catalyst
7986 Dagget Street
San Diego, CA 92111

Participants Representing the MHP

Name	Position	Agency
Name	Position	Agency
Alfredo Aguirre	Director, BHS	HHSA-BHS
Amanda Lance-Sexton	BHS Pathways to Well Being Liaison	HHSA-BHS
Amy Chadwick	CYF Outcomes & Reporting	CASRC
Ana Briones-Espinoza	Director of Finance & Operations	Optum
Andrea Carlin	Supervisor	SFS Patient Advocacy Program
Ana Briones-Espinoza	Director of Finance & Operations	Optum
Andrea Carlin	Supervisor	SFS Patient Advocacy Program

Name	Position	Agency
Andrew Sarkin	Director of Evaluation Research	UCSD HSRC
Angela Rowe	Program Manager	Vista Hill-Incredible Families
AnnLouise Conlow	Sr MIS Manager	HHSA-BHS
Anselma Danque	Associate Accountant	HHSA-BHS
Aracelli Diaz	Youth Support Partner	Families Forward
Becky Lanier	CWS Pathways to Well Being	CWS
Betsy Knight	AOA Program Coordinator	HHSA-BHS
Bill Simpson	Program Manager	CRF NVFS
Bobbi Cannon	Case Manager & Clinician	CAC-Crisis Action & Connection
Brenda Estrada	Program Manager	CRF-MAST
Bret Vedder	Admin Analyst III	HHSA-BHS
Cara Evans Murray	Behavioral Health Program Coordinator, CYF	HHSA-BHS
Carlos Hernandez	Program Services, Assistant Manager	NAMI
Carol Burns	Clinical Supervisor	UPAC
Cecily Thornton-Stearns	BHPC	HHSA-BHS
Celeste Hunter	Family Support Partner	WPAC/ACE Program & CASRC
Charity White-Voth	Program Coordinator	HHSA-BHS
Chona Penalba	Principal Accountant	HHSA-BHS
Chris Strows	AA III	BHS QI PIT
Christopher Guevara	AA I	BHS QI PIT
Dan Maccia	Program Manager	CRF Vista Balboa/START
Danyte Mockus-Valenzuela	Prevention & Planning Manager	HHSA-BHS
Dasha Dahdouh	Research Analyst, QI, PIT	HHSA-BHS
Debbie Malcarne	Behavioral Health Program Coordinator	HHSA-BHS
Donna Marto	CYF Liaison	Family and Youth Roundtable
Emily Trask	Senior Mental Health Consultant	USCD CASRC
Eric Camerino	Admin Analyst II	BHS QI PIT
Erika Hess	Senior Mental Health Clinician	Survivors of Torture
Erin Jensen	AOA Analyst	HHSA-BHS

Name	Position	Agency
Erin Ryan	Program Manager	MHS - NCMHC
Francine Edwards	Chief, Juvenile Forensics	HHSA-BHS
George Scolari	Behavioral Health Manager	Healthy San Diego
Green Wells	CWS Pathways to Well Being	CWS
Heidi Stern-Ellis	Clinical Supervisor	Chadwick Center
Holly Salazar	Assistant Director, BHS	HHSA-BHS
Janet Cacho	QM Specialist	HHSA-BHS
Jean Avila	Manager, Perinatal Services	HHSA-BHS
Jo Ann Scott	Senior Psychiatric Social Worker	BHA/ECMHC
Josh Snyder	Therapist	San Diego Center for Children
Joshua Turov	Program Manager	North County Lifeline
Junida Bersabe	Principal Administrative Analyst	HHSA-BHS
Kassandra Fears	Therapist	North County Lifeline
Katie Cabral	Program Evaluation Specialist	UCSD HSRC
Katie Rule	Management Fellow, CAO Staff Officer	HHSA-BHS
Kristi Lee	Analyst PIT	HHSA-BHS
Kya Barounis	Senior Researcher	USCD CASRC
Latysa Flowers	Family Support Specialist	Say San Diego
Laura Colligan	BHS Manager	HHSA-BHS
Laura Vluegels, MD	Supervising Child & Adolescent Psychiatrist, CYF	HHSA-BHS
Lavonne Lucas	Medical Claims Manager	HHSA-BHS
Leah Aguirre	Lead Clinician	SDYS
Liz Miles	PAA, QI, PIT	
Lizeth Tapia	AA III	BHS AOA SOC
Maggie Knight	Therapist	Rady Children's KidSTART
Mark Griego	Family Support Partner	San Diego Center for Children
Marlene Acots	Peer Support Specialist	RI International
Michael J. Bailey	Medical Director	Optum
Michael Kreilstein, MD	Medical Director	HHSA-BHS

Name	Position	Agency
Michael Miller	Behavioral Health Program Coordinator, CYF	HHSA-BHS
Michelle Galvan	Executive Director	Optum
Michelle Ruby	Program Manager	County ECMH
Miguel R Alcorta	Senior Business Analyst	Optum
Mike Phillips	Director	JFS
Minola Clark Manson	BHETA Program Manager	Academy for Professional Excellence
Nicole Fenton	Program Manager	CRF-Heartland
Nilsa Rubenstein	Data IT Analyst	Optum
Patti Groulx	Revenue & Budget Manager	HHSA-BHS
Paulina Martinez	ASM II, ACS/BHS	HHSA-BHS
Perla Arroyo	AB 109 Lead	CRF MSWRC
Piedad Garcia	Deputy Director	HHSA-BHS
Polina Bryson	Clinical Supervisor	CRF MSWRC
RhaeLynne Scher	Program Manager	SBCS
Rose Woods	BHETA	Academy for Professional Excellence
Roseann Myers	CWS Deputy Director	CWS
Sarah Hiller	Research Associate	UCSD HSRC
Shannon Jaccard	CEO	NAMI
Sherry Wilkins	AB 109 Clinical Manager	Exodus
Skylar Hayes	Lead Reporting Services	Optum
Sonia Curtis	Senior Parent Partner	San Diego Center for Children
Stacy Thompson	Peer Run Services, Customer Service Specialist	RI International
Steve Jones	QI	HHSA-BHS
Steve Tally	A/OA Outcomes & Reporting	UCSD HSRC
Steven Wells	Pathways	CWS
Susan Gates	Peer Liaison	RI International
Suzanne Gothard	Discharge Coordinator	New Vistas Community Research Fdn.
Tabatha Lang	Chief, Agency Operations	HHSA-BHS
Tammi Jackson	Family Support Partner	Family and Youth Roundtable

Name	Position	Agency
Tesra Widmayer	Research Analyst	BHS QI PIT
Trisha Patel	Therapist	UPAC
Wendy Maramba	Chief, CYF	HHSA-BHS
Yael Koenig	Deputy Director, CYF	HHSA-BHS

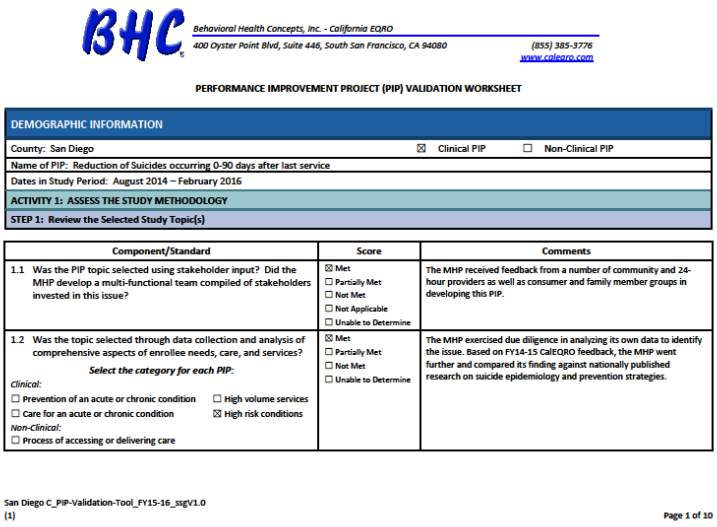
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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:



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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: San Diego	☒ Clinical PIP	☐ Non-Clinical PIP
Name of PIP: Reduction of Suicides occurring 0-90 days after last service		
Dates in Study Period: August 2014 – 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	The MHP received feedback from a number of community and 24-hour providers as well as consumer and family member groups in developing this PIP.
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 MHP exercised due diligence in analyzing its own data to identify the issue. Based on FY14-15 CalEQRO feedback, the MHP went further and compared its finding against nationally published research on suicide epidemiology and prevention strategies.

San Diego C_PIP-Validation-Tool_FY15-16_ssgV1.0 (1)

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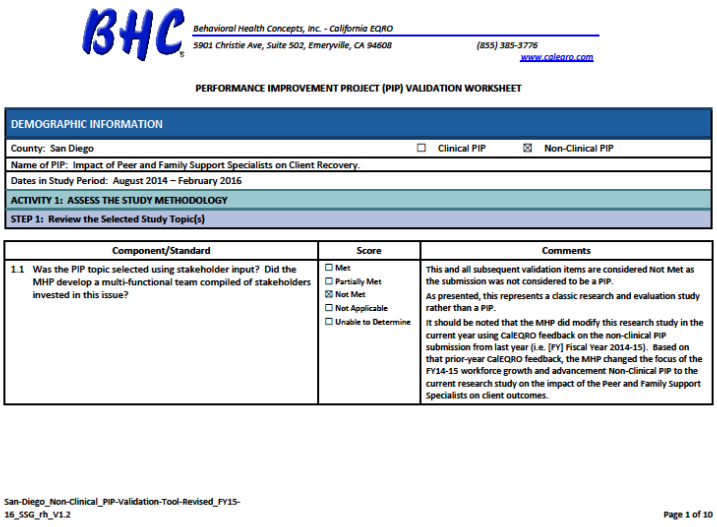
Non-Clinical PIP:



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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.		
Dates in Study Period: August 2014 – 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	This and all subsequent validation items are considered Not Met as the submission was not considered to be a PIP. As presented, this represents a classic research and evaluation study rather than a PIP. It should be noted that the MHP did modify this research study in the current year using CalEQRO feedback on the non-clinical PIP submission from last year [i.e. [FY] Fiscal Year 2014-15). Based on that prior-year CalEQRO feedback, the MHP changed the focus of the FY14-15 workforce growth and advancement Non-Clinical PIP to the current research study on the impact of the Peer and Family Support Specialists on client outcomes.

San-Diego_Non-Clinical_PIP-Validation-Tool-Revised_FY15-16_SSG_rh_V1.2

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