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FY 2018–19 MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA MHP FINAL REPORT

Prepared for:

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

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Contra Costa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Bay Area

MHP Location — Martinez

MHP Beneficiaries Served in Calendar Year (CY) 2017 — 15,883

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures¹

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

Performance Improvement Projects²

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

MHP Health Information System Capabilities³

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2017-18

In this section, the status of last year's (FY 2017-18) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2017-18 Review of Recommendations

In the FY 2017-18 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2018-19 site visit, CalEQRO reviewed the status of those FY 2017-18 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY 2017-18

Recommendation 1: Develop a set of effective procedures that are activated upon the loss of psychiatry coverage, bringing on additional resources until a permanent solution can be developed. This includes resolution of telepsychiatry barriers, and development of externally provided telemedicine resources, coupled with locum tenens providers. *(This recommendation is a partial carry-over from FY 2016-17.)*

Status: Partially Met

- The MHP increased wages for independent psychiatry contractors by 20 percent on July 1, 2018. Contracted psychiatrists provide approximately 75 percent of psychiatric services in the MHP.
- The MHP expanded the loan forgiveness program for psychiatrists and nurse practitioners with the priority being to attract psychiatrists. The program is available to existing part-time staff in exchange for increasing their hours of service.
- The MHP also added a full-time child telepsychiatrist to the MHP Central County children's mental health team. The MHP plans to expand the team by an additional 0.5 full-time equivalent (FTE) in April 2019.

- The MHP expects that additional sites will begin using telehealth in 2019.
- In spite of improvements, there remains a shortage of the number of psychiatrists to meet the needs of beneficiaries; this is especially true for children and Spanish-speaking beneficiaries. There are lengthy wait times across the system of care.

Recommendation 2: Include the Office for Consumer Empowerment (OCE) in all aspects of policies and practices, such as direct operations of clinic programs where planned efforts are needed to ensure there are not silos between staff with lived experience and licensed clinical services. Prioritize hiring individuals with lived experience into newly expanded or developed programs such as mobile crisis.

Status: Met

- The MHP's executive team now includes the OCE Manager, a position that includes mental health lived experience as part of the role. OCE inclusion will affect all aspects of behavioral health care delivery including decision-making, hiring practices, policy development and the development of new programming.
- The MHP employs peers and family members in several positions. The MHP designates peer and family member employees as Consumer Support Workers (CSW), Family Partners (FP), and Family Support Workers (FSW).
- The MHP created and filled twelve new CSW positions in 2018. Currently, 60 of 77 the positions are filled.
- The most recent expansion is in the implementation of the mobile crisis response team. This team is comprised of a CSW and a clinician. The team works in shifts and is available to respond to crisis calls.
- The MHP added nine additional FP positions to support the Continuity of Care Reform (CCR).

Recommendation 3: Continue to mature the deployment of EHR resources, including outcomes tools, to all parts of its system of care, but especially contract organizational providers. Attention should be made to prioritize organizational provider access to mental health history and medical data.

Status: Partially Met

- The MHP's response focused heavily on internal improvements for staff and access to clinical information associated with the implementation of Epic EHR, known locally as ccLink.
- The creation of a community based organization (CBO) provider portal is listed as a current priority, but no date was given for the implementation.
- CBO providers currently do not have access to ccLink.

Recommendation 4: Evaluate the results of expanded children’s crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment.

Status: Not Met

- The MHP states that it is undertaking a feasibility study for a short-term residential therapeutic program (STRTP) and a children’s crisis residential program. While this is a positive step, given the immediacy of the need, this approach is limited in its impact on access to services while the MHP carries out the study.
- The data analysis reported was superficial and referenced the need for further analysis.

Recommendation 5: Fully investigate and explore the high percentage of high-cost beneficiaries, then identify relevant actions that show potential for impacting that population.

Status: Partially Met

- The MHP launched a High-Cost Beneficiary (HCB) workgroup in 2018. Currently, the MHP is in the process of analyzing FY 2017-18 data to identify individual predictors of HCB status.
- Much of the MHP response was in the future tense, indicating intentions rather than accomplishments.
- With five percent of beneficiaries accounting for 43 percent of claims, this remains an important issue to understand and address. It limits the MHP’s ability to serve other beneficiaries and may have some bearing on the reported exceptionally long wait times to access services.

PERFORMANCE MEASUREMENT

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

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

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

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

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

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

2. EPSDT POS Data Dashboards:

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

3. Psychotropic Medication and HEDIS Measures:

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

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

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

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

5. *Katie A. v. Bonta*:

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

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

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

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

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2017 by Race/Ethnicity Contra Costa MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	52,576	19.0%	4,361	27.5%
Latino/Hispanic	98,653	35.7%	4,083	25.7%
African-American	40,123	14.5%	3,173	20.0%
Asian/Pacific Islander	32,424	11.7%	815	5.1%
Native American	775	0.3%	86	0.5%
Other	51,572	18.7%	3,365	21.2%
Total	276,122	100%	15,883	100%
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

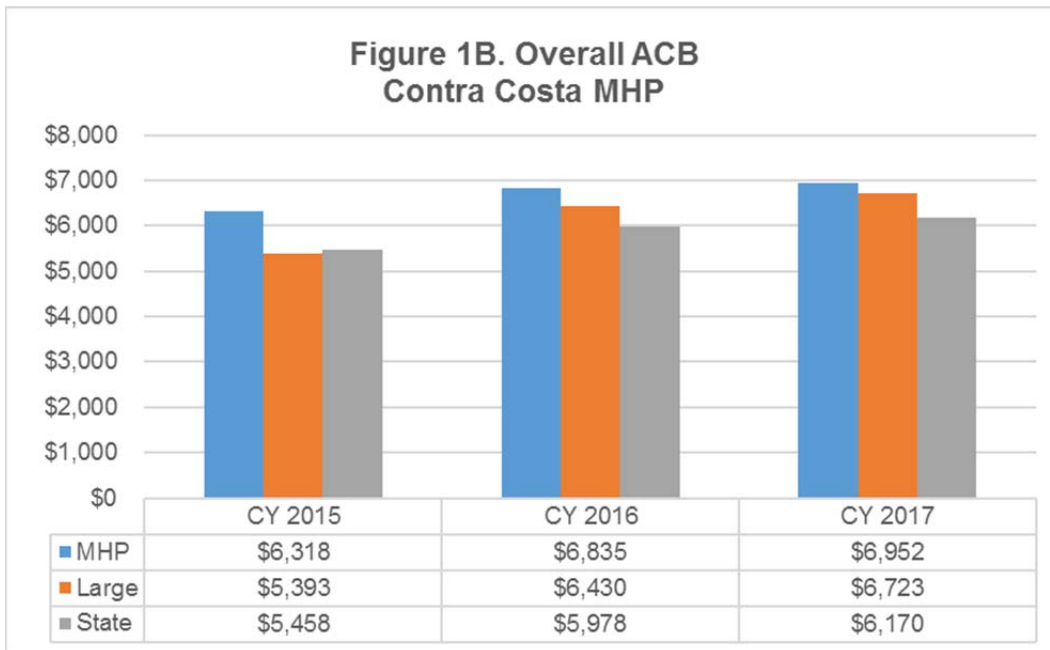
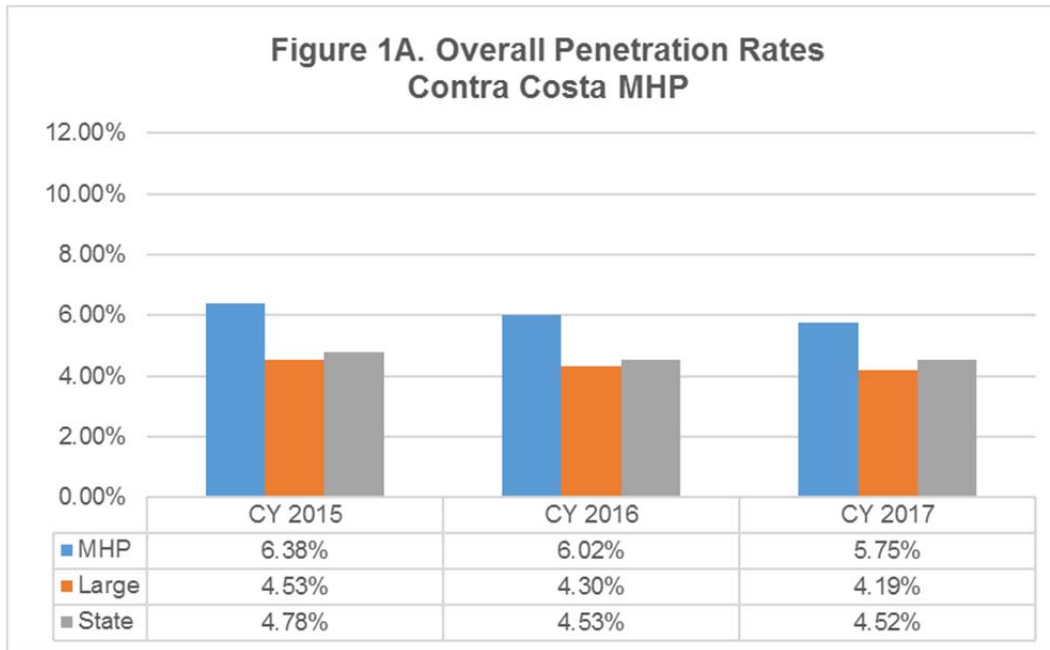
Penetration Rates and Approved Claims per Beneficiary

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

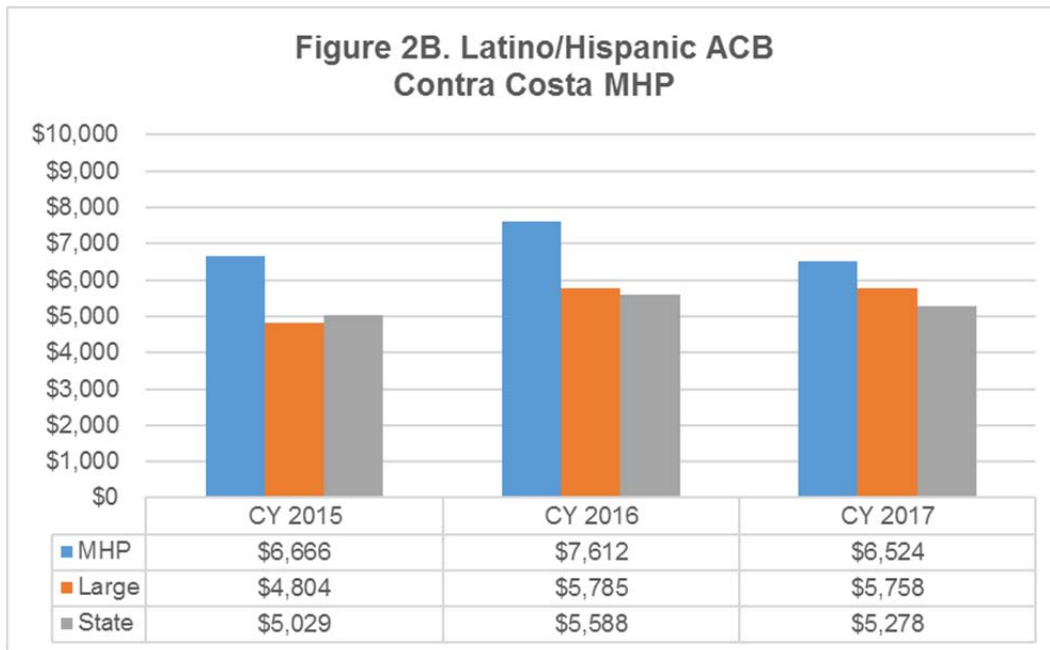
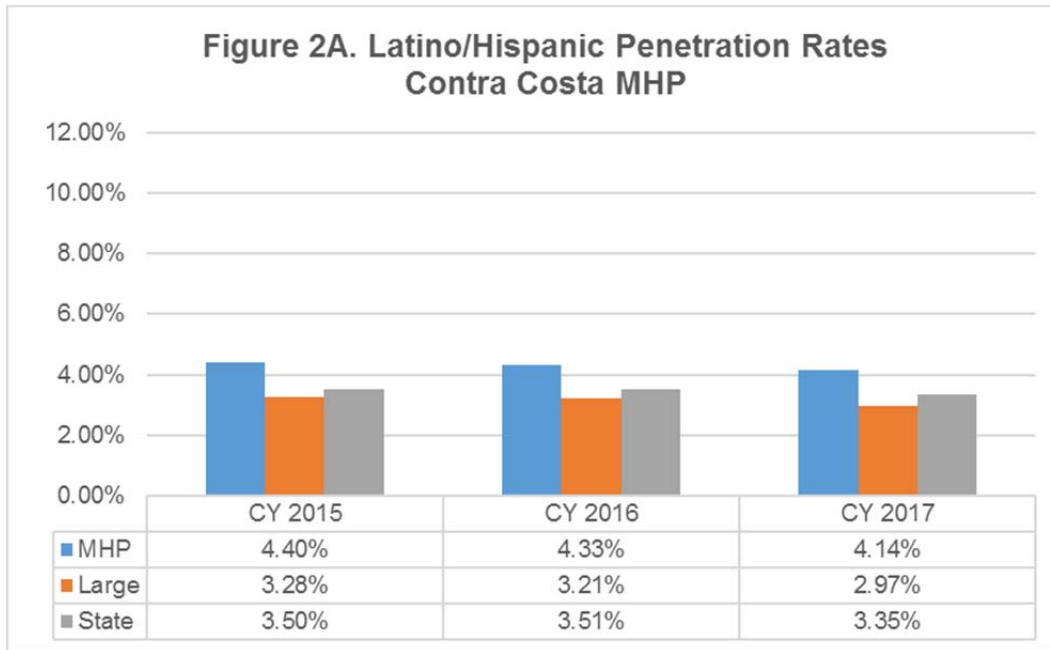
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2017. See Table C1 for the CY 2017 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Contra Costa MHP uses all direct services provided regardless if they were billed or approved to calculate penetration rates.

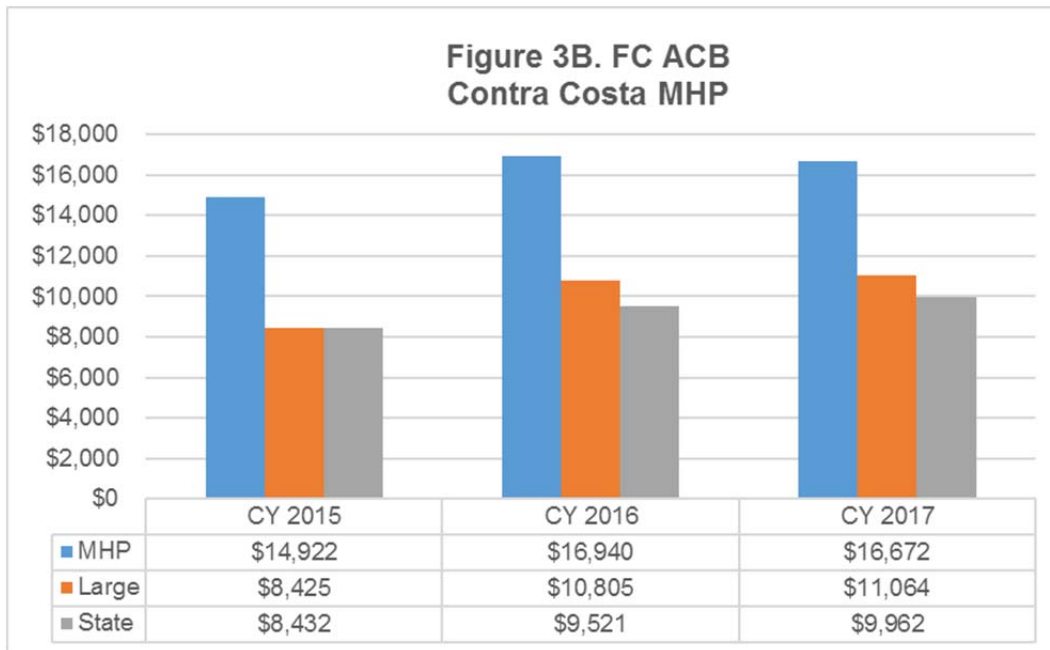
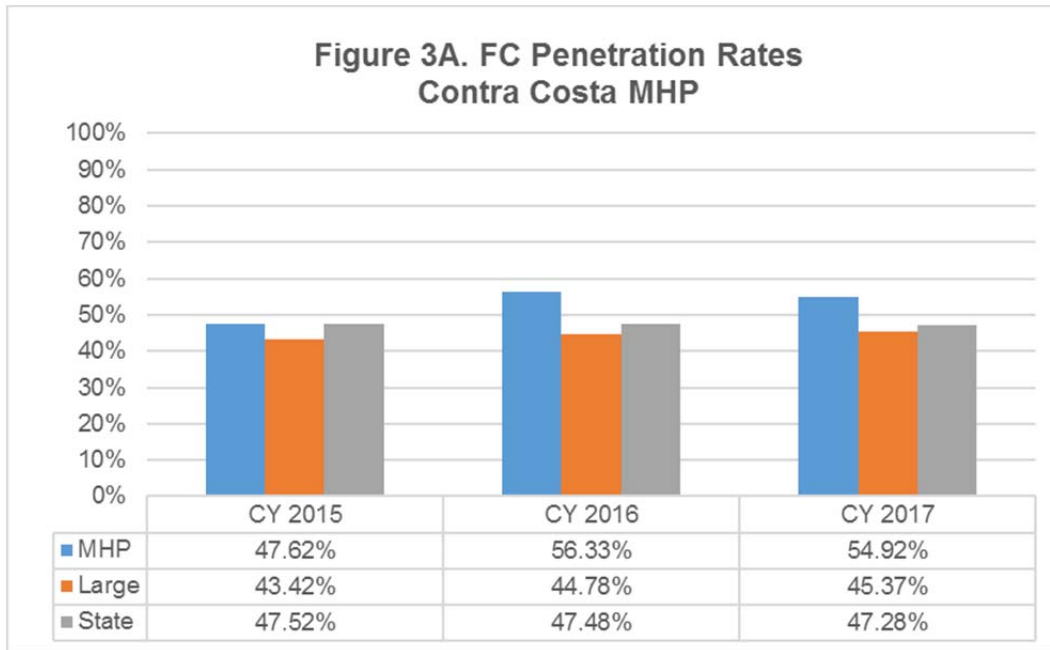
Figures 1A and 1B show three-year (CY 2015-17) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.



Figures 2A and 2B show three-year (CY 2015-17) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.



Figures 3A and 3B show three-year (CY 2015-17) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.



High-Cost Beneficiaries

Table 2 compares the statewide data for HCBs for CY 2017 with the MHP’s data for CY 2017, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than \$30,000 in a year.

Table 2. High-Cost Beneficiaries Contra Costa MHP							
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2017	21,522	611,795	3.52%	\$54,563	\$1,174,305,701	31.11%
MHP	CY 2017	840	15,883	5.29%	\$56,388	\$47,366,301	42.90%
	CY 2016	883	16,930	5.22%	\$60,247	\$53,198,211	45.97%
	CY 2015	808	17,174	4.70%	\$58,015	\$46,875,859	43.20%

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

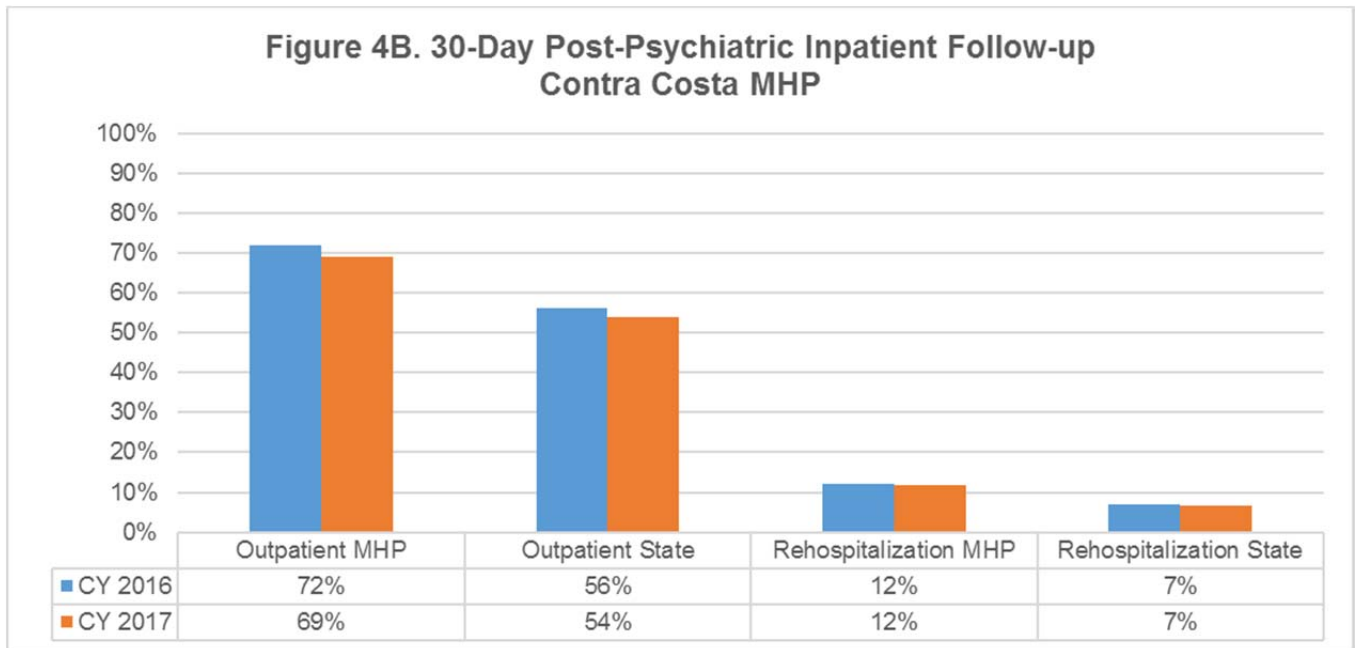
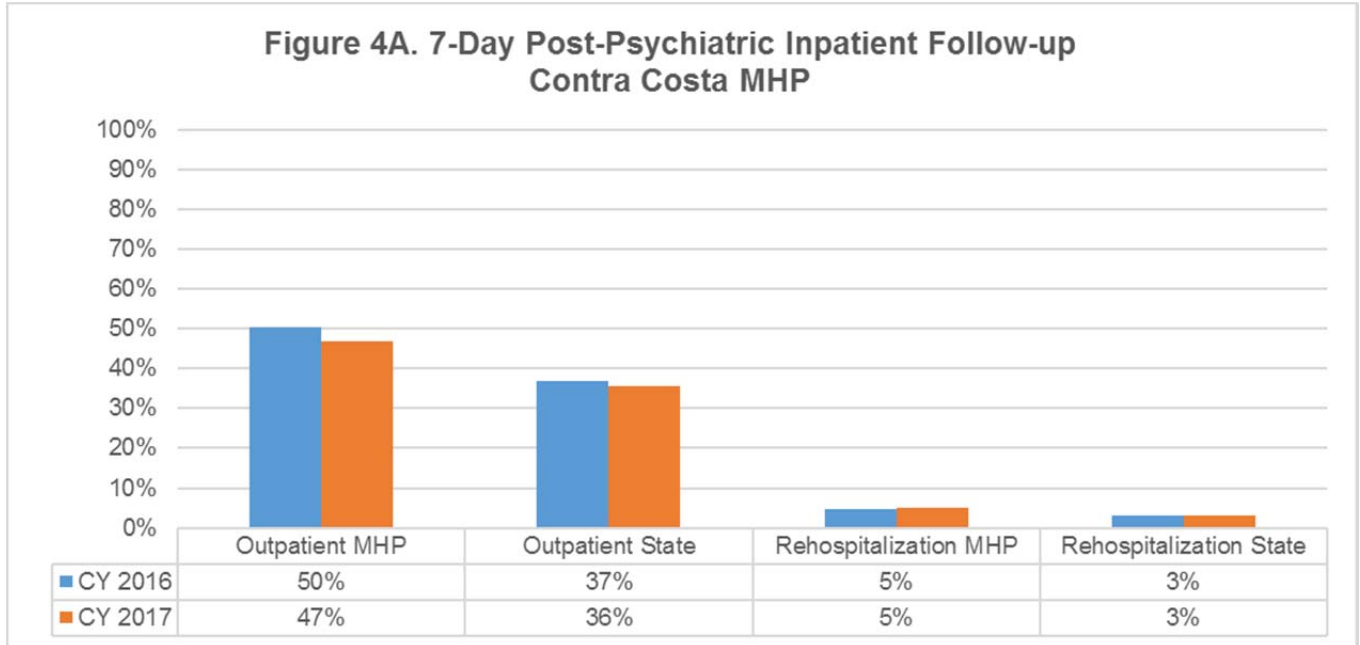
Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2015-17) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 3. Psychiatric Inpatient Utilization - Contra Costa MHP					
Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2017	947	1941	6.23	\$14,090	\$13,343,302
CY 2016	941	1664	6.58	\$13,819	\$13,004,040
CY 2015	795	2007	7.84	\$7,049	\$5,604,180

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

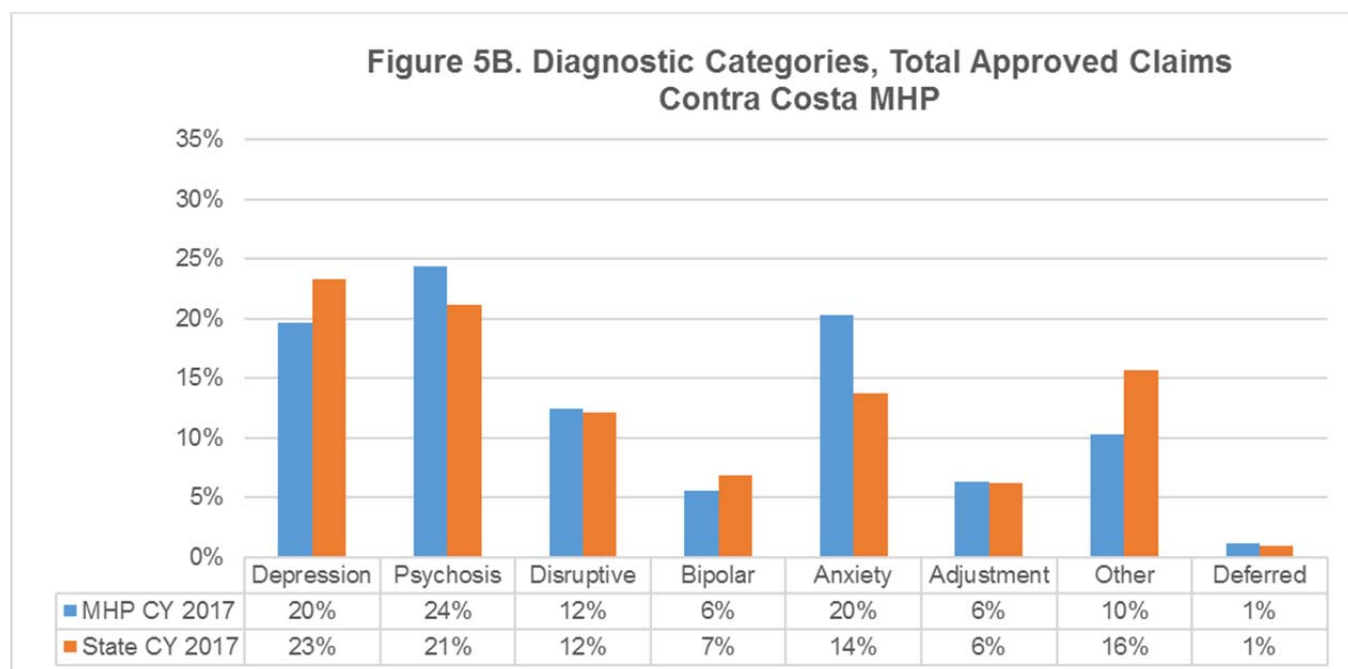
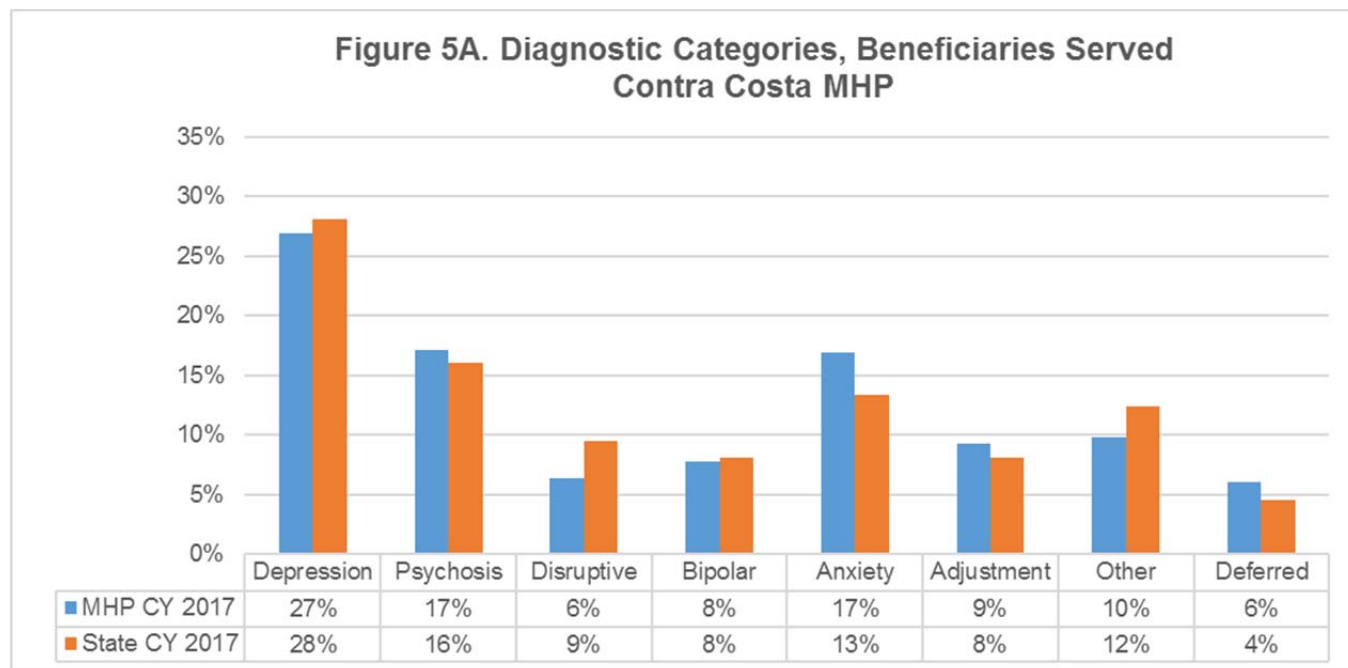
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2016 and CY 2017.



Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2017.

The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 14 percent.



PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Contra Costa MHP PIPs Identified for Validation

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

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.⁵

Table 4: PIPs Submitted by Contra Costa MHP		
PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Redesigning the First Appointment
Non-clinical PIP	1	Improving Appointment Adherence to the First Appointment

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

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

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

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-clinical PIP
Number Met	10	16
Number Partially Met	6	7
Number Not Met	0	0
Unable to Determine	0	2
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16	25
Overall PIP Ratings $((\#M*2)+(\#PM))/(\text{AP}*2)$	81.25%	78%

Clinical PIP—Redesigning the First Appointment

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

“Will re-designing the first assessment appointment to a co-visit with a therapist and psychiatrist result in clients of Contra Costa Mental Health Plan’s (CCMHP) East County Adult Mental Health Services to experience more timely access to psychiatry appointments reflected by the average number of business days from first contact to scheduled appointment not exceeding 15 days?”

Date PIP began: September 2018

Projected End date: September 2020

Status of PIP: Active and ongoing

The clinical PIP focuses on improving timeliness of first contact to first psychiatry appointment and improved coordination of care. The need for this project was born out of a recommendation from CalEQRO and long wait times, especially in the outlying areas of the county. For the period of April 1, 2018 through June 30, 2018, just 38.3 percent of adult appointments met the 15-day standard for timeliness, with the mean number of business days from first contact to scheduled offered appointment being 34.6 days. In the East County Adult Mental Health Services, the mean number of business days to first psychiatry appointment was the highest among the three MHP specialty mental health clinics, being 57.8 days. To address the problem, the MHP utilized the Lean Six Sigma approach to map and identify barriers to access. The MHP implemented the paired scheduling of initial assessments with a clinician and a psychiatrist at its East County Adult Mental Health Services. This intervention, coupled

with automated and warm reminder calls, makes beneficiary access to providers easier and more efficient.

Suggestions to improve the PIP: Given that timeliness is problematic at all locations, the MHP needs to expand the intervention to other sites. Additionally, given the prevalence of psychiatry staffing shortages, it is unclear if the current intervention of paired clinician and psychiatry appointments is a sustainable model for a system with disparate locations. Overall, the MHP described in general the approach for each data element and the method of collection. However, more details on how the MHP maintains the continuity of the data collected and fidelity to its data collection instruments would provide more insight into the actual impact of interventions. Lastly, the MHP's PIP would benefit from a more detailed description of its planned statistical analysis approach.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of recommendations to expand the intervention to additional sites, as well as identification and implementation of new interventions, e.g., increasing telehealth time.

Non-clinical PIP—Improving Appointment Adherence to the First Appointment

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

“Will implementing direct client outreach defined by CSWs/FSWs calling clients one to five days in advance of their initial outpatient mental health appointment utilizing Motivational Interviewing (MI) techniques and linking clients to resources such as Overcoming Transportation Barriers (OTB) program (which fosters transportation independence through educating clients on public transportation options), increase appointment adherence to the initial assessment from 41 percent at the MHP's East County Adult Mental Health Services, and from 35 percent at the MHP's East County Children's Behavioral Health, to 25 percent, to ensure clients receive timely access to mental health services?”

Date PIP began: December 2017

Projected End date: December 2019

Status of PIP: Active and ongoing

The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessments among beneficiaries at the East County adult and children's clinics. To improve appointment adherence, the MHP implemented improved beneficiary outreach practices that incorporate piloting the use of motivational interviewing (MI) for beneficiaries attending initial outpatient mental

health appointments at the East County adult and children's clinics. The intervention involves a telephone call to the beneficiary (or parent/guardian) one to five days in advance of their appointment from a beneficiary/family support worker using MI as the overarching methodology. The call acts as an appointment reminder, answers any beneficiary questions, addresses ambivalence and provides connection to transportation support services.

Suggestions to improve the PIP: Although the MHP chose interventions that were indicated by the MHP's internal 2016 service improvement survey, a more current assessment detailing the causes/barriers to attendance was not conducted. Also, the impact of the calls would be more measurable if the calls were made on a specific day (not a range). Subsequently, when compared, data would possibly provide information on best practices allowing the intervention's success to be duplicated elsewhere.

Information on how the study will address the entire beneficiary population, or a specific sample of that population was not provided, nor was information on how inclusion of all members will occur. While the MHP provided information on planning for untoward results, it only provided minimal information on the approach to data analysis. The PIP would benefit from a more robust data analysis plan that contains a more detailed outline of each step/action taken in the data analysis along with the reasoning behind it. Otherwise, with the PIP population being limited to the East County Adult and Children's Mental Health Services, it is unclear how the methods produce valid and reliable data applicable to the entire beneficiary population.

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

The TA provided to the MHP by CalEQRO consisted of the need for a formal barrier analysis to allow for fine-tuned selection of interventions. Although the MHP assembled the PIP nicely, for future submissions a more detailed data collection and analysis plan would provide greater understanding on the applicability to the system at large.

INFORMATION SYSTEMS REVIEW

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

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

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

The budget determination process for information system operations is:

- Percentage of total annual MHP budget dedicated to supporting IT operations (includes hardware, network, software license, and IT staff): 0.1 percent.

CalEQRO notes that this number is not credible unless the umbrella organization, Health Services Information Technology Department (HS IT), is funding everything. CalEQRO was unable to confirm and the MHP did not provide additional information when asked. If there were any veracity to this, the MHP would not have direct control of any IT assets, making it difficult for the MHP to make impactful improvements to its system of care.

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

Table 7 shows the percentage of services provided by type of service provider.

Table 7: Distribution of Services, by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	27%
Contract providers	61%
Network providers	12%
Total	100%*

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

Table 8 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP’s EHR system, by type of input methods.

Table 8: Contract Providers Transmission of Beneficiary Information to MHP EHR System	
Type of Input Method	Frequency
Direct data entry into MHP EHR system by contract provider staff	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

- Yes No In pilot phase

Number of remote sites currently operational: Two

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

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

- Telehealth services are available with English and Spanish-speaking practitioners (not including the use of interpreters or language line).
- This last year, approximately five telehealth sessions were conducted in Spanish.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by FTE since the previous CalEQRO review are shown in Table 9.

Table 9: Technology Staff			
IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
22	0	1	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 10.

Table 10: Data Analytical Staff			
IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
20.5	5	2	4.5

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

- The technology and data analytical staffing are aligned with resources in the MHP and the HS IT.
- All technology resources are in HS IT with dedicated support to the MHP.
- The MHP’s research/evaluation team has seven planners/evaluators and three of them are recent hires.
- Technology and data analytical staff support both mental health and substance use disorder programs and services.
- There is no position within the MHP that is either clearly identified or generally understood to provide IT leadership. Such a position would, by virtue of direct daily contact with MHP managers and staff, be intimately familiar with MHP operations and its most pressing problems. Combined with a knowledge of the MHPs existing technology assets, and as part of the executive leadership team, this position could help the MHP make more informed decisions about its technology direction and priorities.

Current Operations

- The MHP does not participate in an HIE; however, it is capable of exchanging health information with other organizations that use the Epic EHR using Epic’s CareEverywhere module. Epic is the dominant EHR in the area, so that gives them rather broad coverage, but it does not include the CBOs.
- The MHP implemented Epic HealthLink, known locally as ccLink, in September 2017. In July 2018, the MHP implemented the Echo Group ShareCare to replace its legacy InSyst, also from Echo, as its billing system.
- HS IT manages MHP applications, performs upgrades and provides helpdesk support. HS ITs Business Intelligence Unit (BIU) extracts data from MHP

systems and creates reports, dashboards, and custom data sets for further analysis by MHP planner evaluators.

- MHP planners/evaluators analyze data extracted by BIU and trend utilization and performance metrics; they also support MHP projects.
- A business governance structure with joint participation from the MHP and HS IT was created to triage and prioritize system-related concerns, oversee optimization requests, facilitate change management and prioritize future projects. The potential downside of this arrangement is that all of the technology expertise is one or more steps removed from MHP day-to-day operations and business concerns.
- Discipline-specific champions and super users provide on-site ccLink support at all MHP clinics and programs. Each Super User group meets monthly to identify best methods for promoting EHR-literacy and comprehension among staff, identify possible training needs, and propose system enhancement to improve ccLink workflows and efficiency of use. The Champions meet monthly to review and triage new requests for enhancements and changes to ccLink, and identify possible training needs and areas for communication improvement.
- The MHP has in place a workflow between its EHR (ccLink) and billing system (ShareCare). The two systems are not integrated.
- Clinicians write progress notes into ccLink. Service log reports are generated from ccLink and used to manually enter service data into ShareCare. The MHP does have a reconciliation report which support staff views weekly that shows discrepancies, which are then corrected.
- Another opportunity to review service data is during chart review procedures by Utilization Management unit.

Table 11 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 11: Primary EHR Systems/Applications				
System/ Application	Function	Vendor/ Supplier	Years Used	Operated By
ccLink	Clinical documentation and care coordination	Epic		HS IT
Cadence	Scheduling	Epic	2	HS IT

Table 11: Primary EHR Systems/Applications				
System/ Application	Function	Vendor/ Supplier	Years Used	Operated By
Tapestry	Referral management	Epic	2	HS IT
CPOE	Lab results	Epic	2	HS IT
ShareCare	Billing (new)	Echo Group	0.6	HS IT
InSyst	Billing (old)	Echo Group	16	HS IT
OnBase	Enterprise scanning and document management system	Hyland	1	HS IT
Panoramic	Public Guardian – Conservatorship SAAS	PanaSoft	7	HS IT

The MHP’s Priorities for the Coming Year

- Implement automated data exchange between the MHP Clinical Documentation module in Epic (ccLink) and the ShareCare Billing System. Phase Two of this project will implement EHR clinical documentation for substance use disorders (SUD).
- Integrate the ShareCare billing system with the Epic EHR system to allow collection and maintenance of Electronic Clinical Data for both the MHP and SUD to provide improved clinical documentation and data analysis, treatment, and performance improvements, enhanced timeliness of service, and better beneficiary outcomes. (Pending)
- A 42CFR Part 2 steering committee and governance structure has been established at the MHP. HS IT joins with the MHP to plan and participate in initiatives to address SUD beneficiary privacy issues and 42CFR Part 2 compliance on all IT systems and processes for data exchange.
- Adapt the patient portal, called myccLink, to include additional features for behavioral health beneficiaries. This project should offer beneficiaries greater visibility of their behavioral health information including medication refills, After Visit Summary, and other pertinent behavioral health information.
- Create the CBO Provider Portal. This will allow CBO providers access to beneficiaries mental health services history through ccLink to improve continuity of care and allow for more informed early decision making on behalf of beneficiaries.

- Provide CBOs that deliver services under DMC-ODS with a dedicated secure Provider Portal as part of the ccLink integration project for SUD. This capability is also being implemented for Mental Health system of care. (Pending)
- Begin submitting assessment data to DHCS along with CSI data submissions as required by the State. (Pending)

Major Changes since Prior Year

- InSyst, the MHP's legacy practice management and billing system, was replaced by the ShareCare system in July 2018. ShareCare is producing Medicare, Medical and Commercial Insurance claims and CSI reporting.
- Initiation of all MHP and SUD Consumer Episodes/Encounters (Admissions) are now live on Epic EHR with automatic system integration via HL-7 interface to the ShareCare Billing system for Client Service Entry. As of November, 2018, MHP Services data are now available in both our Epic EHR and ShareCare billing systems.
- The MHP implemented telehealth in the Central Children's Mental Health Program in November 2018 after a pilot in the East County Adult Mental Health Services significantly reduced first psychiatry appointment wait time.
- The Child and Adolescents Needs and Strengths (CANS-50) templates (0-5, 6-21) and Pediatric Symptom Checklist (PSC-35) were added to ccLink and implemented across MHP directly-operated programs in October 2018. CBO providers submit paper forms to the MHP which are scanned into a separate database for reporting purposes. A data management system is under consideration to more efficiently capture CBO CANS-50 and PSC-35 data.
- The Patient Health Questionnaire-9 Item (PHQ-9) and Generalized Anxiety Disorder-7 Item (GAD-7) were piloted in the East County Adult Mental Health Services and a SUD treatment program in July 2018.
- The MHP participated in a variety of DHCS' beta test programs launched on the State's new Behavioral Health Information System (BHIS) platform. These included the re-write and migration of CalOMS system from ITWS to BHIS, online and batch submission of Functional Assessment Screening Tools (FAST) data (i.e., CANS-50 and PSC-35), initial and quarterly ongoing submissions of Network Adequacy Data (NACT), and online monthly submission of Level of Care (LOC) data for SUD.
- In partnership with Contra Costa County's Mental Health Commission, MHP leadership has started building executive dashboards to enable a common understanding of the state of the MHP in seven domains:
 - Requests for service
 - Access to service

- Staffing capacity
- Finance
- Services provided
- Quality assurance
- Areas of interests

Other Areas for Improvement

- Of the seven IT initiatives for the coming year, only two reference CBOs. CBOs deliver 61 percent of services in this MHP, but they seem almost an afterthought for technology-driven service improvement initiatives.
- CBO providers who have EHRs are doing double data entry in ShareCare and their own systems. This raises the cost of service delivery and slows down administrative and billing processes for the CBO. Other counties have successfully established electronic data exchange between the MHPs EHR/billing system and the CBO EHRs.
- None of the initiatives for the coming year address CBO providers' most consistent concerns:
 - Site certification process that can delay opening new service delivery sites for months. When beneficiaries wait as long as six months to begin services, these delays directly impact access to care, timeliness of services, and ultimately outcomes.
 - Clinician credentialing processes that take weeks, even months, and prevent a newly hired clinician from delivering services that can be billed to Medi-Cal. This leads to unplanned use of other funding sources, as well as provider cost of doing business.
 - Service authorization based on hard-copy documents which must be physically delivered to the MHP to initiate a process that can take as much as six weeks. CalEQRO reviewers are not aware of any other county in California that currently uses a similar process.

All three of these issues were cited as obstacles to delivering timely services to beneficiaries. The MHP plans to do a Lean Six Sigma Rapid Improvement Event (RIE) on CBO processes and all three of these processes should be included.

- CBO billing under ShareCare has been problematic, especially for groups and co-therapy sessions. CBOs have had to hire new staff to manage the claiming. Because they did not get clear information regarding business rules at the time of the rollout, they have had to re-enter claims manually back to July 1, 2018. ShareCare was described as a “moving target.”

- ShareCare reports have been released with inaccurate data. In some cases, they showed the agency owed money to the MHP when they did not. It has been very time consuming to get these things corrected.

Plans for Information Systems Change

- Behavioral Health Services has a new system in place, Epic ccLink was implemented in 2017 with Version 2016. Version 2017 upgrades were installed prior to CalEQRO site visit.

Current EHR Status

Table 12 summarizes the ratings given to the MHP for EHR functionality.

Table 12: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	Epic ccLink	X			
Assessments	Forms in Epic ccLink	X			
Care Coordination	Epic ccLink	X			
Document Imaging/Storage	Hyland OnBase	X			
Electronic Signature—MHP Beneficiary				X	
Laboratory results (eLab)	Epic CPOE	X			
Level of Care/Level of Service				X	
Outcomes	CANS-50, PSC-35, RAS, ILSS, PHQ-9, GAD-7	X			
Prescriptions (eRx)	Epic	X			
Progress Notes	Epic ccLink	X			
Referral Management	Epic Tapestry	X			
Treatment Plans	Epic TIP	X			
Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality:		10	0	2	0
FY 2017-18 Summary Totals for EHR Functionality*:		8	1	3	0
FY 2016-17 Summary Totals for EHR Functionality:		3	0	7	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

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

- For the County-operated programs, the MHP decided to integrate the CANS-50 into the initial assessment in ccLink. For contract providers, the MHP modified the initial assessment form so that the assessment and the CANS-50 do not

duplicate information that needs to be gathered. Contract providers who do not utilize EHRs either submit hard copies or scan in forms to the MHP via a shared drive for reporting. Providers with EHRs have the option to mail or scan in forms or submit a .txt file.

- The MHP does not yet use beneficiary electronic signatures.

Personal Health Record (PHR)

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

- Yes In Test Phase No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

- Yes No

If yes, product or application:

Local SQL database, Access database and Excel worksheets.

Method used to submit Medicare Part B claims:

- Paper Electronic Clearinghouse

Table 13 summarizes the MHP’s SDMC claims.

Table 13. Summary of CY 2017 Short Doyle/Medi-Cal Claims Contra Costa MHP							
Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Claim Adjustments	Dollars Approved
422,381	\$124,113,794	11,020	\$3,489,643	2.81%	\$120,624,151	\$14,496,653	\$106,127,498
Includes services provided during CY 2017 with the most recent DHCS claim processing date of May 2018. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2017 was 2.73 percent .							

Table 14 summarizes the top three reasons for claim denial.

Table 14. Summary of CY 2017 Top Three Reasons for Claim Denial Contra Costa MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Medicare or Other Health Coverage must be billed prior to submission of claim.	6,603	\$1,744,730	50%
Beneficiary not eligible. Or emergency services or pregnancy indicator must be "Y" for aid code.	3,535	\$1,289,233	37%
Void/replacement error. Or ICD-10 code incomplete or invalid with procedure code.	346	\$161,583	5%
TOTAL	11,020	\$3,489,643	NA
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- The 50 percent of total denied claims with reason “Medicare or Other Health Coverage must be billed prior to submission of claim” are generally re-billable within state guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who receive services in East County and who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The group was consistent with that requested by CalEQRO. The group was held at East County Children's Behavioral Health, 2335 Country Hills Drive, Antioch, CA 94509.

Number of participants: Nine

The four participants who entered services within the past year described their experiences as the following:

- Participants waited between three and six months for therapy services after assessment.
- Participants waited three months for a psychiatry evaluation.

Participants' general comments regarding service delivery included the following:

- Some words used by participants to describe access and quality of crisis services, including hospitalization, were "scary" and "horrible." The participants reported long delays in authorization for treatment and for transportation, with minimal or no communication with parents/caregivers.
- Participants indicated that Seneca had an after-hours number for support but for others, they were only aware of 911.
- While most received information about medications from the psychiatrist, participants did not feel that the psychiatrist communicated well with the pharmacist and primary care provider.

- Participants reported that they did not have information on the MHP's available services and that the county website is outdated. Clinicians will ask beneficiaries what they might need but most do not know what to ask for because there is no knowledge of what is available.

Participants' recommendations for improving care included the following:

- More activities such as music, dance or other child-centered activities.
- More feedback groups for parents so they can share their experiences.
- More funding for services so beneficiaries do not have to wait so long to start receiving services.
- Improved transportation and services closer to where beneficiaries live.
- Transportation for children to and from the clinic.

Interpreter used for focus group one: Yes Language(s): Spanish

CFM Focus Group Two

CalEQRO requested a culturally diverse group of adult beneficiaries who receive services in East County and who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The group was consistent with that requested by CalEQRO. The group was held at the East County Adult Mental Health Services, 2311 Loveridge Rd., (1st Floor Conference Room) Pittsburg, CA 94565.

Number of participants: Eight

The four participants who entered services within the past year described their experiences as the following:

- The majority of group participants experienced wait-times for assessment from six months to one year.
- Most participants entered services through Psychiatric Emergency Service (PES).

Participants' general comments regarding service delivery included the following:

- Participants see psychiatrists every two to three months.
- Navigating the system is difficult, but case management helps.
- Information on services is not available in an easy fashion.
- Participants were not aware of the wellness center.

- Transportation is an issue; however, in Pittsburgh it is free.
- Participants reported that the MHP is much improved, as compared to other family members' experiences in the past.
- Participants had not been asked to participate on a planning committee.

Participants' recommendations for improving care included the following:

- Improve access to timely therapy services.
- Provide better access to psychiatry appointments for medication changes, including better responsiveness from the care coordinator.
- Provide timely psychiatry appointments.
- Provide one-on-one peer assignment through the clinic to educate and help beneficiaries navigate.
- Hire more culturally competent staff and Spanish-speaking staff to help beneficiaries navigate the system.

Interpreter used for focus group two: Yes

Language(s): Spanish

CFM Focus Group Three

CalEQRO requested a culturally diverse group of Transition Age Youth (TAY) beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The group was consistent with that requested by CalEQRO. The group was held at First Hope, 391 Taylor Blvd, Suite 100, Pleasant Hill, CA 94523.

Number of participants: Ten

The two participants who entered services within the past year described their experiences as the following:

- Participants experienced varied wait-times, up to six months.

Participants' general comments regarding service delivery included the following:

- Participants indicated that if a person is not suicidal, that person cannot get support. Self-harm or harm to others has to be stated to get services.
- Participants reported varying levels of satisfaction with services, which was primarily dependent upon personalities of service providers.

Participants' recommendations for improving care included the following:

- Housing for women without children.

- Therapists who provide longer sessions.
- Increased safety for people of color who have mental health issues by providing education on mental health issues to therapists, teachers, doctors, and law enforcement.
- Allow beneficiaries the choice in whether they are medicated and provide more information on the medications prescribed.
- Provide activities for youth.
- Establish leadership groups at youth homes so they have a say in what activities are planned.
- Monitor housing.
- Provide more resources for lesbian, gay, bisexual, transgender, questioning, and queer (LGBTQ) youth. Shelters are Christian-based and not supportive and/or accepting.

Interpreter used for focus group three: No Language(s): NA

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP’s use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are described below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 15 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 15: Access to Care Components		
Component		Quality Rating
1A	Service accessibility and availability reflective of cultural competence principles and practices	M
<p>The Ethnic Service and Training Coordinator in the BH Operations group oversees the MHP’s Reducing Health Disparities Workgroup and chairs the Training Advisory Work Group. The Reducing Health Disparities Workgroup, which acts as the MHP’s Cultural Competence Committee (CCC), updates the Cultural Competence Plan (CCP) annually.</p> <p>The MHP identifies strategies to address disparities through the stakeholder feedback process at MHSA meetings. The MHP, through an advisory work group, held a community forum on the needs of the immigrant community to address fear and anxiety within the culture. The MHP administered a post-evaluation survey to over 100 attendees (January 2019).</p> <p>Stakeholder feedback confirms that the MHP identifies the cultural and linguistic needs of its beneficiaries, but that barriers exist to addressing them. These include lengthy hiring processes, a minimal bilingual pay differential, and limitations on the length of employment of interns (no more than one year).</p>		
1B	Manages and adapts its capacity to meet beneficiary service needs	PM
<p>The MHP monitors system demand caseload numbers and hospital admissions, LOS, and discharge data; however, the MHP did not provide evidence of any data-driven</p>		

Table 15: Access to Care Components		
Component		Quality Rating
<p>system change. The MHP has the ability to utilize a caseload system for distribution of beneficiaries by level of care and service type; however, there are gaps in service provision, namely with the connection to ongoing services after assessment. Credentialing of service locations and/or providers cause significant problems for service access.</p> <p>Service authorization processes contribute to timeliness issues including services through Access, a screening and referral call center. Paper-based referral processes required of the CBOs delay access to routine outpatient treatment. Further, CBOs do not have access to the EHR nor have a method of secure referral exchange.</p> <p>The MHP addressed capacity through the addition of psychiatrists and an expansion of telehealth. Additionally, the average number of available appointments has increased. Scheduled telehealth appointments increased from 20 in March 2018 to 205 in October 2018. The MHP expanded its children’s crisis service hours as well. To address staffing issues, the MHP participated in the Mental Health Loan Assumption Program through California's Office of Statewide Health Planning and Development (OSHPD) to provide scholarships for line staff at the county and CBO level.</p>		
1C	Integration and/or collaboration with community-based services to improve access	M
<p>The MHP collaborates with a variety of community-based services. They are in the planning stages of implementing a housing program, No Place Like Home, in partnership with the Health, Housing and Homeless Services division and the Department of Conservation and Development.</p> <p>Also, Child and Family Services (CFS) and MH are collaborating closely around the implementation of CCR in a number of work groups and at all levels. MHP and CFS renewed the Interdepartmental Agreement (IDA) that forms the basis for data sharing between CFS and MH. The MHP also developed and implemented a mobile crisis response team for adult beneficiaries, which went live in July 2018; it is county-operated and managed by the forensic program. This collaboration also involves coordination with local law enforcement and fire departments.</p>		

Timeliness of Services

As shown in Table 16, CalEQRO identifies the following components as necessary to support a full-service delivery system that provides timely access to mental health services. This ensures successful engagement with beneficiaries and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 16: Timeliness of Services Components		
Component		Quality Rating
2A	Tracks and trends access data from initial contact to first offered appointment	PM
<p>The MHP, as mandated by DHCS, adopted the NACT standards and complies with quarterly submissions of NACT data; however, the MHP does not collect or require its contract providers to submit timeliness data nor do CBOs have access to the EHR to enter timeliness data.</p> <p>The MHP is able to offer most assessment appointments within the 10-day standard for adult and children’s services. For adults, 95 percent of offered assessments fall within 10-days. For children, 81 percent of offered assessments fall within 10 days. However, for foster care, only 26 percent of offered assessments meet the standard. However, very few FC assessment appointments meet the standard. Likewise, for the older adult program, only 10 percent of the appointments meet the standard.</p> <p>Most kept appointments meet the 10-business day standard. However, a low proportion of FC and older adult kept appointments meet the standard. For adults, 83 percent of kept assessments fall within 10-days. For children, 81 percent of kept assessments fall within 10 days. However, for foster care, only 33 percent of kept assessments meet the standard.</p> <p>Stakeholder feedback indicates that after an assessment, there is a long wait time for therapy, from six months to one year for adults, and over three months for children.</p>		
2B	Tracks and trends access data from initial contact to first offered psychiatric appointment	PM
<p>Overall, 41 percent of first offered psychiatry appointments meet the 15-business day standard. However, there is marked differences between the MHP sites. For example, nearly 40 percent of appointments at Central County adult services meet the standard, as compared to 14 percent at East County and 68 percent at West County. Likewise, for children Central County is at 27 percent, with East County at 57 percent and West County at 83 percent.</p> <p>The MHP initiates performance improvement activities, but they are not system-wide.</p>		

Table 16: Timeliness of Services Components		
Component		Quality Rating
2C	Tracks and trends access data for timely appointments for urgent conditions	PM
<p>The MHP reported that for adults, 73 percent of urgent service requests met the 2-business day standard. Although, the MHP refers children with urgent appointment requests to the Miller Wellness Center for immediate service needs, the MHP did not provide data on children’s services.</p>		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	PM
<p>Between January 2018 and June 2018, there were 587 discharges. Overall, 56 percent of the discharge appointments occurred within the 7-day standard.</p>		
2E	Tracks and trends data on rehospitalizations	M
<p>The MHP reported a 30-day rehospitalization rate of 8 percent overall, 8 percent for adults, and 9 percent for children.</p>		
2F	Tracks and trends no-shows	M
<p>The no-show rate for psychiatrists was 18 percent overall, 18 percent for adults, 21 percent for children’s and 23 percent for FC.</p> <p>The no-show rate for clinicians was 15 percent overall, 15 percent for adults, 16 percent for children and 10 percent for FC.</p> <p>The standard for both psychiatry and clinicians is 10 percent.</p>		

Quality of Care

In Table 17, CalEQRO identifies the 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 CFM staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 17: Quality of Care Components		
Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	M
<p>The QI unit has a research manager and planner evaluators for data analysis. The QI unit provides data for PIPs, timeliness reporting, and other required reports. The MHP has an analytics team of report writers and programmers, who design mechanisms to extract data for QI unit to perform analysis. The QA unit is responsible for beneficiary protection and rights, grievances, and appeals. They also perform sentinel reviews, an extensive chart review and evaluation involving all service providers, when there is a suicide/homicide. They also evaluate any unusual occurrence in the system ranging from HIPPA violations to community crises. They prepare for reviews and audits, and compliance, policies and procedures, and works with subject matter experts.</p>		
3B	Data used to inform management and guide decisions	PM
<p>The MHP uses claims data, timeliness data, outcome data, productivity data, fiscal data, and clinical data as required for reporting. Data use to improve service delivery and operations is not optimal for a county of this size and sophistication. QI is now able to access EHR data through ccLink. The MHP could become a data-driven organization if it prioritizes regular reporting, trending and concretely responding to identified system gaps. The CANS-50 is in ccLink and is part of every new child assessment. The MHP has access to preliminary data. The MHP is currently developing an algorithm for LOC use of the CANS-50 for children. Once this is in place, they will use this model for the adult system of care and the Adult Needs and Strengths Assessment (ANSA).</p>		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	NM
<p>The MHP communicates to and receives feedback from stakeholders throughout the system. Information is provided to staff through a variety of methods including</p>		

emails/letters, group and individual supervision, and staff meetings. However, staff feedback indicates that new information on policies and procedures is not consistently provided between departments and/or supervisors. Staff reported learning about new changes by word of mouth. Staff provide feedback through surveys and directly to supervisors. The MHP does hold contract provider meetings; however, contract providers do not participate at program planning or decision-making. Likewise, clinicians would like to be invited to attend the QIC and CCC for program planning and decision-making opportunities.

The MHP receives beneficiary feedback through the MHSA stakeholder process. The OCE manager is now a part of administration and planning. Focus group participants indicated that they were unaware of many services offered by the MHP and that they found it difficult to navigate the system. There is no consistent communication of resources available to beneficiaries.

3D	Evidence of a systematic clinical continuum of care	PM
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While the MHP has a comprehensive range of options, access to ongoing therapeutic services is virtually non-existent due to lengthy wait times.

There are multiple avenues for crisis services: PES, adult and children’s mobile crisis, and the ER. The hospital has a psychiatric component and there are multiple FSP programs and other mental health initiatives. However, stakeholders report that the experience accessing PES and hospitalization services is very poor and fraught with timeliness and communication problems. Also, crisis residential units are not handicap accessible and thus are inaccessible for non-ambulatory persons.

Mobile crisis went live in July 2018. Mobile crisis receives calls from an 800 number and service providers respond in the field for evaluation and possible 5150. Mobile crisis staff are permitted a 30-day window for follow-up contact to link beneficiaries to services. Mobile crisis is available Monday through Friday from 7:30 a.m. to 11:30 p.m. and is staffed with clinicians and a CSW.

The MHP also expanded the Children’s Mobile Response Team by adding staff through a contract with Seneca. This team is also bilingual.

3E	Evidence of peer employment in key roles throughout the system	M
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The MHP contracted with the National Alliance on Mental Illness (NAMI) in Contra Costa to recruit, train and develop family members with lived experience. Family members will act as subject matter experts in a volunteer capacity to educate and support other family members navigate the public mental health system.

There are three positions which are available for advancement. These are Adult Services Coordinator, Children’s Services Coordinator, and OCE Coordinator. Supervision and annual evaluations are also provided. Advancement is possible with additional education and training.

3F	Peer-run and/or peer-driven programs exist to enhance wellness and recovery	M
<p>The MHP's wellness centers are run by its contractor RI International and are located in each of the three county regions. Wellness centers are staffed completely by beneficiaries and peer employees. This area could be expanded to the TAY population as there is currently no organized activities for youth that support their recovery or build connections.</p>		
3G	Measures clinical and/or functional outcomes of beneficiaries served	PM
<p>The MHP implemented CANS-50 to track outcomes, but data submission procedures vary by provider. The MHP has just begun gathering CANS-50 information.</p>		
3H	Utilizes information from beneficiary satisfaction surveys	M
<p>The MHP administered the Performance Outcomes and Quality Improvement (POQI) survey and collected 1261 surveys in May 2018. The MHP also administers its own surveys to assess ongoing access and quality issues.</p>		

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2018-19 review of Contra Costa MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths, Opportunities and Recommendations

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Recommendations:

- For the clinical PIP, the MHP should expand the intervention to additional sites, as well as identify and implement new interventions, i.e., increasing telehealth time.
- For the non-clinical PIP, the MHP should complete a formal barrier analysis to further inform the selection of new interventions. The MHP should collect data on the when the reminder calls are made, to help identify the best practice for warm reminder calls.

Access to Care

Changes within the Past Year:

- The overall penetration rate and the Latino/Hispanic penetration rate are above the statewide rate and other large county averages, but they have been declining for the last three years.
- Mobile Crisis Response for adults started on July 9, 2018. The MHP has seen a reduction in PES visits as a result. The goal is to decrease 5150s, but if needed, the team can initiate 5150s.
- Referrals from the Access Line used to be sent to providers by fax and included enough information to open a case and initiate contact with the beneficiary. Referrals now consist of instructions to the beneficiary to call the provider directly and the provider has no information about them when they call. This is a step backwards.
- The Access Line was reported by some as overwhelming and, among other things, suffering from a lack of Spanish-speaking clinicians.
- The MHP is planning to roll out the co-visit model for first visit with a clinician and a psychiatrist, to all clinics; a timeline was not provided. The co-visit model has

reduced the time to a first psychiatrist visit, but it is unclear yet whether it reduces time to continuing treatment.

Strengths:

- CoCo LEAD Plus, a three-year, innovative point-of-arrest diversion program, provides funding to implement programs that reduce the cycle of recidivism among low-level misdemeanor offenders.
- Each clinic has one rapid access clinician to address urgent needs or serve someone who has not been assigned a regular clinician within the 10-day standard.
- First Hope is an intensive outpatient treatment program focused on clinically high-risk youth ages 12 to 25 experiencing their first psychotic episode. Fifty percent of its referrals come from schools.

Opportunities for Improvement:

- HCBs account for 43 percent of approved claims for the MHP. This limits funds available to service other beneficiaries.
- Out of 1,154 telehealth sessions within the past year, five were delivered in Spanish. This equals a rate of 0.4 percent, as compared to the 35.7 percent of the MHP's beneficiaries who identify as Latino/Hispanic.
- The crisis residential treatment program is not handicap accessible for beneficiaries who are disabled and non-ambulatory.
- Stakeholders indicated that transportation to and from services is problematic, in particular for the outlying areas, and that it would be helpful to have transportation for children, unaccompanied by a parent, for mental health appointments.
- Parents, caregivers and TAY indicated that more activities are needed for children and adolescents, along with parenting support groups.
- Stakeholders identified the need for assistance in navigating the complex mental health system, as well as the need for Spanish-speaking support staff.

Recommendations:

- By the next EQRO review, fully investigate the high percentage of high-cost beneficiaries and identify relevant actions that show potential for impacting that population. (*This is a repeat recommendation from FY 2017-18.*)
- Continue to prioritize hiring psychiatrists and increase the number of psychiatrists capable of delivering telehealth services in Spanish.

- Evaluate potential accessibility barriers at crisis residential treatment facilities and prioritize correction and/or implement workarounds so that all facilities are ADA compliant and are accessible by all persons.
- Evaluate and identify gaps in transportation for beneficiaries. Implement strategies to improve transportation and inform beneficiaries of updated transformation services that are newly available.
- Evaluate available activities for parents, caregivers, children and TAY. Implement additional activities including children's groups, TAY groups and parenting support groups where gaps are identified.
- Provide one-on-one peer assignment for both adult and children's clinics, to educate and help beneficiaries navigate the system, including Spanish-speaking peer staff.

Timeliness of Services

Changes within the Past Year:

- In the East County Adult Mental Health Services, even with the newly introduced co-visit model, it can take as long as six months from initial contact to the beneficiary receiving treatment.

Strengths:

- There is a timeliness PIP in East County.
- The MHP is experiencing low hospital readmission rates for both children and adults.

Opportunities for Improvement:

- In Section B.1 of the ISCA, the MHP indicates that their expectation for timely entry of MHP service/progress notes is within 24 hours. In Section B.1.2, in response to a question about how the MHP audits timely entry of service/progress notes, the MHP stated, "Because staff productivity is tracked on a monthly basis, most service data is done within thirty days." These statements suggest a disparity between the MHP expectation and actual practice that can affect beneficiary service delivery, quality of care, and timeliness and quality of the data management uses to monitor operations.
- Even though the overall timeliness data falls within the standard for offered assessment, the timeliness data provided indicates that for older adult services, only 21 percent of the kept assessment appointments met the 10-business day standard.
- Timeliness data provided indicates that for psychiatry services overall, 59 percent of the kept assessment appointments did not meet the 15-business day

standard. Significantly long delays occur in the East County Adult Mental Health Services. The MHP must offer a psychiatric appointment within 15 business days per the state timeliness metric as per IN 18-011.

- Timeliness data for urgent services for children was not provided.
- Only 44 percent of the follow-up appointments for hospital discharge did meet the state required 7-day HEDIS standard.
- Beneficiaries and providers report wait times as long as six months from the initial contact with the MHP to their first assessment. Those who came from other counties described this MHP as far more difficult to navigate.

Recommendations:

- Implement process as soon as practical that automates the electronic exchange of service transactions from ccLink to ShareCare to eliminate manual data entry and the need to review reconciliation reports.
- Investigate the low rate of offered assessment appointments within the 10-day standard for older adult services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.
- Investigate the rate of both offered and kept psychiatry appointments for the system overall, as well as East and West County clinics for both adults and children's services. Through a formal barrier analysis, identify the causes/barriers to attendance of the offered appointment as well as the kept appointment. Identify and implement interventions specific to the causes identified.
- Begin tracking and reporting on the timeliness for urgent services for children's service.
- Track and trend the causes of timeliness barriers for post-hospitalization follow-up appointments which fall outside the 10-working day goal. Identify and implement interventions specific to the causes identified.
- Track and trend the causes of timeliness barriers for initial contact to first assessment. Identify and implement interventions specific to the causes identified.

Quality of Care

Changes within the Past Year:

- Availability of psychiatrists has improved, especially for children.
- The MHP Executive Team now includes the OCE Manager, a position which includes mental health lived experience, as part of the role. The position has input in the development of policy, procedure and programing.

Strengths:

- The MHP's pharmacist plays an unusually broad and, based on multiple reports, an exceptionally effective role in clinical service delivery. The pharmacist is a great resource to physicians, and helps monitor medication use patterns, including polypharmacy, and provide guidance on pharmacy policy and procedures.
- The MHP has made significant efforts to improve the employment package when hiring psychiatrists through higher pay and tuition reimbursement programs.
- The MHP uses a variety of evidenced based practices in service delivery. Ongoing trainings and supervision groups support fidelity to the practice.

Opportunities for Improvement:

- Based on an informal survey by the MHP in 2019, of 21 behavioral health medical directors in California, the average psychiatrist caseload for adults is 226. In Contra Costa County it is 332, or 47 percent higher than the average statewide. For child psychiatry, the disparity was not as great, but Contra Costa County child psychiatrists still carried a larger average caseload than their peers in other counties. This directly affects access, timeliness and quality of care and likely has a role in psychiatrist employee recruitment and retention.
- Providers and clinicians report that documentation takes longer in this MHP than in other counties they have worked in which they have experience. Interpretation of rules by the MHP is viewed as risk averse to the detriment of beneficiaries. This may present an opportunity to improve available service capacity without increasing regulatory compliance or billing risk.
- Stakeholder feedback indicates that PES services are markedly inadequate with long delays for treatment, transportation, and minimal or no communication to the beneficiaries, parents or caregivers.
- Stakeholders report that they are unaware of the different services available to them through the MHP or how to access services. Stakeholders also found the website to be outdated.

Recommendations:

- Continue to prioritize hiring psychiatrists, especially those who are Spanish-speaking.
- Given the long time it takes to access services, and the reported extraordinary documentation requirements for staff, review and amend documentation requirements with an eye towards a minimum necessary approach, consistent with quality of care, as an opportunity to increase service delivery capacity.
- Evaluate the process for accessing PES from the beneficiary perspective. Include the Office of Empowerment Coordinator in all aspects of this evaluation and identify both major and minor contributors to negative experiences. Identify and implement interventions which improve beneficiary experience.
- Evaluate and identify gaps in communication with beneficiaries. Implement strategies to improve communication and inform beneficiaries of services that are available with clear and simple instructions on how to access services. Update the website regularly with service information.
- Evaluate the results of expanded children's crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment. *(This recommendation is a carry-over from FY 2017-18.)*

Beneficiary Outcomes

Changes within the Past Year:

- Collection of CANS-50 and PSC-35 data began in October 2018.

Strengths:

- Regular evaluation of beneficiary outcomes for those served with specific evidenced based practices occurs on an individual basis.

Opportunities for Improvement:

- In CY 2016, 941 beneficiaries averaged 1.77 inpatient visits each. In CY 2017, 947 beneficiaries averaged 2.04 visits each. While average length of stay was down slightly in this period, the increasing number of visits per beneficiary is not an auspicious trend.
- Although the CANS-50 and the PSC-35 are implemented in the EHR, system-wide outcomes are not tracked consistently. CBO providers send paper forms to the MHP which are then keypunched into a separate database for reporting purposes.

Recommendations:

- Investigate the causes for the increasing number of inpatient visits per beneficiary in 2017, including determining if the trend continued into CY 2018. It is possible that a small number of HCBs could be driving this, in which case implement a focused intervention which may be effective in lowering the number of visits per beneficiary; however, if the increase is more broadly based, look into access to care following inpatient services for possible reasons for recidivism. Address accordingly.
- Take steps to automate the process of receiving outcome data from contractors, i.e., develop and implement a mechanism for secure information exchange, eliminating the use of paper forms.

Foster Care

Changes within the Past Year:

- The MHP is partnered with the State to do a secondary review of JV220s and authorizations for medication for FC youth. Prior to being required by the state, they collected much of the newly required data. For 2019, they are tracking all required measures.

Strengths:

- The MHP tracks concurrent medications within 90 days collaboratively with public health nurses, psychiatrists, and social workers, including those that are juvenile hall case specific.

Opportunities for Improvement:

- There are limited referrals and difficulty with delivering Katie A. services. Katie A. contracts require dedicated staff, but the referrals are too few for the program to be sustainable by contracted providers. Some providers have dropped contracts when there is lack of flexibility, making them unsustainable. This directly impacts the MHP's capacity to service its beneficiaries.
- Even though the overall timeliness data falls within the standard for offered assessment, the timeliness data provided indicates that for FC services, 33 percent of the kept assessment appointments met the 10-business day standard.

Recommendations:

- Evaluate current capacity and scope of contracts for Katie A. services along with the referral process, to identify barriers to implementation and access. Address barriers within the referral process and create flexibility within the contracts so that qualifying beneficiaries have unfettered access.

- Investigate the low rate of kept assessment appointments within the 10-day standard for foster care services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.

Information Systems

Changes within the Past Year:

- ShareCare, a new billing system, was implemented in July 2018.
- CANS-50 and PSC-35 were rolled out as outcome tools in October 2018.
- PHQ-9 and GAD-7 were piloted in an adult mental health clinic and a SUD treatment program in July 2018.
- Both the ccLink and ShareCare implementations were demanding of staff resources and limited the MHP's ability to take on other initiatives.

Strengths:

- CCBHS has been using ccLink for clinical documentation for over one year, and as a result is more effectively coordinating care with providers across county-operated health services.
- All MHP and SUD locations, including the jail and telepsychiatrists working off-site, have access to the same EHR.
- The ability to share clinical information with other healthcare providers in the area using the Epic CareEverywhere module.

Opportunities for Improvement:

- Site certification, clinician credentialing, and service authorization processes directly impact the ability to deliver services and the timeliness of those services. This is an opportunity to directly address improvements that can impact 61 percent of services delivered by this MHP.
- CBOs must currently do double data entry to claim for the 61 percent of MHP services that they have delivered to MHP beneficiaries. This is an outmoded approach, expensive and inefficient, and consumes resources that could otherwise be directed to badly needed service delivery. CBO providers submit paper forms to the MHP which are scanned into a separate database that extracts the data for reporting purposes.
- There is a SQL Server-based data warehouse for homeless, ccLink and custody data, but it is not clear that this data warehouse includes data from the CBOs.

- There is a ticketing system at the Help Desk for CBO ShareCare issue tracking and reporting, but the providers do not find the Help Desk helpful. They routinely call individuals in the MHP that have a history of providing reliable information and as such, these issues are not tracked in the Help Desk system.

Recommendations:

- By the next EQRO, initiate the planned Rapid Improvement Event (RIE) focused on processes that directly impact beneficiary access to and timeliness of services and CBO provider operational efficiency and cost of service delivery. The scope should include site certification, clinician credentialing, and service authorization processes. Include CBO representatives in all aspects of the process.
- Develop a plan to support data interoperability for those CBOs who have local EHR systems that meet MHPs minimum standards to eliminate double data entry into ShareCare. The MHP to include CBOs throughout the planning and technical specification phase to create and support a collaborative working environment.
- By the next EQRO review, begin collecting and reporting timeliness data from all CBOs without increasing the double data entry burden they already face for claims submission to ShareCare. This is an essential first step in addressing the reported wait lists and long wait-times to begin treatment.
- By the next EQRO, improve the level of ShareCare expertise on the Help Desk and the responsiveness to contract provider ShareCare issues. Document all calls and the resolution of each ticket opened so that trends can be identified and addressed at the source.

Structure and Operations

Changes within the Past Year:

- More data analytical resources were added to CCBHS' Research/Evaluation team.
- There have been a number of employee departures at the senior level for both the MHP and Contra Cost Health Services. There is optimism in the organization and among providers about the new leadership. There are also challenges associated with a loss of continuity that are reflected in some confused messaging to stakeholders.

Strengths:

- The MHP has a business governance structure with participation from HS IT to triage and prioritize system-related concerns, oversee optimization requests, facilitate change management and prioritize future projects.

- The MHP deploys Champions and Super Users to provide on-site ccLink support to county clinics and programs. Champions and Super User groups meet monthly to identify best methods for promoting EHR-literacy and comprehension among staff, identifying possible training needs, and proposing system enhancement to improve ccLink workflows and efficiency of use.
- The MHP has an exemplary peer employment structure in place. The other clinical staff and managers perhaps need further training on how to use this resource and learn the peer employees' roles.

Opportunities for Improvement:

- Two MHP speakers gave contradictory information in the same recent provider meeting. Clear and reliable channels of communication need to be reestablished throughout the MHP.
- Utilization Review regional representatives are often inconsistent in their messaging. Policy and procedure changes are not routinely provided in writing in advance of the implementation date. This adds to the confusion in messaging when important changes are delivered orally by a variety of people who may interpret the change differently.
- Contract renewal documents are not provided timely and sometimes arrive after the effective date.
- The MHP contracts used to be cost-report based. It is now unclear whether CBOs need to do a cost report this year.
- Staff turnover is a problem because other counties and other mental health service providers in the area pay more and clinicians have smaller caseloads. For contract providers, challenges with staff retention are mainly due to the benefits and salary compared to other employers in the area.
- County Counsel has a very conservative interpretation of what constitutes whether a person is meeting conservatorship criteria. When a conserved beneficiary improves, they are discharged. Without supportive treatment, they decline and then they become eligible for the program again. It is a difficult step-down process and one not optimized to promote stable wellness.
- The MHP's system includes contractors, county employees, telehealth and locum tenens providers. While all are providing services, the MHP is not unified as a single system, as evidenced by authorization, credentialing and timeliness issues. There are numerous 'work groups' which are formed ad hoc to address any number of issues. Changes to the system, when made, are incremental with a lengthy process for implementation which does not serve beneficiaries at large.

Recommendations:

- Institute policy and procedure changes by providing to CBOs in writing in advance of the implementation date, ideally after CBO involvement in the decision-making process (when possible).
- Develop a consistent practice of clear messaging to stakeholders which is consistent and timely delivered.
- As soon as possible, clarify in writing to the CBOs whether cost reporting is required for FY 2018-19.
- Deliver contract renewal documents with enough time for CBO review and well in advance of their effective date.
- Evaluate MHP and CBO salaries and benefits relative to organizations competing for the same resources.
- By the next EQRO, the MHP should work with its county counsel to address current policy and practice that do not promote stable wellness upon release from conservatorship and lead to unnecessary recidivism. Develop policies and procedures that facilitate a supportive transition from conservatorship to independent living. Develop policies and procedures that facilitate a supportive transition from conservatorship to independent living without delay in access to services.
- Institute a rapid process improvement effort with defined performance indicators to quickly improve authorization timeliness.
- Institute a rapid process improvement effort with defined performance indicators to quickly improve credentialing timeliness.

Summary of Recommendations

FY 2018-19 Recommendations:

- Continue to prioritize hiring psychiatrists and increase the number of psychiatrists capable of delivering telehealth services in Spanish.
- Evaluate potential accessibility barriers at crisis residential treatment facilities and prioritize correction and/or implement workarounds so that all facilities are ADA compliant and are accessible by all persons.
- Evaluate and identify gaps in transportation for beneficiaries. Implement strategies to improve transportation and inform beneficiaries of updated transformation services that are newly available.
- Evaluate available activities for parents, caregivers, children and Transition Age Youth (TAY). Implement additional activities including children's groups, TAY groups and parenting support groups where gaps are identified.
- Provide one-on-one peer assignment for both adult and children's clinics, to educate and help beneficiaries navigate the system, including Spanish-speaking peer staff.
- Implement process as soon as practical that automates the electronic exchange of service transactions from ccLink to ShareCare to eliminate manual data entry and the need to review reconciliation reports.
- Investigate the low rate of offered assessment appointments within the 10-day standard for older adult services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.
- Investigate the rate of both offered and kept psychiatry appointments for the system overall, as well as East and West County clinics for both adults and children's services. Through a formal barrier analysis, identify the causes/barriers to attendance of the offered appointment as well as the kept appointment. Identify and implement interventions specific to the causes identified.
- Begin tracking and reporting on the timeliness for urgent services for children's service.
- Track and trend the causes of timeliness barriers for post-hospitalization follow-up appointments which fall outside the 10-working day goal. Identify and implement interventions specific to the causes identified.
- Track and trend the causes of timeliness barriers for initial contact to first assessment. Identify and implement interventions specific to the causes identified.

- Continue to prioritize hiring psychiatrists, especially those who are Spanish-speaking.
- Given the wait lists and long wait times to access services, and the reported extraordinary documentation requirements, review documentation requirements with an eye towards a minimum necessary approach, consistent with quality of care, as an opportunity to increase service delivery capacity.
- Formally evaluate the process for accessing Psychiatric Emergency Services (PES) from the beneficiary perspective. Include the Office of Empowerment Coordinator in all aspects of this evaluation and identify both major and minor contributors to negative experiences. Identify and implement interventions which improve beneficiary experience.
- Evaluate and identify gaps in communication with beneficiaries. Implement strategies to improve communication and inform beneficiaries of services that are available with clear and simple instructions on how to access services. Update the website regularly with service information.
- Investigate the causes for the increasing number of inpatient visits per beneficiary in 2017, including determining if the trend continued into CY 2018. It is possible that a small number of HCBs could be driving this, in which case implement a focused intervention which may be effective in lowering the number of visits per beneficiary; however, if the increase is more broadly based, look into access to care following inpatient services for possible reasons for recidivism. Address accordingly.
- Take steps to automate the process of receiving outcome data from contractors, i.e. develop and implement a mechanism for secure information exchange, eliminating the use of paper forms.
- By the next EQRO, initiate the planned Rapid Improvement Event (RIE) focused on processes that directly impact beneficiary access to and timeliness of services and CBO provider operational efficiency and cost of service delivery. The scope should include site certification, clinician credentialing, and service authorization processes. Include CBO representatives in all aspects of the process.
- Develop a plan to support data interoperability for those CBOs who have local EHR systems that meet MHPs minimum standards to eliminate double data entry into ShareCare. The MHP to include CBOs throughout the planning and technical specification phase to create and support a collaborative working environment.
- By the next EQRO review, begin collecting and reporting timeliness data from all CBOs without increasing the double data entry burden they already face for claims submission to ShareCare. This is an essential first step in addressing the reported wait lists and long wait times to begin treatment.

- By the next EQRO, improve the level of ShareCare expertise on the Help Desk and the responsiveness to contract provider ShareCare issues. Document all calls and the resolution of each ticket opened so that trends can be identified and addressed at the source.
- Institute policy and procedure changes by providing to community-based organizations (CBO) in writing in advance of the implementation date, ideally after CBO involvement in the decision-making process (when possible).
- Develop a consistent practice of clear messaging which is consistent and timely delivered.
- As soon as possible, clarify in writing to the CBO whether cost reporting is required for FY 2018-19.
- Develop a consistent practice of delivering contract renewal documents with enough time for CBO review and well in advance of their effective date.
- Evaluate MHP and CBO salaries and benefits relative to organizations competing for the same resources.
- By the next EQRO, the MHP should work with its county counsel to address current policy and practice that do not promote stable wellness upon release from conservatorship and lead to unnecessary recidivism. Develop policies and procedures that facilitate a supportive transition from conservatorship to independent living without delay in access to services.
- Institute a rapid process improvement effort with defined performance indicators to quickly improve authorization timeliness.

Institute a rapid process improvement effort with defined performance indicators to quickly improve credentialing timeliness.

FY 2018-19 Foster Care Recommendations:

- Evaluate current capacity and scope of contracts for Katie A. services along with the referral process, to identify barriers to implementation and access. Address barriers within the referral process and create flexibility within the contracts so that qualifying beneficiaries have unfettered access.
- Investigate the low rate of kept assessment appointments within the 10-day standard for foster care services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.

Carry-over and Follow-up Recommendations from FY 2017-18:

- Evaluate the results of expanded children's crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment.
- By the next EQRO review, fully investigate the high percentage of high-cost beneficiaries and identify relevant actions that show potential for impacting that population.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment F: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions – Contra Costa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employee/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Wellness Center Site Visit
Contract Provider Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Quality Reviewer
Saumitra SenGupta, Executive Director, Quality Reviewer
Robert Greenless, Information Systems Reviewer
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 in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

Contra Costa County Behavioral Health Services (CCCBHS)
1340 Arnold Drive, Suite 200
Martinez, CA 94553

East County Adult Mental Health Clinic
2311 Loveridge Road (1st Fl. Conf. Rm)
Pittsburg, CA 94565

Antioch Children's Behavioral Health Clinic
2335 Country Hills Drive
Antioch, CA 94509

First Hope,
391 Taylor Blvd, Suite 100
Pleasant Hill, CA 94523

Contract Provider Sites

RI International Wellness City
3701 Lone Tree Way
Antioch, CA 94509

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Aguirre	Priscilla	QM Program Coordinator	CC Behavioral Health
Ahad	Terry	Program Supervisor	CC Behavioral Health
Andreev	Oleg	HS IS Programmer/Analyst	CCHS Info Technology
Ang	JR	Director of Patient Accounting	CCHS Finance
Battis	Claire	HS Planner/Evaluator	CC Behavioral Health
Becerra	Marina	MH Clinical Specialist	CC Behavioral Health
Beecher	Karly		Hume Center
Bennet	Cathy	Hospital Liaison (CSOC)	CC Behavioral Health
Bergesen	David	Executive Director	COFY
Berlingieri	William	Lead Psychiatrist	CC Behavioral Health
Bianchi	Charlene	Katie A. Program Manager	CC Behavioral Health
Bigol	Maria	Administrative Services Asst. III	CC Behavioral Health
Blee	Liz	MH Clinical Specialist	Seneca
Boyd	Stephen	MH Community Support Worker	CC Behavioral Health
Brooks	Eileen	MH Program Manager	CC Behavioral Health
Bruggeman	Jennifer	PEI Program Supervisor	CC Behavioral Health
Burton-Flores	Margie	MH Program Supervisor	CC Behavioral Health
Caldwell	Pete	Executive Director	We Care Children
Callaghan	Jim	CEO/President	Mental Health Systems
Calloway	Vernon	Lead InSyst Support Analyst	CCHS Info Technology
Casselberry	Ila	HS Planner/Evaluator	CC Behavioral Health
Castillo	Jack	MH Clinical Specialist	CC Behavioral Health
Cathey	Kellee	MH Clinical Specialist	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Celio	Chris	Director	Hume Center
Charwathakyi	Dickyi	MH Clinical Specialist	CC Behavioral Health
Chavez	Rudy	HS IS Programmer/Analyst	CCHS Info Technology
Chavez	Beatriz	MH Clinical Specialist	CC Behavioral Health
Christopher	Jim		Hope House
Cobaleda-Kegler	Jan	Adult/Older Adult Program Chief	CC Behavioral Health
Collier	Candace	MH Community Support Worker	CC Behavioral Health
Cooper	Zabeth	Ambulatory Care Clinic Coord.	CC Behavioral Health
Danko	Adam	Psychiatric MH Nurse Practitioner	CC Behavioral Health
Diaz	Alicia	MH Clinical Specialist	CC Behavioral Health
Dimidjian	Natalie	MH Program Supervisor	CC Behavioral Health
Dold	Amanda	Integration Services Manager	CC Behavioral Health
Donahue	Jessica	Executive Director	Seneca
Down	Adam	Ethnic Services & Training Coord.	CC Behavioral Health
Ebbert	Nancy		CC Behavioral Health
Emelle	Brittany	HS Planner/Evaluator	CC Behavioral Health
Eriksson	Gabriel	Director of Operations	COFY
Espinoza	Lucy	MH Community Support Worker	CC Behavioral Health
Fattah	Hala	Adult Lead Psychiatrist	CC Behavioral Health
Fernandez	Nancy	Manager	CC Child & Family Services
Fox	Rebecca	Lead Psychiatrist	Seneca
Franklin	Marylin	MH Clinical Specialist	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Fuhrman	Beverly	MH Program Manager	CC Behavioral Health
Gallagher	Ken	Research & Evaluation Manager	CC Behavioral Health
Gargantiel	Paolo	MH Clinical Specialist	CC Behavioral Health
Garrison	Juanita	Clerical Supervisor	CC Behavioral Health
Gibson	Teresa	MH Clinical Specialist	CC Behavioral Health
Grewats	Jennifer	MH Community Support Worker	CC Behavioral Health
Hanna	Elizabeth (Betsy)	MH Clinical Specialist	CC Behavioral Health
Haridas	Arun	Lead Psychiatrist	CC Behavioral Health
Hasenpusch	Colleen	MH Community Support Worker	CC Behavioral Health
Hayes	Warren	Mental Health Program Chief	CC Behavioral Health
Heher	Kirsten	MH Community Support Worker	CC Behavioral Health
Heinla	Cheryl	MH Clinical Specialist	CC Behavioral Health
Hernandez	Rustico	Contractor	CCHS Finance
Heslinga	Tyler	HS IS Programmer/Analyst	CCHS Info Technology
Huynh	Winnie	MH Program Supervisor	CC Behavioral Health
Jacob	Jean	HS Planner/Evaluator	CC Behavioral Health
Johnson	Jessica	MH Clinical Specialist	CC Behavioral Health
Johnson	Kennisha	MH Program Manager	CC Behavioral Health
Jones	Erin		CC Behavioral Health
Juaregui-Ornelas	Cecilia	MH Clinical Specialist	CC Behavioral Health
Jun	Jimmy	MH Clinical Specialist	CC Behavioral Health
Kaji	Troy	Dir. Ambulatory Med. Informatics	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Kalaei	Susan	BH Pharmacist	CC Behavioral Health
Kearns	Helen	BH Chief of Operations	CC Behavioral Health
Kennard	Sarah	Administrative Services Assistant	CC Behavioral Health
Kevsten	Melissa	MH Clinical Specialist QI/QA Unit	CC Behavioral Health
Khan-Amirkani	Shereen	Clinical Administrator	ECMHP
Lau	Edward	Lead Psychiatrist	CC Behavioral Health
Lee	Hazel	MH Clinical Specialist	CC Behavioral Health
Loenicker	Gerold	CSOC Program Chief	CC Behavioral Health
Lopez	Cristobal	Program Manager	ANKA
Lukas	Brian	Executive Director	Child Therapy Institute
Luu	Matthew	Behavioral Health Deputy Director	CC Behavioral Health
Madrugá	Christine	MH Program Supervisor	CC Behavioral Health
Martin	Diana	MH Clinical Specialist	CC Behavioral Health
Masadas	Ja-Nel	MH Community Support Worker	CC Behavioral Health
Matal Sol	Fatima	AOD Chief	CC Behavioral Health
Matthews	Zakee	Lead Psychiatrist	First Hope
May	Leslie	Mental Health Commissioner	Mental Health Commission
Melendez	Robin	Information System Specialist	CC Behavioral Health
Mendoza	Floris	MH Clinical Specialist	CC Behavioral Health
Menjivar-Beltran	Gloria	MH Community Support Worker	CC Behavioral Health
Merrett-Armhs	Nicole	MH CSWI	CC Behavioral Health
Messerer	Mark	AOD Program Manager	CC Behavioral Health
Naghshineh	Morvarid	HS Planner/Evaluator	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Nasrul	Kimberly	QI & Compliance Coordinator	CC Behavioral Health
Nawy	Jena	MH Clinical Specialist	CC Behavioral Health
Nobori	Michelle	MH Project Manager	CC Behavioral Health
Ny	Faye	HS Accountant	CCHS Finance
O'Neill	Robin	MH Program Manager	CC Behavioral Health
Orme	Betsy	MH Program Manager	CC Behavioral Health
Otis-Miles	Laura	Senior Vice President	Mental Health Systems
Pena	Jorge	Lead InSyst Support Analyst	CCHS Info Technology
Perez	Danielle	MH Clinical Specialist	CC Behavioral Health
Pierce	Chad	MH Program Manager	CC Behavioral Health
Powers	Karen	Intensive Care Coordinator Program Supervisor	CC Behavioral Health
Quittman	Judy	MH Clinical Specialist	CC Behavioral Health
Rice	Megan	ccLink Behavioral Health PM	CCHS Info Technology
Rogers	Kimberly	MH Community Support Worker	CC Behavioral Health
Sanabria	Bernardita	MH Program Supervisor	CC Behavioral Health
Sanches	Blanca	MC Clinical Specialist	CC Behavioral Health
Scannell	Marie	MH Program Manager	CC Behavioral Health
Serrano	Kristina	MH Program Supervisor	CC Behavioral Health
Serwin	Barbara	Mental Health Commissioner	Mental Health Commission
Shah	Maansi	HS Planner/Evaluator	CC Behavioral Health
Shirgul	Ellen	MH Program Supervisor	CC Behavioral Health
Simes	Michele	Clerical Supervisor	CC Behavioral Health
Smith	Raymond	MH Community Support Worker	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	First Name	Position	Agency
Spikes	Chet	Asst. HS IT Director	CCHS Info Technology
Surio	Bles	UR Program Manager	CC Behavioral Health
Sweeten-Healy	Heather	MH Program Manager	CC Behavioral Health
Tarvins	Denise	MH Clinical Specialist	CC Behavioral Health
Taylor	Windy	MHSA Project Manager	CC Behavioral Health
Temeltas	Ates	Manager, Health Plan Systems	CCHS Info Technology
Terry	Jonathan	Lead Psychiatrist	CC Behavioral Health
Thigpen	Robert	MH Family Services Coordinator	CC Behavioral Health
Tuipulotu	Jennifer	Consumer Empowerment Coord.	CC Behavioral Health
Underwood	Kenneth	Program Supervisor	CC Behavioral Health
Visbal	Kristin	MH Community Support Worker	CC Behavioral Health
Waters	Susan	MH Community Support Worker	CC Behavioral Health
White	Katy	Access Line Care Mgmt Unit PM	CC Behavioral Health
White	Vicki	MH Community Support Worker	CC Behavioral Health
White	Matthew P.	Acting Behavioral Health Director	CC Behavioral Health
Wilbur	Kathryn	Vice President	Mental Health Systems
Zesati	Genoveva	Administrative Services Assistant	CC Behavioral Health

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2017 Medi-Cal Expansion (ACA) Penetration Rate and ACB Contra Costa MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,816,091	147,196	3.86%	\$703,932,487	\$4,782
Large	1,848,772	68,086	3.68%	\$362,898,987	\$5,330
MHP	75,369	3,506	4.65%	\$14,796,455	\$4,220

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

Table C2. CY 2017 Distribution of Beneficiaries by ACB Cost Band Contra Costa MHP								
ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< \$20K	14,462	91.05%	93.38%	\$48,919,324	\$3,383	\$3,746	44.30%	56.69%
>\$20K - \$30K	581	3.66%	3.10%	\$14,129,678	\$24,320	\$24,287	12.80%	12.19%
>\$30K	840	5.29%	3.52%	\$47,366,301	\$56,388	\$54,563	42.90%	31.11%

Attachment D—List of Commonly Used Acronyms

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

Table D1—List of Commonly Used Acronyms

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

Table D1—List of Commonly Used Acronyms

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

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Contra Costa	
PIP Title: Redesigning the First Appointment	
Start Date: 09/24/2018 Completion Date: 09/30/2020 Projected Study Period: 24 Months Completed: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Date(s) of On-Site Review: February 5, 6 & 7, 2019 Name of Reviewer: Cyndi Lancaster	Status of PIP (Only Active and ongoing, and completed PIPs are rated):
	Rated
	<input checked="" type="checkbox"/> Active and ongoing (baseline established and interventions started) <input type="checkbox"/> Completed since the prior External Quality Review (EQR)
	Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.
	<input type="checkbox"/> Concept only, not yet active (interventions not started) <input type="checkbox"/> Inactive, developed in a prior year <input type="checkbox"/> Submission determined not to be a PIP <input type="checkbox"/> No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The clinical PIP focuses on improving timeliness of first contact to first psychiatry appointments and improved coordination of care. The need for this project was born out of a recommendation from CalEQRO and long wait times, especially in the outer lying areas of the county. For the period of April 1, 2018 through June 30, 2018, just 38.3 percent of adult appointments met the 15-day standard for timeliness, with the mean number of business days from first contact to scheduled offered appointment being 34.6 days (range: 1-	

289 days). In the East County Adult Mental Health Services, the mean number of business days to first psychiatry appointment was the highest among the three specialty mental health clinics, being 57.8 days. When this metric is tracked by time from first contact to scheduled psychiatric appointment, this number increases to 68 days for the same period. To address the problem, the MHP utilized the Lean Six approach to map and identify barriers to access. The MHP implemented the paired scheduling of initial assessments with a clinician and a psychiatrist at its East County Adult Mental Health Services. This intervention, coupled with automated and warm reminder calls, was designed to make access to providers easier and more efficient for beneficiaries. Although the Clinical PIP is set up well, the intervention is limited in application across the system of care, given that timeliness is problematic at all locations for both adults and children. Expansion of intervention to other sites, or in the alternative, a different intervention which increases access to timely psychiatry appointments is needed. Given psychiatry staffing shortages, it is unclear if the current intervention of paired clinician and psychiatry appointments is a sustainable model for a system with disparate locations.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

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

<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Between April and June, 2018, just 38.3 percent of adult appointments met the 15-day standard for timeliness, with the mean number of business days from first contact to scheduled appointment being 34.6 days (range: 1-289 days). In the East County Adult Mental Health Services, the mean number of business days to first psychiatry appointment was the highest among the three specialty mental health clinics, being 57.8 days.</p> <p>The MHP deployed a Value Stream Mapping event, a Lean Six Sigma method, for observing and tracking the flow of processes to determine inefficiencies and potential interventions.</p> <p>Among the factors identified are: 1) psychiatry staffing turnover; 2) requiring attendance at clinical appointment before being scheduled for their first psychiatry appointment; 3) coordination issues; 4) a high no-show rate; 5) the lack of physical signage directing beneficiaries to behavioral health services once on-site; and 6) coordination issues with primary care clerks for check-ins.</p>
<p>Select the category for each PIP:</p> <p><i>Clinical:</i></p> <p><input type="checkbox"/> Prevention of an acute or chronic condition services <input type="checkbox"/> High volume services</p> <p><input checked="" type="checkbox"/> Care for an acute or chronic conditions <input type="checkbox"/> High risk</p>		<p><i>Non-clinical:</i></p> <p><input type="checkbox"/> Process of accessing or delivering care</p>

<p>1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Timeliness for psychiatry is problematic across the system of care. The intervention is limited to the East County Adult Mental Health Services.</p>
<p>1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>All adults new to services at the East County Adult Mental Health Services were included; however, the intervention could have been deployed on a larger scale, thus impacting more beneficiaries.</p>
Totals		<p>2 Met 2 Partially Met</p>
STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? <i>Include study question as stated in narrative:</i> Will re-designing the 1st assessment appointment to a co-visit with a therapist and psychiatrist result in beneficiaries of The MHP's East Adult clinic to experience more timely access to psychiatry appointments reflected by the average number of business days from first contact to scheduled appointment not exceeding 15 days?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
Totals		<p>1 Met</p>

STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? <i>Demographics:</i> <input checked="" type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input checked="" type="checkbox"/> Other: Service Location</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>New beneficiaries referred to the East Adult Specialty Mental Health clinic for their first appointment.</p>
<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? <i>Methods of identifying participants:</i> <input checked="" type="checkbox"/> Utilization data <input checked="" type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other:</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	
Totals		2 Met

STEP 4: Review Selected Study Indicators

4.1 Did the study use objective, clearly defined, measurable indicators?

- Met
- Partially Met
- Not Met
- Unable to Determine

List indicators:

- Mean business days from first contact to first scheduled psychiatric appointment
- Rate of missed appointments (includes no-show, cancellation, and left without seen)
- Percentage of beneficiaries successfully contacted with a warm reminder call
- Percentage of beneficiaries hospitalized during a six month period after completing a co-visit 1st assessment
- Percentage of beneficiaries having a PES visit during a six month period after completing a co-visit 1st assessment
- Mean score on PHQ-9
- Mean score on GAD-7
- Days from first contact to first ordered medication
- Client Satisfaction with first appointment
- Client hopefulness for recovery

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused.</p> <p><input checked="" type="checkbox"/> Health Status <input checked="" type="checkbox"/> Functional Status</p> <p><input checked="" type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		2 Met
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event?</p> <p>b) Confidence interval to be used?</p> <p>c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		3 NA
STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met	

<input checked="" type="checkbox"/> Member <input type="checkbox"/> Claims <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: EHR	<input type="checkbox"/> Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The MHP described in general the approach for each data element and the method of collection. However, more details on the approach to maintaining continuity throughout all data collection periods would provide more insight.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input checked="" type="checkbox"/> Survey <input checked="" type="checkbox"/> Medical record abstraction tool <input checked="" type="checkbox"/> Outcomes tool <input checked="" type="checkbox"/> Level of Care tools <input type="checkbox"/> Other:	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The MHP uses reporting modules in its EHR, symptom/mood questionnaires, and surveys. However, methods by which the MHP maintains fidelity to its identified instruments remains unclear.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The MHP described the analysis plan in general; however, information on the statistical analysis approach was not provided.

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Priscilla Aguirre Title: Quality Management Program Coordinator Role: Chair</p> <p><i>Other team members:</i> Names: See 1.1</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
Totals		3 Met 3 Partially Met
STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i> Provide-visit first appointment with therapist and psychiatrist Automated and Warm reminder calls from Care Team before appointment</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Paired first visit - 12/17/2018</p> <p>Automated and Warm Calls - All clinic Live: 12/17/2018</p> <p>Though a positive step, the intervention is limited in application, given that timeliness across the system is problematic.</p>
Totals		1 Partially Met

STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: _____</p> <p>Indicate the statistical analysis used: _____</p> <p>Indicate the statistical significance level or confidence level if available/known: ____percent _____ Unable to determine</p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i></p> <p><i>Conclusions regarding the success of the interpretation:</i></p> <p><i>Recommendations for follow-up:</i></p>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		4 NA

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

<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement? <input type="checkbox"/> Weak <input type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		5 NA

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

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

Conclusions:

Met	10
Partially Met	6
Not Met	0
UTD	0
# Not applicable	12
Score	81.25%

Although the Clinical PIP is set up well, the intervention is limited in application across the system of care, given that timeliness is problematic at all locations for both adults and children.

Recommendations:

Expansion of intervention to other sites, or in the alternative, a different intervention which increases access to timely psychiatry appointments is needed. Given psychiatry staffing shortages, it is unclear if the current intervention of paired clinician and psychiatry appointments is a sustainable model for a system with disparate locations. The MHP described in general the approach for each data element and the method of collection. However, more details on the approach to maintaining continuity throughout all data collection periods would provide more insight. The MHP uses reporting modules in its EHR, symptom/mood questionnaires, and surveys. However, methods by which the MHP maintains fidelity to its identified instruments remains unclear. The MHP described the analysis plan in general; however, information on the statistical analysis approach is needed.

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

**PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP**

GENERAL INFORMATION

MHP: Contra Costa County

PIP Title: Improving Appointment Adherence to the First Appointment

Start Date: 12/01/2017

Completion Date: 12/31/2019

Projected Study Period: 24 Months

Completed: Yes No

Date(s) of On-Site Review:

February 5, 6 & 7, 2019

Name of Reviewer:

Cyndi Lancaster

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

Rated

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

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

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

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

The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessment among beneficiaries who receive services. To improve appointment adherence, the MHP implemented improved beneficiary outreach practices that incorporate piloting the use of Motivational Interviewing (MI) for beneficiaries attending initial

outpatient mental health appointments at the East County Adult Mental Health Services and the East County child clinic. This intervention is designed to: 1) remind the beneficiary (or parent/guardian for those under 18 years) of their initial intake assessment appointment; 2) provide the beneficiary with more information about the appointment (what to expect, length of appointment, etc.); 3) address any ambivalence about attending this appointment through the use of MI; and 4) connect the beneficiary with any needed resources to attend the appointment such as providing a warm handoff to a Commute Navigation Specialist in the OCE who can provide resources and peer support surrounding navigating the public transportation system. This initial contact involves a telephone call to the beneficiary (or parent/guardian) one to five days in advance of their appointment from a CSW or FSW using MI as the overarching methodology. The MHP hopes that the use of this evidence-based practice can help determine what barriers beneficiaries may be experiencing.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
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<p>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?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Contra Costa Mental Health Plan has assembled a multidisciplinary team to provide oversight of the proposed Timeliness intervention. Stakeholders involved include: Deputy Director of Behavioral Health Services, Quality Management Program Coordinator, Research and Evaluation Manager, Planner/Evaluator, Adult Program Chief, Behavioral Health Access & Care Management Unit Program Manager, Adult/Older Adult Mental Health Program Managers, Children/Adolescent Mental Health Program Managers, Adult Family Services Coordinator, OCE Coordinator, Overcoming Transportation Barriers (OTB) Navigation Specialists, Access Line Operations Lead Health Service IS Specialist, and Community/Family Support Workers. This multidisciplinary team reflects MHP and clinic leadership, practitioners, quality improvement & assurance personnel, beneficiaries and family members.</p>
<p>1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The average time from referral to first completed outpatient mental health service appointment increased to 15 business days county-wide, but more revealing was the realization that 37 percent of beneficiaries referred for care were missing their first scheduled appointment for outpatient mental health. In addition to timeliness data, the MHP utilized information from a survey where respondents identified barriers to attending appointments.</p>

<p>Select the category for each PIP:</p> <p><i>Non-clinical:</i></p> <p> <input type="checkbox"/> Prevention of an acute or chronic condition <input type="checkbox"/> High volume services <input type="checkbox"/> Care for an acute or chronic condition <input type="checkbox"/> High risk conditions <input checked="" type="checkbox"/> Process of accessing or delivering care </p>		
<p>1.3 Did the Plan’s PIP, over time, address a broad spectrum of key aspects of enrollee care and services? <i>Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.</i></p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	<p>The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessment among beneficiaries who receive services system-wide. A key strategy that is being implemented involves more direct contact with new beneficiaries (or parents/guardians for those under 18 years) prior to their first outpatient mental health appointment using MI as the overarching methodology. Use of this evidence-based practice can help determine what barriers beneficiaries may be experiencing that keep them from acting, in this case, following through with scheduled appointments.</p>
<p>1.4 Did the Plan’s PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? <i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input type="checkbox"/> Other </p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine </p>	
Totals		4 Met

STEP 2: Review the Study Question(s)		
<p>2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population?</p> <p><i>Include study question as stated in narrative:</i> Will implementing direct client outreach defined by CSWs/FSWs calling clients one to five days in advance of their initial outpatient mental health appointment utilizing Motivational Interviewing (MI) techniques and linking clients to resources such as Overcoming Transportation Barriers (OTB) program (which fosters transportation independence through educating clients on public transportation options), increase appointment adherence to the initial assessment from 41 percent at the MHP's East County Adult Mental Health Services, and from 35 percent at the MHP's East County Children's Behavioral Health, to 25 percent, to ensure clients receive timely access to mental health services?</p>	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>It would be more measurable if the calls to beneficiaries were made on a specific day (not a range), and possibly compared, to provide information to allow for success to be duplicated elsewhere.</p>
Totals		1 Partially Met
STEP 3: Review the Identified Study Population		
<p>3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?</p> <p><i>Demographics:</i> <input type="checkbox"/> Age Range <input type="checkbox"/> Race/Ethnicity <input type="checkbox"/> Gender <input type="checkbox"/> Language <input checked="" type="checkbox"/> Other: Clinic Location</p>	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>The MHP has identified the East County region as the primary focus for initial interventions. Both East County adult and East County on; however, information on how the study will address the entire beneficiary population, or a specific sample of that population was not provided in this section, nor information on how inclusion of all members will occur.</p>

<p>3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?</p> <p><i>Methods of identifying participants:</i></p> <p><input type="checkbox"/> Utilization data <input type="checkbox"/> Referral <input type="checkbox"/> Self-identification <input type="checkbox"/> Other:</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine</p>	
Totals		1 Partially Met 1 UTD
STEP 4: Review Selected Study Indicators		
<p>4.1 Did the study use objective, clearly defined, measurable indicators?</p> <p><i>List indicators:</i></p> <ul style="list-style-type: none"> • First Scheduled Outpatient Mental Health Missed Appointment Rate • Business Days from Referral to First Completed Routine OP Appointment (mean) • Rate of New Beneficiaries Contacted for Initial Appointment Engagement • Rate of Completed Appointments among Successful Contacts • Percent of Beneficiaries referred to Commute Navigation Specialists (Overcoming Transportation Barriers resource) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	

<p>4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused.</p> <p><input type="checkbox"/> Health Status <input type="checkbox"/> Functional Status <input type="checkbox"/> Member Satisfaction <input type="checkbox"/> Provider Satisfaction</p> <p>Are long-term outcomes clearly stated? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are long-term outcomes implied? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine</p>	<p>Indicators measured processes of care with strong associations with improved outcomes.</p>
Totals		2 Met
STEP 5: Review Sampling Methods		
<p>5.1 Did the sampling technique consider and specify the:</p> <p>a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?</p>	<p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	

<p>5.2 Were valid sampling techniques that protected against bias employed?</p> <p><i>Specify the type of sampling or census used:</i></p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
<p>5.3 Did the sample contain a sufficient number of enrollees?</p> <p>_____ N of enrollees in sampling frame _____ N of sample _____ N of participants (i.e. – return rate)</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	
Totals		3 NA
STEP 6: Review Data Collection Procedures		
<p>6.1 Did the study design clearly specify the data to be collected?</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
<p>6.2 Did the study design clearly specify the sources of data?</p> <p><i>Sources of data:</i></p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met	

<input type="checkbox"/> Member <input type="checkbox"/> Claims <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Other: EHR	<input type="checkbox"/> Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? <i>Instruments used:</i> <input type="checkbox"/> Survey <input type="checkbox"/> Medical record abstraction tool <input type="checkbox"/> Outcomes tool <input type="checkbox"/> Level of Care tools <input type="checkbox"/> Other:	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	While information on untoward results planning was provided, minimal information was provided on the approach to data analysis. The PIP would benefit from a more robust data analysis plan (similar to that which was provided in the Clinical PIP) that contains a more detailed outline of each step/action taken in the data analysis along with the reasoning behind it. This information would answer the question "How do these factors produce valid and reliable data representing the entire beneficiary population to which the study indicators apply?"

<p>6.6 Were qualified staff and personnel used to collect the data?</p> <p><i>Project leader:</i> Name: Priscilla Aguirre Title: Quality Management Program Coordinator Role: Chair</p> <p><i>Other team members:</i> Names: Planner/Evaluator (Jean Jacob) Research & Evaluation Manager (Kenneth Gallagher)</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine					
Totals		4	Met	1	Partially Met	1 UTD

STEP 7: Assess Improvement Strategies		
<p>7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?</p> <p><i>Describe Interventions:</i></p> <ul style="list-style-type: none"> CSW/FSW calls New Beneficiaries between 1 to 5 days in advance of the initial outpatient Mental Health appointment to remind the beneficiary of their initial intake assessment appointment and provide the beneficiary with more information about the appointment (what to expect, length of appointment, etc.). Additional calls are made to the beneficiary as deemed necessary by CSW/FSW staff to provide an additional reminder of appointment, if necessary, such as for those with cognitive functional limitations, or to follow-up on resources needed to overcome barriers to attending appointment. If beneficiary expresses any ambivalence about attending this appointment, the CSW/FSW will use MI to help beneficiary work through ambivalence and attend appointment. The CSW/FSW will identify any beneficiaries who have transportation barriers and will provide a warm hand off to OTB for transportation assistance in navigating the public transportation system or for referrals for transportation vouchers. 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	<p>Although the MHP chose interventions which were indicated by the 2016 respondent survey, a more current assessment detailing the causes/barriers to attendance was not. A current and formal barrier analysis would provide better information upon which to base interventions, boosting the likelihood of success.</p> <p>Second, it would be more measurable if the calls to beneficiaries were made on a specific day (not a range), and possibly compared, to provide information to allow for success to be duplicated elsewhere.</p>
Totals		1 Partially Met

STEP 8: Review Data Analysis and Interpretation of Study Results		
<p>8.1 Was an analysis of the findings performed according to the data analysis plan?</p> <p><i>This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)</i></p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>8.2 Were the PIP results and findings presented accurately and clearly?</p> <p>Are tables and figures labeled?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are they labeled clearly and accurately?</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	

<p>8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?</p> <p>Indicate the time periods of measurements: 1/3/2017 through 11/22/2017 1/24/2018 through 11/30/2018</p> <p>Indicate the statistical analysis used: Paired T test</p> <p>Indicate the statistical significance level or confidence level if available/known: Unable to determine</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
<p>8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities?</p> <p><i>Limitations described:</i> None</p> <p><i>Conclusions regarding the success of the interpretation:</i> Analysis is detailed and thorough.</p> <p><i>Recommendations for follow-up:</i> None</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	
Totals		4 Met

STEP 9: Assess Whether Improvement is “Real” Improvement		
<p>9.1 Was the same methodology as the baseline measurement used when measurement was repeated? <i>Ask: At what interval(s) was the data measurement repeated?</i> <i>Were the same sources of data used?</i> <i>Did they use the same method of data collection?</i> <i>Were the same participants examined?</i> <i>Did they utilize the same measurement tools?</i></p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>Data measurement was repeated every 4-6 weeks and reviewed by the PIP committee.</p>

<p>9.2 Was there any documented, quantitative improvement in processes or outcomes of care?</p> <p>Was there: <input checked="" type="checkbox"/> Improvement <input type="checkbox"/> Deterioration</p> <p>Statistical significance: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Clinical significance: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>First Scheduled Outpatient Mental Health Appointment Adherence Rates: For beneficiaries of The MHP's East County Adult Mental Health Services, there was a statistically significant reduction in the percentage of missed appointments ($X^2(1) = 5.37, p. = .02$). Similarly, for beneficiaries of the MHP's Children's Behavioral Health, there was also a statistically significant reduction in missed appointments ($X^2(1) = 4.34, p. = .04$).</p> <p><u>Rate of Completed Appointments among Successful Contacts:</u> For beneficiaries of the MHP's East County Adult Mental Health Services, there was a statistically significant relationship between being successfully contacted and attending the first appointment ($X^2 = 5.1, p. = .02$). Among those who were successfully contacted, 68 percent attended the appointment whereas among those who were not contacted, 58 percent attended the first appointment. For beneficiaries of the MHP's Children's Behavioral Health, the relationship between being successfully contacted was not significantly related to attending the first appointment ($X^2(1) = .73, p. = .39$). Of beneficiaries who were successfully contacted, 79 percent, attended the first appointment compared to 74 percent for those not successfully contacted.</p>
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<p>9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?</p> <p><i>Degree to which the intervention was the reason for change:</i></p> <p><input type="checkbox"/> No relevance <input type="checkbox"/> Small <input checked="" type="checkbox"/> Fair <input type="checkbox"/> High</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Unable to Determine</p>	<p>The MHP has some concerns about overall data quality for the appointment non-adherence indicator. For the period of July 1, 2018-September 30, 2018, 10.3 percent of cancellations for all appointment types were due to clerical errors, and not actual cancellation of appointments by providers or beneficiaries. Although the MHP has no reason to believe that the number of errors varied systematically from the time baseline data were calculated to when other calculations were performed, this issue does increase the overall amount of random error associated with these measures. The MHP will be working on excluding clerical errors from the reporting of canceled appointments.</p>
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<p>9.4 Is there any statistical evidence that any observed performance improvement is true improvement?</p> <p><input type="checkbox"/> Weak <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Strong</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine</p>	<p>There was a statistically significant decrease in the percentage of missed appointments for both the MHP's East County Adult Mental Health Services and East County children's clinic from the period before the PIP. The East County Adult Mental Health Services achieved a 17 percent reduction in missed appointments and the East County children's clinic experienced a 26 percent reduction. Similarly there was a statistically significant decrease in the business days from referral to completed appointment at each clinic. At the East County Adult Mental Health Services there was a reduction of ten days, and at East County Children's Behavioral Health there was a reduction of nine days. At the East County Adult Mental Health Services, there was also a statistically significant relationship between beneficiaries having been successfully contacted and appointment adherence. Although this relationship was not statistically significant for the East County Children's Behavioral Health, the data did show a higher percentage of beneficiaries who were contacted, attended their appointment than those who were not contacted (79 percent vs 74 percent, respectively).</p>
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<p>9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unable to Determine	<p>The observed improvement in appointment adherence was sustained over each quarter of observation. The decrease in business days from referral to completed first appointment demonstrated an immediate improvement over the first quarter after implementing the PIP, and this improvement was sustained over the course of the PIP. The MHP, however, needs to implement additional interventions, particularly in adult clinics, to achieve the goal of no more than 25 percent missed appointments.</p>
Totals		5 Met

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

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

Conclusions:

Met	16
Partially Met	7
Not Met	0
UTD	2
# Not applicable	3
Score	78.00%
total items in rating	25

Although the MHP chose interventions which were indicated by the 2016 respondent survey, a more current assessment detailing the causes/barriers to attendance was not. A current and formal barrier analysis would provide better information upon which to base interventions, boosting the likelihood of success. Second, it would be more measurable if the calls to beneficiaries were made on a specific day (not a range), and possibly compared, to provide information to allow for success to be duplicated elsewhere.

Recommendations:

Information on how the study will address the entire beneficiary population, or a specific sample of that population was not provided in, nor information on how inclusion of all members will occur. While information on untoward results planning was provided, minimal information was provided on the approach to data analysis. The PIP would benefit from a more robust data analysis plan (similar to that which was provided in the Clinical PIP) that contains a more detailed outline of each step/action taken in the data analysis along with the reasoning behind it. This information would answer the question “How do these factors produce valid and reliable data representing the entire beneficiary population to which the study indicators apply?”

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