

FY 15-16

Medi-Cal Specialty Mental Health

External Quality Review

San Bernardino Final Report

San Bernardino

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Prepared by:



Behavioral Health Concepts, Inc.

5901 Christie Avenue, Suite 502

Emeryville, CA 94608

www.caleqro.com

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INTRODUCTION

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

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

Due to extraordinary circumstances arising from terrorist acts that took place in San Bernardino County during FY 15-16 and demanded significant diversion of MHP resources, this MHP was granted a desk review for this period, consisting of a half-day onsite to perform consumer and family member focus groups, with the remainder of the review conducted with conference calls over the course of two days.

- MHP information:
 - Beneficiaries served in CY14—30,057
 - MHP Size—Large
 - MHP Region—Southern
 - MHP Threshold Languages—Spanish
 - MHP Location—San Bernardino

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

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

(1) VALIDATING PERFORMANCE MEASURES¹

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

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.

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

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS²

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

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES³

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

CalEQRO also conducted one/two/three/four/five 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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.

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

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

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

PRIOR YEAR REVIEW FINDINGS, FY14-15

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

STATUS OF FY14-15 REVIEW RECOMMENDATIONS

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

Assignment of Ratings

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

Key Recommendations from FY14-15

- Recommendation #1: Develop plans and strategies to implement Health Information Exchange standards to support the interoperable exchange of health related data between MH and other healthcare systems that protects confidentiality, privacy, and security of client information.

Fully addressed Partially addressed Not addressed

- The MHP is working to resolve two key areas which directly impact their ability to participate in comprehensive health information exchange. CalEQRO is aware that large projects require both significant time and resources to accomplish.
 - ▷ The pause in the Electronic Health Record (EHR) system implementation.

- ▷ Challenges regarding Inland Empire Health Information Exchange (IEHIE) which currently does not allow for the exchange of behavioral health information due to concerns about legal restrictions and confidentiality of medical records.
- The MHP continues to implement business processes for two specialized projects, Cal Medi-Connect and Behavioral Health Integration Initiative (BHI-I).
 - Cal Medi-Connect demonstration project includes collaboration with both Inland Empire Health Plan (IEHP) and Molina, the County's Managed Care Plans. As part of the effort the MHP has dedicated resources to bi-directionally share client-level data for both administrative and care coordination efforts.
 - BHI-I initiative is in its early implementation stages. The project is focused on improving, testing, developing best practices in care coordination between behavioral health and primary health care integration for the Medi-Cal population.
- Recommendation #2: Improve accuracy of timeliness measurement standard for initial contact date as the current method underestimates average wait time. The current method uses episode opening date, which may not reflect the initial access contact date that can frequently be a phone call, e-mail or walk-in contact preceding the episode opening date.

Fully addressed Partially addressed Not addressed

- This functionality was originally planned as part of the EHR deployment. Since that implementation was delayed the MHP held collaborative meetings with county-operated and contract providers to develop intermediary plans to ensure the new 1915(b) Waiver Special Terms and Conditions (STC) are accurately and completely collected.
- After assessing multiple options it was determined to use the Initial Contact Log (ICL) standalone SQL server database and develop web-based portal that could be accessed by both county-operated and contract providers. And will capture key data elements of First Appointment Offered and First Appointment Given.
- The MHP anticipates the newly revised ICL database will begin to provide data reports on timeliness measures during the summer of 2016, which fully supports 1915(b) Waiver STCs.
- Recommendation #3: Develop further strategies to recruit and retain psychiatrists and other clinicians as well as explore alternative ways for access in the underserved population centers such as the High Desert and Morongo Basin areas.

Fully addressed Partially addressed Not addressed

- The MHP has identified financial incentives in the recruitment and retention of psychiatrists, utilizing the National Health Service Corps Loan Repayment program and the Mental Health Loan Assumption Program as mechanisms of supporting this activity.
- The MHP has also been working with County Human Resources Department to identify positions and regions that qualify for the Remote Assistance Program. During this process, the MHP has concluded that the entire county should qualify for the National Health Service Corps, with the exception of Jail and Juvenile Hall, making substantial tuition reimbursement available. The number of covered practitioners has quadrupled.
- The more remote areas of the MHP, including Needles, Barstow, Victorville and Hesperia, continue to have a psychiatry vacancy, but other vacancies are resolving. The MHP significantly utilizes interns in these remote areas, and later assist them through the permanent hire process.
- Workforce, Education and Training (WET) Division created a “San Bernardino County Community Cradle to Career Roadmap” which provides a long term response to the need to develop a sustainable workforce.
- WET attended 35 career fair’s during 2014/15 and interacted with 9,425 participants in an effort in engage future members of the behavioral health workforce.

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

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

- Access to Care
 - The MHP’s community, employees, and consumers experienced the tragic incidents of the December 2nd terrorist attack in San Bernardino County. While maintaining regular operations, the MHP was able to provide rapid response to mobilize internal and external mutual aid resources to offer comprehensive and robust crisis response and trauma recovery services to their community due to the Specialty Mental Health Services carve out and community mental health infrastructure. In the eight weeks following the incident, DBH provided a sustained response through **300** behavioral health providers to ten county departments, including Public Health, as well as, nine community organizations, and the community at large, providing up to **10,000** counseling/supportive contacts both via telephone and in person, in shifts, 24 hours-a-day, 7 days-a-

- week, for a total of **1,344** hours of continuous Behavioral Health care. Seven day a week support for survivors continues. This demonstrated a responsive capacity of an extraordinary nature, emphasizing the value in the SMHS carve out and community mental health infrastructure.
- San Bernardino County Department of Behavioral Health (DBH) is engaged in planning for the Drug Medi-Cal Waiver, with activities that include collaboration of quality improvement activities and implementation plans between Mental Health and Substance Use Disorder Services
 - The MHP has significantly expanded the Crisis System of Care, with California Health Facilities Financing Authority (CHFFA) and Investment in Mental Health Wellness Act of 2013 (SB-82), resulting in funding for three Crisis Residential Treatment Centers and one Crisis Stabilization Unit.
 - DBH has been preparing for Continuing Care Reform (CCR), with implementation slated for January 2017. Activities include Requests For Proposals (RFPs) for Foster Family Agencies (FFAs) and group home contracting. Discussions have occurred regarding budget impacts and funding allocations for both clinical resources and additional administrative and utilization review of CCR activities.
 - The MHP is continuing to refine its collaboration and bi-directional referral process with the two Medi-Cal Managed Care Plans, Inland Empire Health Plan (IEHP) and Molina Healthcare of California (Molina). The intent of this collaboration is to assure smooth referral and transitions for beneficiaries who present with differing level of treatment needs.
- Timeliness of Services
 - In response to State-level changes regarding the 1915(b) Waiver Renewal, specifically the Special Terms and Conditions, DBH has worked to improve the accuracy of timeliness data reporting for both directly-operated and contract programs.
 - Quality of Care
 - DBH has engaged in significant quality of care and outcome activities, including participation in the State Metrics Workgroups and Performance Outcome Systems Workgroups. The MHP has designed an Outcomes Evaluation framework and standards for its system of care, including Mental Health Services Act (MHSA) and Medi-Cal funded programs, and also a System-Wide Performance Outcomes Committee (SPOC), which meets consistently to design, evaluate and develop interventions related to data-driven decision making across the entire system of care.
 - The MHP/DBH has created the Managed Care Coordination Unit that furnishes complex care coordination for beneficiaries experiencing severe physical and mental illness impairments. This work has included development of a care

- matrix and case handling protocol related to all complex care coordination cases.
- Implementation of ICD-10-CM diagnostic coding has impacted all department operations as DBH works to test each section of clinical and business processes to ensure that accurate diagnostic codes are documented, reported in data fields and aligned with claims.
 - The MHP has accomplished preparations for succession planning for all DBH leadership positions, to assure continuity when change occurs.
 - The MHP operates under the guidelines of its strategic plan that includes: a focus on wellness and recovery; assurance of high caliber services including the development of improved practices; a focus on system-wide communication to support empowerment and staff inclusion; and the recruitment and retention of a high-caliber workforce.
- Consumer Outcomes
 - None identified

PERFORMANCE MEASUREMENT

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

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

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

TOTAL BENEFICIARIES SERVED

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

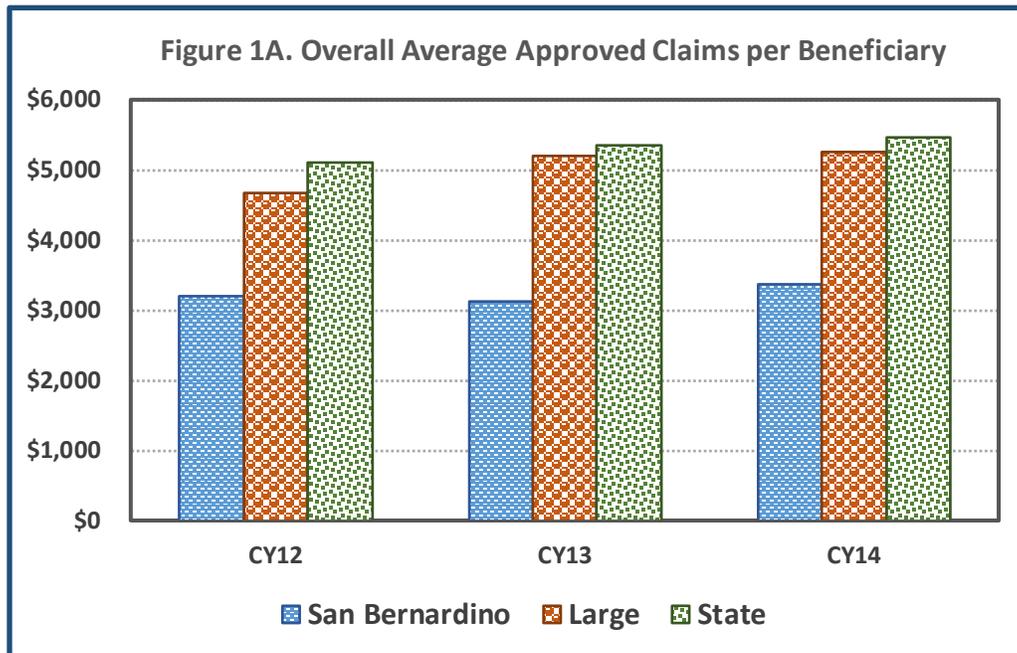
Table 1—San Bernardino MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	112,221	9,056
Hispanic	362,681	11,679
African-American	69,670	4,880
Asian/Pacific Islander	24,660	662
Native American	1,463	118
Other	62,898	3,662
Total	633,591	30,057

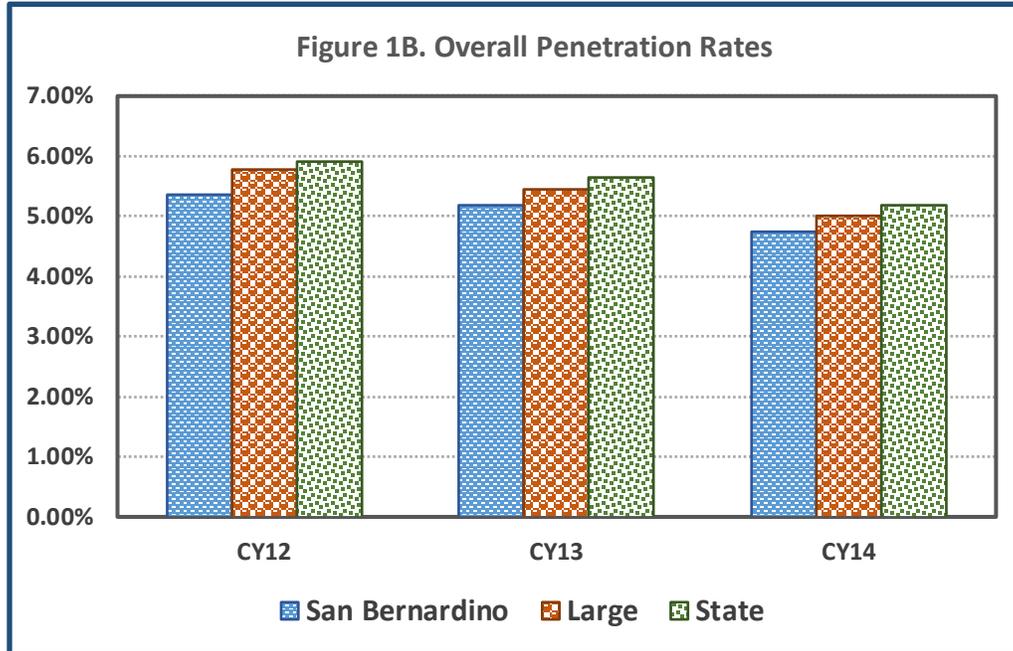
**The total is not a direct sum of the averages above it. The averages are calculated separately.*

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

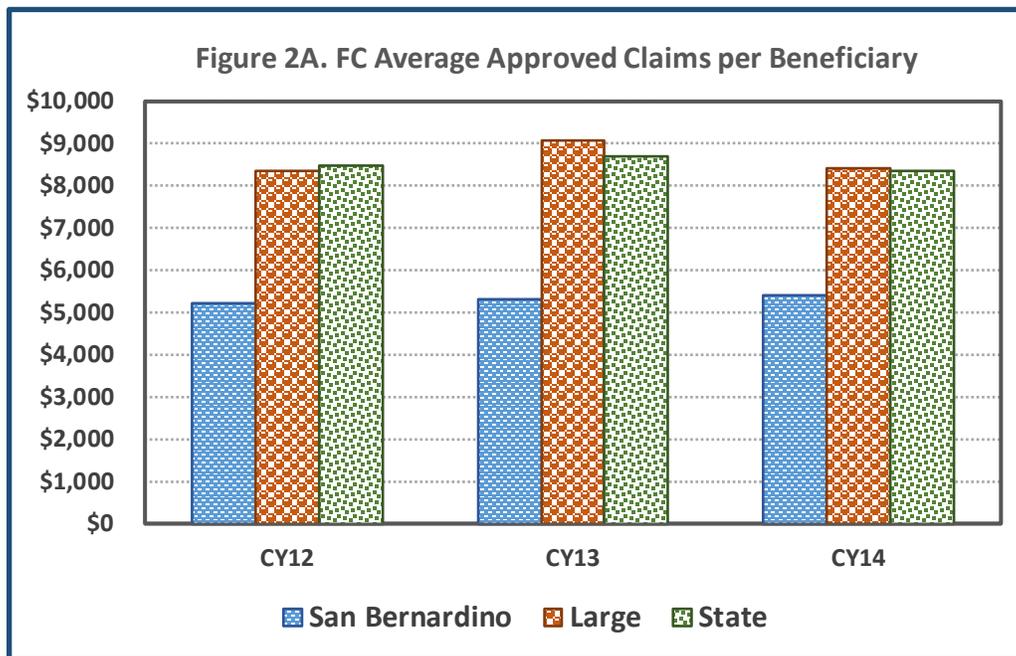
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

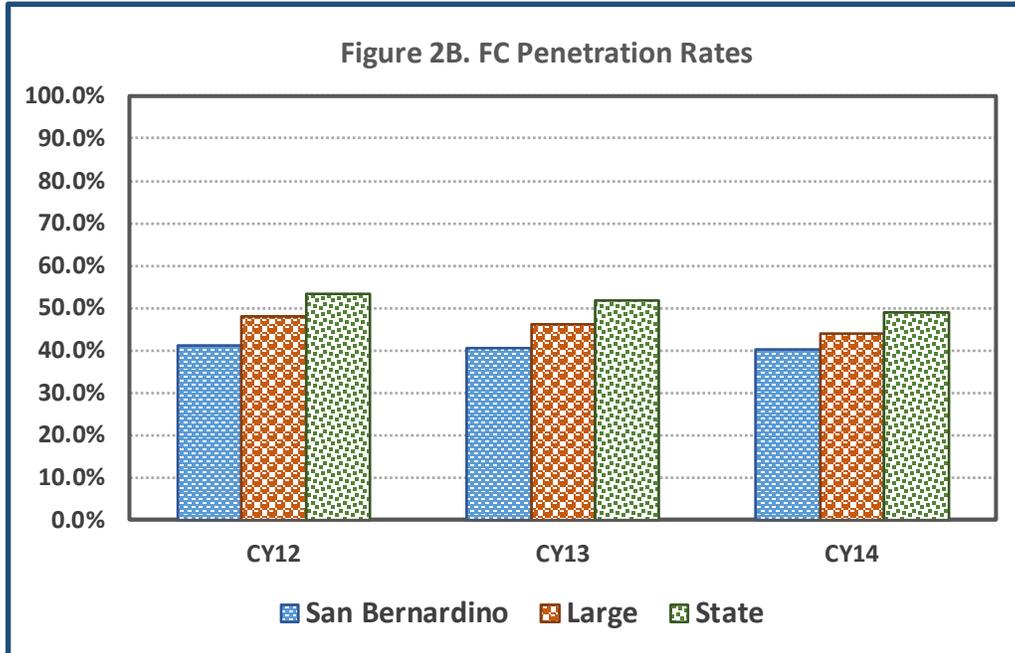
Figures 1A and 1B show 3-year trends of the MHP’s overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large size category MHPs.



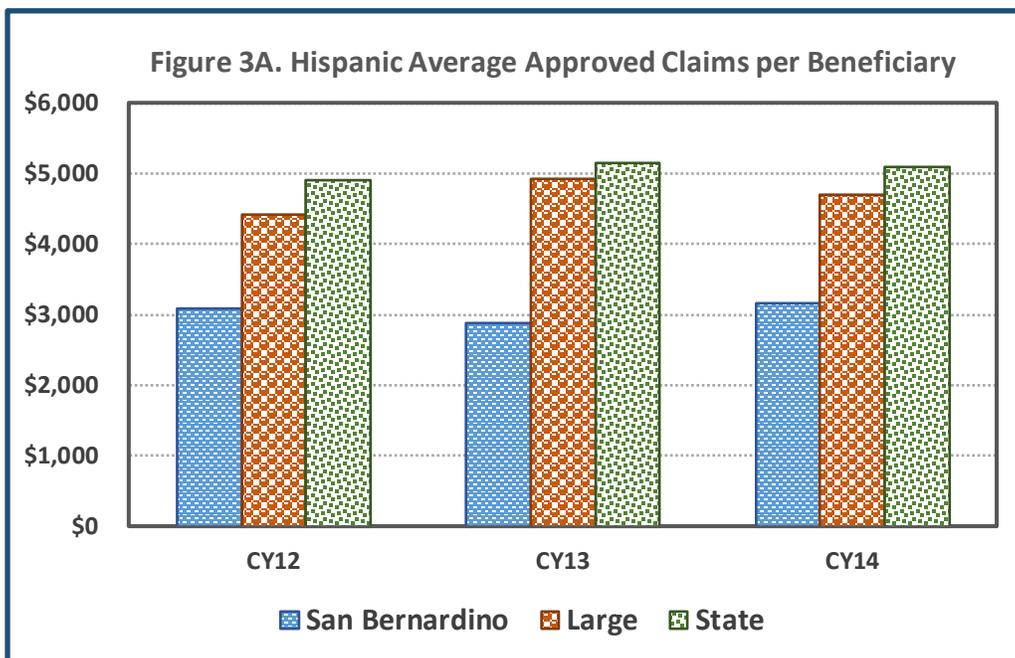


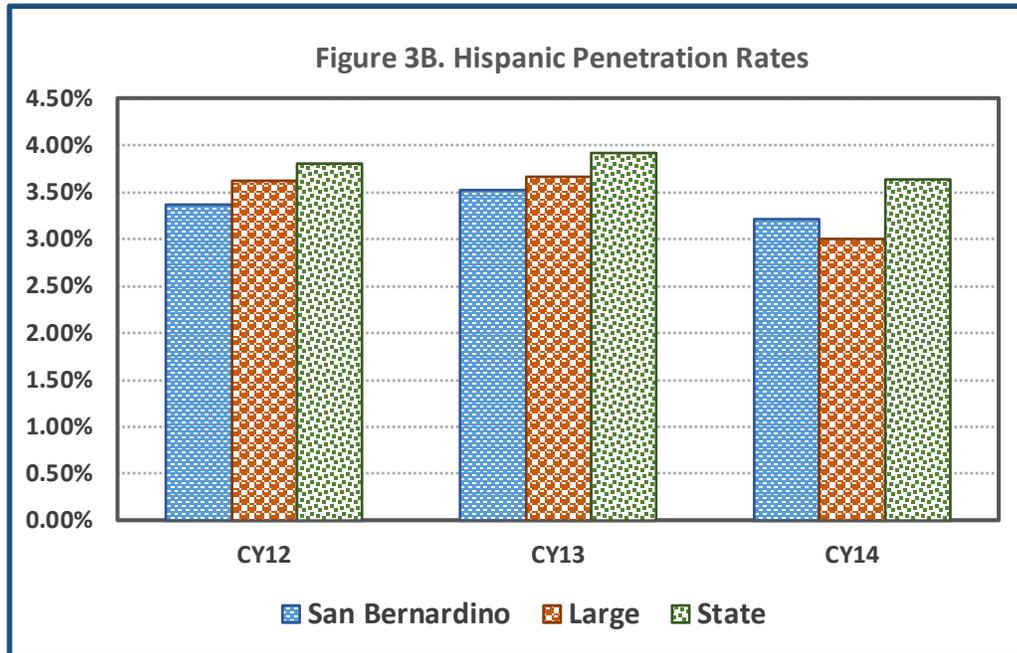
Figures 2A and 2B show 3-year trends of the MHP’s foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for Large size category MHPs.





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





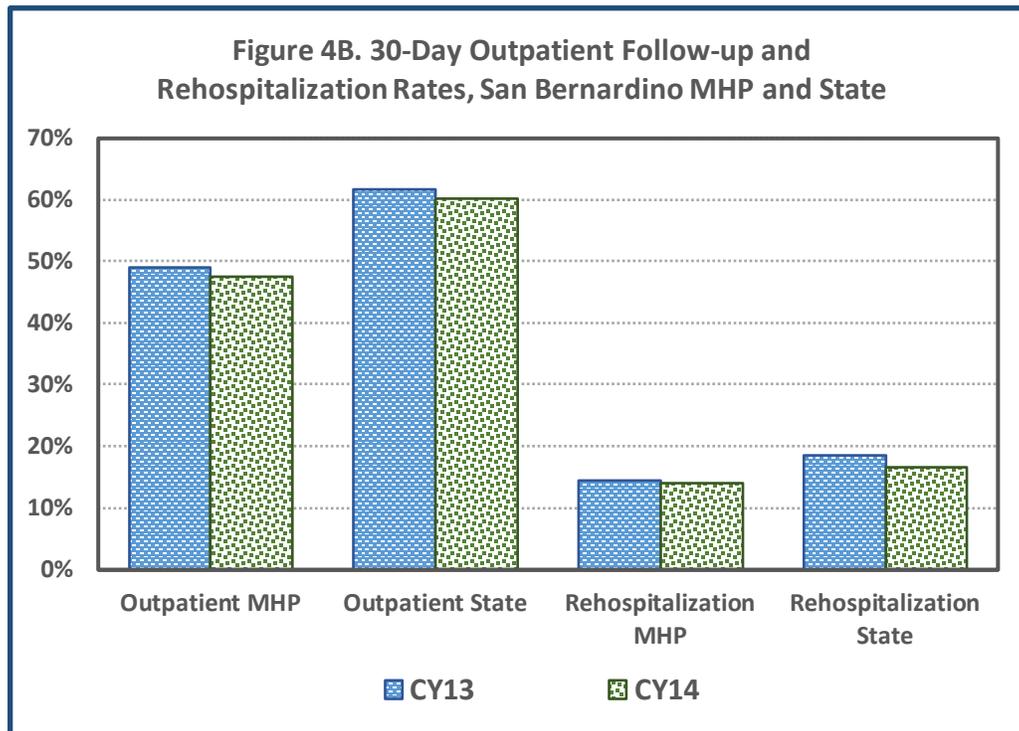
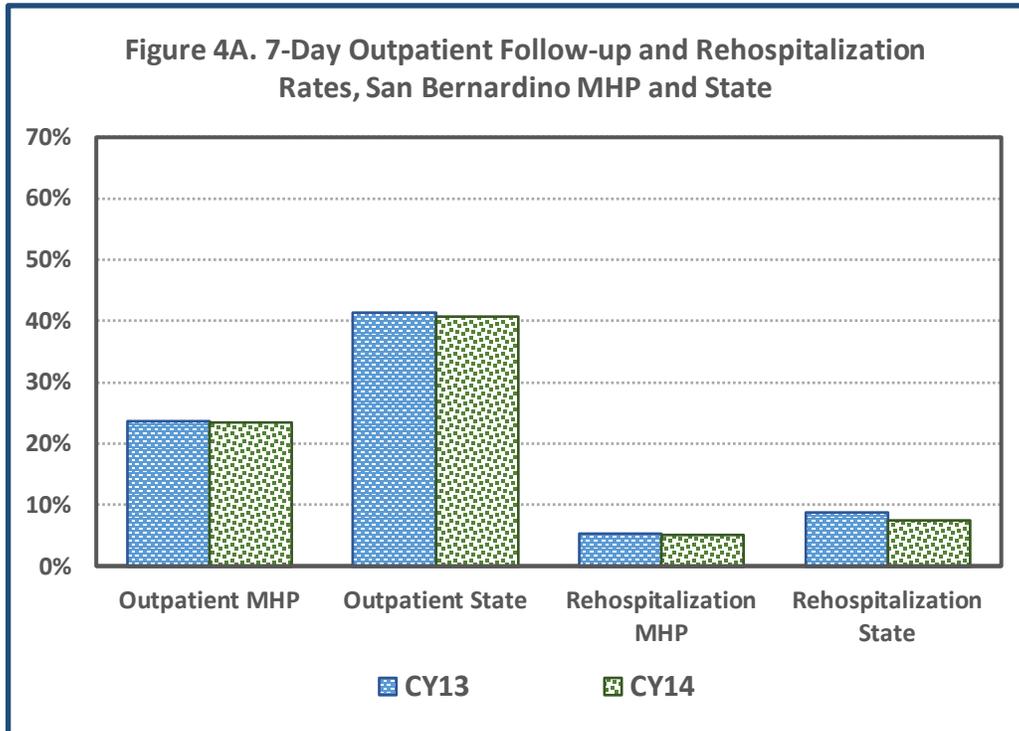
HIGH-COST BENEFICIARIES

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

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY14	12,258	494,435	2.48%	\$50,358	\$617,293,169	24.41%
San Bernardino	CY14	266	29,694	0.90%	\$42,905	\$11,412,790	12.60%
	CY13	308	29,077	1.06%	\$43,801	\$13,490,758	14.82%
	CY12	273	27,011	1.01%	\$46,027	\$12,565,503	14.53%

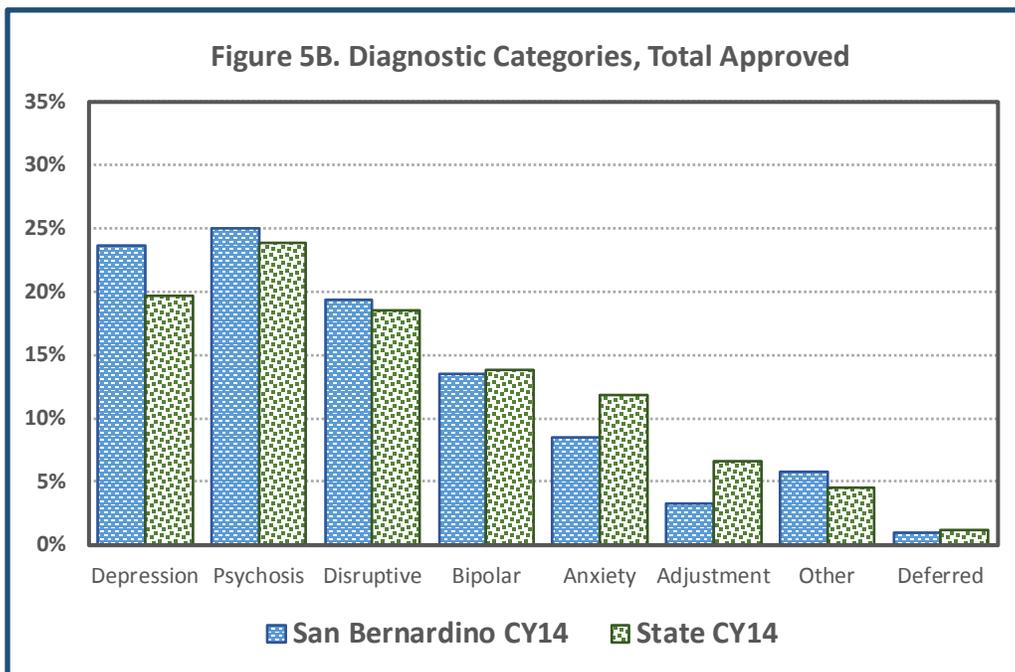
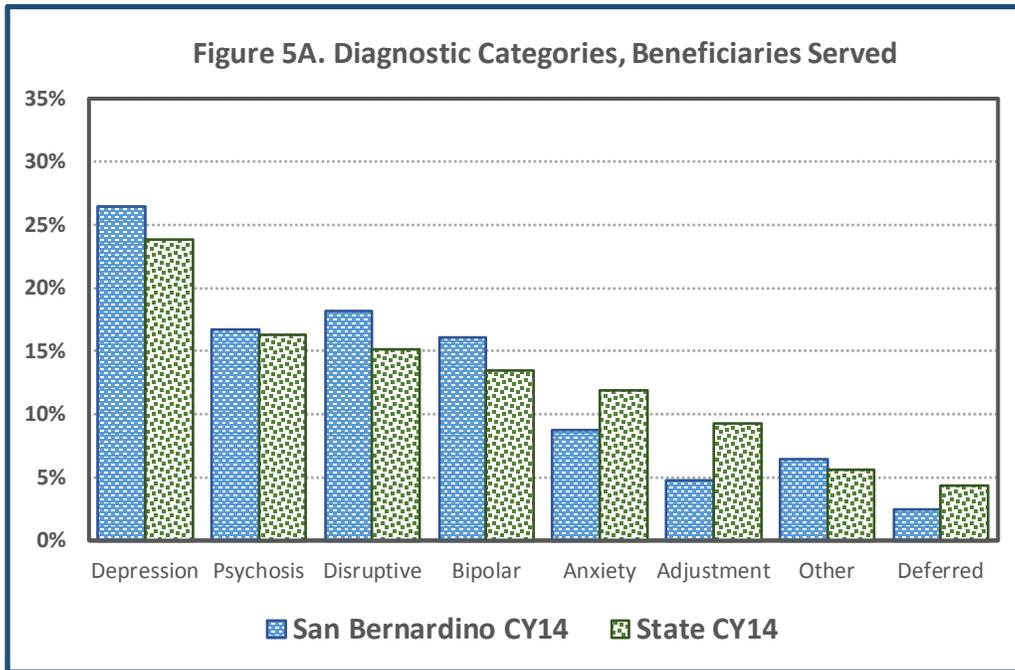
TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

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



DIAGNOSTIC CATEGORIES

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



PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP penetration rate slightly declined during three-year period. Its penetration rate was slightly lower than Large MHPs and statewide averages during the most recent three-year period. (See Fig. 1B.)
 - The MHP Approved Claims per Beneficiary Served (ACBS) remain stable during the three-year period and was significantly lower than Large and the statewide experience. (See Fig. 1A.)
 - The Foster Care penetration rate during the three-year period remain stable but much lower than Large MHPs and the statewide averages. (See Fig. 2B.)
 - Foster Care ACBS remain stable during the three-year period but was significantly lower than Large MHPs and the statewide experience. (See Fig. 2A.)
 - The MHP Hispanic beneficiary penetration rates continue to be comparable to the statewide experience; and Hispanic ACBS was significantly lower than Large MHPs and the statewide experience during the three-year period. (See Figs. 3A&B.)
- Quality of Care
 - The MHP's percentage of High Cost Beneficiaries (HCB) declined in CY14 to 0.90%, which was significantly less than statewide experience at 2.48%. The MHP's total percentage of approved claims for HCBs in CY14 at 12.60% was significantly less than the statewide figure at 24.41% (See Table 2).
 - Both HCB count and HCB total claim dollars have trended downward during CY13 and CY14 period. (See Table 2).
 - The MHP's identification of Depression and Disruptive diagnoses is slightly higher than statewide figures, and the claims dollars approved for these categories is higher than that of the statewide averages. (See Figs. 5A&5B.)
 - The MHP's identification of Psychosis diagnosis is within range of the statewide figure. The claims dollars approved for this category is lower than that of the statewide average. (See Figs. 5A&5B).
- Consumer Outcomes
 - The MHP's 7-day and 30-day outpatient follow-up rates for CY14 are similar to its CY13 rates. (See Figs. 4A and 4B).

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

SAN BERNARDINO MHP PIPS IDENTIFIED FOR VALIDATION

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

PIPs for Validation	PIP Titles
Clinical PIP	CHOICE Program Advancing Recovery Collaborative
Non-Clinical PIP	Hospitalized Patients Linkage and Engagement in Outpatient Clinic Services

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

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

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

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

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

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

Table 3B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	19	24
Number Partially Met	10	4
Number Not Met	1	2
Number Applicable (AP) (Maximum = 30)	30	30
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	80%	87%

CLINICAL PIP—CHOICE PROGRAM ADVANCING RECOVERY COLLABORATIVE

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

- “Will incorporating strength-based tools in treatment plans assist in decreasing criminal recidivism and psychiatric hospitalizations among CHOICE Program consumers?
 - Will there be a decrease in psychiatric hospitalizations?
 - Will there be a decrease in new criminal charges?”
- Date PIP began: October, 2013
- Status of PIP:
 - Active and ongoing
 - Completed
 - Inactive, developed in a prior year
 - Concept only, not yet active
 - Submission determined not to be a PIP
 - No PIP submitted

The MHP identified the topic of forensic-involved consumers experiencing high re-offending and hospitalization rates, as evident from local experience and review of literature on the topic. This has been particularly noted following the AB-109 realignment of a significant component of the forensic population to local communities. Since 2011, when AB-109 passed, over 10, 259 individuals have been released from state facilities to the local probation department. Over 600 of these were screened for mental health needs, with 393 (64%) determined to require services for mental health and/or substance use disorder needs.

The targeted population includes 85% of the forensic consumers served by DBH, but is limited to 1% of the total consumers receiving services. However, since this is a highly at-risk group, with significant clinical and forensic consequences, this population was considered an appropriate focus of departmental quality improvement activity.

The MHP turned to literature for assistance in identification of the strategy to apply to this population, the strength-based approach. This approach taps into a consumer-centric strategy, utilizing the resources and successes of each consumer in the approach to treatment, including the assessment and the development of a personal plan.

The PIP indicators involved the tracking of psychiatric hospitalization percentages, and occurrence of additional criminal charges, comparing intervention locations with non-intervention locations.

The resultant data was inconclusive: Hospitalization rates between the intervention and non-intervention sites reflected a statistically insignificant reduction for test site participants. Criminal charges decreased more at the non-intervention site groups than with the test sites. In addition, difficulties in tracking the forensic/criminal charges emerged, exacerbated by the change in court tracking system that occurred.

The interventions involved the creation of strengths assessment and the development of a personal recovery plan, applied to consumers at the intervention locations. The interventions of assessment and plan might have been augmented by a specific, structured approach to serving this population. A specific clinical approach that all staff were trained to provide, with frequency of contact also being tracked, might have provided additional activities and data to improve efficacy of this PIP.

This PIP was concluded in February of 2016, with data collection and summarization following.

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

The technical assistance provided to the MHP by CalEQRO consisted of recommendation that the topic under consideration for the next clinical PIP be discussed with EQRO prior to finalization. The MHP was not prepared to discuss this developing PIP yet.

NON-CLINICAL PIP—HOSPITALIZED PATIENTS LINKAGE AND ENGAGEMENT IN OUTPATIENT CLINIC SERVICES

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

- “Will the implementation of the Access, Coordination, and Enhancement of services program (ACE), increase the engagement in outpatient services post hospitalization?
 - Will consumers discharged from Arrowhead Regional Medical Center (ARMC) receive a scheduled outpatient appointment within 7 days of discharge?
 - Will an appointment with a psychiatrist or a medication support service be provided within 14 days of discharge, when medically necessary?
 - Will DBH’s percentage of beneficiaries that engage in outpatient services within 7 days upon inpatient hospital discharge increase from a rate of 15%?
 - Will ARMC recidivism rate for hospital re-admission within 30 days fall below 29%?”
- Date PIP began: August, 2013
- Status of PIP:
 - Active and ongoing
 - Completed

- Inactive, developed in a prior year
- Concept only, not yet active
- Submission determined not to be a PIP
- No PIP submitted

The MHP identified the relatively low post-hospital discharge follow-up rate (FY12-13: 21%) and related 30-day rehospitalization rates (FY12-13: 23%) as a focus benefitting from improvement efforts. The population the MHP targeted with this PIP was limited to those hospitalized at the Arrowhead Regional Medical Center (ARMC) where the MHP has a strong working relationship and constitutes 60% of all admissions.

The MHP utilized the following indicators to track the success of this PIP:

- Percentage of individuals scheduled with a post-hospital discharge follow-up appointment within 7 days. Goal of 100%
- The 30-day rehospitalization rates. Goal of 10%.
- Clinic engagement rate (completed appointment) within 7 days. Goal of 40%.

Applied to this issue is the Access, Coordination and Enhancement (ACE) services of the MHP, and includes: 1) contact and engagement of consumers prior to appointments, and in the event of no-shows; 2) education of consumers on diagnosis and medications and the plan of care by clinical and medical ACE staff; 3) completion of a needs assessment by ARMC staff, with linkage to a clinic and ACE representative in the area the consumer resides with the intention of addressing barriers to service follow-up and assurance that basic needs are met; 4) individuals not open to the MHP's outpatient services at the time of hospitalization are provided an outpatient intake appointment within 7 days of discharge/existing consumers are scheduled with a psychiatry follow-up appointment within 14 days of discharge.

The results of this PIP were as follows:

- Scheduled appointments demonstrated a consistent increase, with both referrals and scheduled appointments, across all measurement periods. The 100% goal was not achieved.
- The 30-day re-hospitalization rate increased following the baseline period, but then decreased across the subsequent measurement periods. The end periods reflected a 1% drop over the base line. The 10% goal was not achieved.
- The completed appointment statistic varied between the two methods used by the MHP. The method based on the number of referrals (Method #1) showed significant decreases during the six comparison periods, except for two periods. The method based on the

recorded attended appointments (Method #2) showed increases through all comparison periods except for the first and third.

The conflicting results may be related to inconsistent documentation in the ACE log. Furthermore, review of this data has identified related possible causative factors: ACE positions incompletely filled, including psychiatry, resulting in workforce challenges. The training of all staff and partners is a clear issue. The tracking system exists outside of the existing practice management system/SIMON/InSyst. Tracking of medical necessity for follow-up was not possible as originally conceived. Business practices for referrals of consumers between hospitals and DBH are not well established.

The MHP has ended this PIP and is working on the development of a replacement topic.

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

The technical assistance provided to the MHP by CalEQRO consisted of discussions with the MHP of the importance of reviewing the next PIP topic that is under development in advance of finalization. The MHP was not prepared at the time of this review to discuss the next topic.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The Non-Clinical PIP ACE program services are intended to provide improve access to care and help resolve potential service barriers.
- Timeliness of Services
 - Non-Clinical PIP's focused efforts to improve post-hospital appointments that are scheduled and provided to consumers within seven days of discharge will likely improve clinical status of consumers and reduce re-hospitalizations.
- Quality of Care
 - The Clinical PIP's use of the strength-based assessment and plan has the potential of leading to improved engagement and clinical status for forensic consumers, with possible reductions of re-hospitalization and reoffending.
- Consumer Outcomes
 - Efforts to improve engagement of forensic consumers through a strength-based assessment and plan have the potential for impacting re-offending behavior as well as stabilizing mental health and substance use disorder conditions as well as improve outcomes.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

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

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	The MHP operates with a Cultural Competence Plan that received a 2015 update. Within this structure, leadership is advised by a Latino Coalition, LGBTQ, Native American, Spirituality, TAY subcommittees, along with many other sector input.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	In response to analysis of populations and regional needs, the MHP has expanded crisis services in the more distant regions which had been under-served. The MHP regularly monitors beneficiary distribution and considers these findings in the alignment of resources. The MHP has engaged in extensive analysis of staffing needs and recruitment and retention strategies to maintain a stable workforce.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP collaborates with local Medical Managed Care Organizations to manage bi-directional referrals for care. The MHP collaborates with Child Welfare regarding services for Foster Care children and youth. The MHP has relationships with hospitals and other organizations to assure linkage with services.

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

Timeliness of Services

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

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	<p>The MHP utilizes a 14-day standard for the time from initial contact to first appointment. The average for adult consumers is 2.82 days and children 6.41 days. The achievement of standard overall stands at 93.8%.</p> <p>It should be noted that this parameter is based upon the time from the episode opening to the first following service. This approach likely under-represents the actual time of first request for services for consumers, and the MHP has plans to improve tracking in this area.</p>
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	<p>The MHP utilizes a 30-day standard for the time to the first psychiatry appointment. For this MHP, this data represents the days from the clinical intake to first meds appointment, and may understate the consumer experience of time from first request to the psychiatry service.</p> <p>MHP data on this issue reflects a 31.3 day average for adults and 39.8 days for children and youth.</p>
2C	Tracks and trends access data for timely appointments for urgent conditions	FC	<p>The MHP provides services for urgent conditions through Crisis Walk-In Centers and Community Crisis Response Teams, which utilize a same-day access standard. These services occur through directly-operated and contract provider programs.</p> <p>The MHP reports 100% of all requests meeting standard.</p>

Table 5—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	PC	<p>The MHP utilizes a 7-day (HEDIS) standard for follow-up after hospitalization. The standard is met 21% of the time for adults and 32% for children.</p> <p>The average days to follow-up are 35 for adults and 23 for children – compared to the prior review, this constitutes an increase of 6 days for adults and decrease of 3 days for children.</p> <p>This data is based on directly operated/county and fee-for-service hospitals.</p>
2E	Tracks and trends data on rehospitalizations	FC	<p>The MHP reports hospital admissions for FY14-15 of 8,490 adults and 1,498 children. The 30-day rehospitalization rate for this period was 24.6% for adults and 11.5% for children.</p>
2F	Tracks and trends No Shows	FC	<p>The MHP has not created a No-Show standard for psychiatry or non-psychiatry clinicians.</p> <p>MHP reports data for psychiatry no-shows is 14.22% in adult services and 17.25% in children's.</p> <p>Non-psychiatry clinicians have No-Show rates of 4.48% in adult services, and 7.54% in children's.</p> <p>This data is similar to the prior review period.</p>

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

Quality of Care

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

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP operates with a current Quality Improvement Performance Plan (QIPP), supported by QIPP Minutes and the evaluation of the previous year's plan. The minutes are notable in the information which is communicated, enabling readers to understand and track the improvement activities of the department.
3B	Data are used to inform management and guide decisions	FC	Data compilation and review is deeply embedded in departmental culture and operations. This is evident within the dashboards produced of services, outcomes, and demographics. Using this information, the MHP has expanded East Valley, Morongo Basin and High Desert locations, with Mobile Crisis Response and Crisis Walk-In Centers. The SAS Data Warehouse and use of data is Best/Exemplary Practice.
3C	Evidence of effective communication from MHP administration	FC	The MHP uses a variety of mechanisms to communicate with stakeholders, many of which are detailed in the MHP's Outreach Log. The MHP utilizes "Web Blasts" that are emails of information about services and cultural competence issues. Other communications are provided to contract providers through in-vivo meetings and emails. Consumers and staff are participants in other communication efforts that include meetings and emails.

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	<p>The MHP continues to utilize information gained from the 2014 Vision Survey of staff. Other input is obtained from District Advisory Committees, the Behavioral Health Commission and Health Reform meeting discussions, and contract provider meetings.</p> <p>The MHP collected and analyzed its survey of contract providers during the October 2015 through January 2015 periods. Feedback on aspects of interface were detailed and analyzed.</p>
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	<p>The MHP has significant collaborations that involve improving quality of care. Examples include integration with the Inland Empire Health Plan (IEHP) and Molina Health Care, the two Medi-Cal Managed Care plans, Child Welfare Services to improve care for Katie A eligible, and CalMedi-Connect.</p>
3F	Measures clinical and/or functional outcomes of beneficiaries served	PC	<p>The MHP established the “DBH Framework for Performance Outcomes” September 2015, that maps MHPA outcome measurement reporting. The Child and Adolescent Needs and Strengths (CANS) instrument is fully implemented in contract children’s programs and in the process of rolling out into directly operated children’s programs. The Adult Needs and Strengths Assessment (ANSA) is rolled out to Full Service Partnership (FSP) programs and the next phase will include contract and directly operated MHP services.</p>

Table 6—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP administered the Fall 2015 Consumer Perception Survey (CSP), receiving 2,975 responses. The survey received participant analysis by demographic variables and location of service. The MHP also analyzed and published the resultant consumer perception responses the CSP surveys from Fall 2014 and Spring 2015.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP has a job description for Peer/Family Advocates, which contains a I/II and III series ladder. The MHP maintains a committee for Consumer/Family Member concerns and memorializes these activities in minutes and other communications.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	Wellness centers utilize consumer employees and volunteers to support operations. Content of programming targets issues relevant to supporting recovery.

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

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
 - The MHP is in the process of implementing the approved expansion of crisis residential and crisis stabilization programs in underserved regions of the county. This should provide consumers with more rapid access to local intensive services and reduce the need to utilize hospital beds.
 - The MHP tracks the ethnicity and cultural needs of consumers in each of its regions, integrating his tracking with efforts to improve access for under-served populations.
 - The MHP is working with the local managed care health plans on a collaborative approach to bi-directional referrals, accepting the more seriously ill consumers for MHP services and referring to managed care plan resources those who are mild-to-moderate.
- Timeliness of Services

- The MHP tracks and reports initial timeliness, for which a low number of average days is reported for all populations. However, the MHP's current approach of tracking episode opening to first claimed appointment has the potential for significant under-reporting of actual time to first service. The MHP plans to use the Initial Contact Log application, which will improve timeliness reporting tracking.
- The MHP's has a 30-day standard for initial psychiatry services, a duration that is considered long. It uses the clinical intake service date as the basis for starting the clock on psychiatry timeliness.
- Hospital aftercare follow-up significantly exceeds the 7-day HEDIS standard, averaging 35 days for adults and 23 for children/youth; achievement of the HEDIS standard is low, at 21% for adults and 32% for children/youth.
- Quality of Care
 - The MHP operates with a Quality Improvement Performance Plan (QIPP) that bases goals in a data-driven and process framework. The prior year's plan and results were evaluated and the information utilized in the current plan. The MHP's minutes and other documents support the tracking of long-term data trends.
 - Data compilation and review is evident and embedded in dashboards formulated and utilized by the MHP to plan its changes to distribution of services.
 - The MHP's efforts to broadly communicate with stakeholders is evident in its use of "web blasts," emails of information about services and changes, as well as utilizing various forums to gather and communicate cultural and ethnic issues. Consumers are involved throughout these processes. This has included use of information from the 2014 Vision Survey of staff.
 - The MHP's effort to partner with the two local Medi-Cal Managed Health plans, Cal Medi-Connect, and partnership with Child Welfare, are examples of its efforts to become an integral part of health care delivery in the county.
- Consumer Outcomes
 - In December 2014, the MHP established a San Bernardino County Department of Behavioral Health "Framework for Performance Outcomes," mapping legislative and funding source requirements across the DBH system of care to appropriate performance outcomes for reporting. The CANS is fully implemented in both contract programs and directly-operated programs.
 - The ANSA is slated for implementation in the coming year for all adult programs.
 - The MHP provided analysis of the Consumer Perception Survey of Fall 2015, considering demographic variables and location of service in that analysis.

- The MHP utilizes peer and family advocates in service delivery, with a three-level employment ladder. Wellness centers also utilize consumer employees as well as volunteers.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested 2 focus groups, which included the following participant demographics or criteria:

- Focus Group 1: 8-10 Adult consumers and family members, culturally diverse group of beneficiaries, including both high and low utilizers of MHP services. At least three beneficiaries who have initiated services within the last year.
- Focus Group 2: 8-10 Parents/caregivers of child/youth beneficiaries, culturally diverse group including both high and low utilizers of MHP services. At least three beneficiaries who have initiated services within the last year.

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

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

Focus Group 1 consisted of adult consumers, culturally diverse, with varying lengths of time receiving services. All participants were chosen from Rialto, Ontario and San Bernardino Club Houses.

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

- One person had begun services eight months ago after a break of several years. He defined the entry into services as difficult. The people at the front window were not helpful and initially turned him away.
- All participants in the focus group endorsed that time to see a psychiatrist after referral was within two weeks and often within a few days.

Recommendations arising from this group include:

- All agreed that housing and transportation are issues that need to be addressed in order to improve access to care.
- Club Houses should require more identification required that you actually belong there. Some access control is needed to be sure who is there.
- The referrals that are received for providers need to be checked to make sure they work and are valid.
- More hands on with rehab as far as getting back into society is needed.

- PFAs needed to do more peer family advocating and going on MD appointments with new clients.
- Offer a way for clients who are stable to begin to give back to the system.
- All felt there needs to be consequences of some sort for those who do not follow rules of program in Club Houses.
- More therapists to ensure timely services are offered.

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

Table 7A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants*		8
Number/Type of Participants	Consumer Only	7
	Consumer and Family Member	1
	Family Member	0
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	7
	Older Adult (60+)	1
Preferred Languages	English	8
	Spanish	0
	Bilingual _____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	4
	Hispanic/Latino	2
	African American/Black	1
	Asian American/Pacific Islander	0
	Native American	0
	Other(s) <u>African-American & Caucasian</u>	1
Gender	Male	3
	Female	5
	Transgender	0
	Other	0
	Decline to state	0

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

Interpreter used for focus group 1: No Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

Focus Group 2 consisted of three (3) female foster parents of child/youth beneficiaries, culturally diverse and including both high and low utilizers of MHP services. The children who were the beneficiaries were ages seven (7), ten (10) and eleven (11) years old respectively.

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

- There was one participant who had begun services less than one year ago.
- All participants described access to services as easy when the referral was received.
- Participants stated that they felt supported.
- All participants reported that the response to calls when they have behavioral issues with their children was timely and useful.
- All participants reported that the child beneficiary was seen by a psychiatrist and two receive medication.

Recommendations arising from this group include:

- The participants would like more input into the rewards system that the therapists put in place in working with the children's behavior expectations.
- The participants all reported that they would recommend more frequency of services, especially psychiatric appointments.
- The participants agreed that they recommend more information on diagnosis and treatment for their children.
- Participants agreed they would like a meeting for foster parents to give more social support.

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

Table 7B—Consumer/Family Member Focus Group 2		
Category		Number
Total Number of Participants*		3
Number/Type of Participants	Consumer Only	0
	Consumer and Family Member	0
	Family Member	3
Ages of Focus Group Participants	Under 18	0
	Young Adult (18-24)	0
	Adult (25–59)	2
	Older Adult (60+)	1
Preferred Languages	English	3
	Spanish	0
	Bilingual _____/_____	0
	Other(s) _____	0
Race/Ethnicity	Caucasian/White	0
	Hispanic/Latino	0
	African American/Black	3
	Asian American/Pacific Islander	0
	Native American	0
	Other(s) _____	0
Gender	Male	0
	Female	3
	Transgender	0
	Other	0
	Decline to state	0

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

Interpreter used for focus group 2: No Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
 - Access to housing and transportation are needed.
 - More frequent therapy and psychiatry services is desired by participants.
 - Provide structured support group for foster parents
 - Increase the number of therapists so that services are timely.

- Quality of Care
 - Children's therapists should include caregivers input more in the development of reward systems and behavioral expectations.
 - House need to improve the verification process of consumers to ensure that only individuals who are verified as belonging are attending.
 - Referrals to providers should be verified as an available resource before giving to consumers.
 - PFAs are needed to provide more family advocacy and support with new consumer MD appointments.
 - Club Houses need more rules and consequences for misbehavior.
- Consumer Outcomes
 - More Rehab services are needed so that societal re-integration is supported.
 - Develop ways for consumers to give back when progress has been made.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

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

Table 8—Distribution of Services by Type of Provider	
Type of Provider	Distribution
County-operated/staffed clinics	53%
Contract providers	41%
Network providers	6%
Total	100%

- Normal cycle for submitting current fiscal year Medi-Cal claim files:
 - Monthly More than 1x month Weekly More than 1x weekly

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

14%

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

10.9%

- Does MHP calculate Medi-Cal beneficiary penetration rates?

Yes No

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

- The MHP uses Medi-Cal penetration rates to measure served and underserved populations. Penetration rates are produced quarterly and used to gauge effectiveness of access/engagement efforts.
- The MHP uses prevalence data to measure poverty levels countywide and for program design and resource allocation.

CURRENT OPERATIONS

- The MHP continues to use InSyst as their primary information system that supports practice management, billing, and state-reporting requirements – there is no electronic health record capability. The current software version is Release V9.13, and was implemented October 2015.
- The MHP continues to use eCura for managed care functions that supports the authorization of services and adjudication of claims to Network Providers. The current software version CC3, Release 4.6.14, was implemented December 2015.
- Support for InSyst is provided by Information Services Department, Office of Information Technology. MHP support is currently is allocated 50 FTE positions to support operations and implement the new EHR system. During the past 12 months staff changes included hiring 12 staff; 7 staff retired, transferred, or terminated. As of March 2016 there were 14 unfilled technology positions.
- Most contract providers operate with their own EHR systems. Providers use file transfer protocol (FTP) process to upload billing and other data to InSyst. They are required to use InSyst for data entry and maintenance of consumer demographic and episode information.
- The MHP continues to use a telepsychiatry network to provide services for all county services areas. Most recent data provided shows they served a total of 1,152 clients, of which 163 were adults and 989 were children/youth. Languages supported are English and Spanish.

MAJOR CHANGES SINCE LAST YEAR

- Behavioral Health Management Information System (BHMIS) – e-Prescribing pilot project was implemented.
- ICD-10-CM diagnostic codes were implemented system wide.

- Patient's Rights – Grievance Tracking System was implemented.
- Initial and refresher computer skills training sessions were completed.
- BHMIS – expanded use of virtual server environments to include hosting BHMIS.
- BHMIS – staffing requirements for project implementation were addressed.
- Microsoft SQL Server 2012 migration is ongoing.
- Microsoft Office 2013 migration is ongoing.

PRIORITIES FOR THE COMING YEAR

- BHMIS – Billing system conversion from InSyst to ShareCare.
- BHMIS – Electronic Health Record.
- eCura – Managed Care Replacement Project.
- BHMIS –Treatment Authorization Request (TAR) Replacement Project.
- BHMIS – e-Prescribing Project (move from Phase I pilot).
- e-Lab - Electronic interface for lab requests (transactions).
- BHMIS – Data Integrity and Migration Project.
- BHMIS – Business Process and Systems Change Over Project.
- BHMIS – Communications Project.
- BHMIS – Department Training, Planning, and Management Project.

OTHER SIGNIFICANT ISSUES

- Double data entry for contract providers remains a challenge as the process is prone to errors for providers who have their local Electronic Health Record (EHR) systems, as they also are required to enter clinical data into InSyst system. This issue will not be resolved until the MHP's EHR system becomes operational and two-way exchange of electronic transactions are achieved.
- The lack of a functional EHR also impacts the MHP capability to efficiently implement Behavioral Health Integration Initiative (BHI-I) including local collaboration and shared business processes with Inland Empire Health Plan (IEHP). BHI-I allows the MHP and

IEHP to test the positive impact of intensely coordinated behavioral and primary health care services for the highest-need adult beneficiaries.

- While the paused EHR system implementation has resulted in innovative solutions to ensure state-mandates are met related to data gathering and submissions are accomplished in a “pen and paper” system. The manual processes, or single-purpose system solutions, are burdensome for clinical line and administrative support staffs’ and will be more stressful as significant changes at the State level are further revealed for the following initiatives:
 - 1915(b) Waiver Renewal and associated Special Terms and Conditions
 - Continuing Care Reform – Foster Care Agencies and group home contracting
 - 1115 Waiver incentive projects, including Whole Person Care and Health Homes.

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

Table 9—Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
InSyst – v9.13	Practice Management	The Echo Group	23	DBH IT
eCura – v4.6.14	Managed Care	InfoMC	16	DBH IT
SpectraSoft – v10.42	Appointment Scheduler	SpectraSoft	6	DBH IT
SAS Data Warehouse	Outcomes	SAS	4	DBH IT/Vendor
Objective Arts	Assessment/Outcomes	Objective Arts	4	DBH IT
RAMSELL	Manages Scripts	RAMSELL	5	DBH IT
Data Collection Reporting	FSP & MHSA Reporting	County IT	6	DBH IT/County IT
Initial Contact Log (ICL)	Tracking Initial Requests	DBH IT	5	DBH IT
Integrated Health Referral	Track Client Referrals	DBH IT	5	DBH IT
SAFE Security	Security and Auditing	DBH IT	3	DBH IT

PLANS FOR INFORMATION SYSTEMS CHANGE

- New system selected, not yet in implementation phase.

- The implementation of ShareCare with VHR project began November 2013; with original “go-live on July 2015” for practice management functionality.
- During FY14-15 CalEQRO review, which was March 2015, User Acceptance Testing (UAT) completion and system acceptance dates was not known.
- In May 2015 the County paused UAT and system acceptance. As of May 2016 the project implementation remains “paused”.

ELECTRONIC HEALTH RECORD STATUS

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

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments				X	
Clinical decision support				X	
Document imaging				X	
Electronic signature—client				X	
Electronic signature—provider				X	
Laboratory results (eLab)				X	
Outcomes	Objective Arts/CANS	X			
Prescriptions (eRx)	DrFirst		X		
Progress notes				X	
Treatment plans				X	
Summary Totals for EHR Functionality		1	1	8	0

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

- The CANS (Child and Adolescent Needs and Strengths) assessment instrument has been implemented by all county-operated programs and contract providers who serve children and youth consumers.
- An e-prescribing pilot project using DrFirst was implemented.
- The MHP continues to rely on paper medical record chart.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
 - The MHP continues to measure Medi-Cal penetration rates for both served and underserved populations. Penetration rates are produced quarterly and used to gauge effectiveness of access and engagement efforts.
 - The SAS Data Warehouse provides them the capability measure and project prevalence data to measure poverty levels countywide over time and is used for program design and resource allocation.
- Timeliness of Services
 - The current data system that captures consumers' date of initial phone call, email, or walk-in contact for services is independent of the larger data system, which tracks service provision. This lack of connectivity means that presently, initial timeliness is determined by the first face-to-face contact following episode opening, which has no relationship to consumer's initial contact for service date. The MHP is in the final stages of implementation of an upgraded data system, which will allow for accurate timeliness measures to be reported electronically and not only manually.
- Consumer Outcomes
 - The MHP is currently implementing the ANSA for adult/older adult populations at county-operated sites and their contract providers. The MHP is also evaluating other tools currently being used or considered to ensure the most applicable, useful tool is used in each setting.
 - The MHP uses CANS (Child and Adolescent Needs and Strengths) assessment instrument at all sites that serve children and youth beneficiaries. Data is captured at the consumer level and rolled-up to clinician and provider levels.

SITE REVIEW PROCESS BARRIERS

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

- No barriers to this review were noted.

CONCLUSIONS

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

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
 - Expansion of Crisis System of Care capacity using funding from California Health Facilities Financing Authority (CHFFA) and Investment in Mental Health Wellness Act of 2013 (SB-82) for three (3) Crisis Residential Treatment Centers and one (1) Crisis Stabilization Unit. The treatment centers are located in Fontana, San Bernardino, Victorville, and stabilization unit is in Joshua Tree.
 - The MHP is actively involved in planning for the Drug Medi-Cal Waiver, which will expand the resources available to individuals with substance use conditions and involve increased collaboration between the mental health and substance use divisions of the department.
 - The MHP utilizes the location of Medi-Cal eligibles in determining the areas in which service expansion should occur. This data includes the use of demographic variables to assist with planning.
 - The MHP's efforts to prepare for the Continuing Care Reform is helping to develop and position increased resources essential to improving services to the foster care population.
- Opportunities:
 - Foster Care beneficiary's penetration rates and approved claims per beneficiary served have not improved. Both penetration rates and services provided lag the statewide averages by over 10% during the recent three-year period.

Timeliness of Services

- Strengths:

- The MHP's the Initial Contact Log (ICL) modifications, to be utilized by both contract and directly-operated programs, should provide improved information on timeliness of services and assist in more accurate data collection.
- Opportunities:
 - The MHP's efforts to improve the precision of initial timeliness data is a well-focused effort since the consumer experience of wait time begins with the time of the initial request.

Quality of Care

- Strengths:
 - The MHP's Initial Contact Log will provide improved access information as it begins producing data during the summer of 2016, supporting the need to generate reports consistent with the 1915(b) Waiver Special Terms and Conditions.
 - The MHP's Quality Improvement Performance Plan clearly target quality performance areas and utilizes metrics and goals with clear consumer impact.
- Opportunities:
 - The lack of a functional EHR and creates workflow documentation challenges which require clinical staff to produce paper documents or enter data into standalone systems.
 - The MHP's 7-day post-hospital follow-up data is close to 50% of the statewide average, and is consistent with the MHP's identification of this area as one to receive improvement attention.

Consumer Outcomes

- Strengths:
 - The TCOM tools (CANS and ANSA) implemented by DBH can support decision making, including level of care and service planning, and facilitate the monitoring of service outcomes.
- Opportunities:
 - Continuation of the MHP's implementation plan of the ANSA instrument with directly-operated and contract provider services will address a clear need for uniform collection of outcome information across adult services.

RECOMMENDATIONS

- During FY14-15 CalEQRO review, March 2015, User Acceptance Testing (UAT) completion and system acceptance date was not known. Subsequently, in May 2015 the County paused UAT and system acceptance. As of May 2016 the ShareCare project implementation remains “paused”. The County needs to resolve the conditions that “paused” EHR implementation or consider alternative solutions. The lack of a functional Electronic Health Record (EHR) system continues hamper the MHP’s ability to efficiently design effective systems solutions to respond to changes from both the State level and local initiatives.
- Continue with the FY14-15 CalEQRO recommendation of development of plans and strategies to implement Health Information Exchange standards that support interoperable exchange of electronic health data between MHP and other healthcare systems that protects confidentiality, privacy, and security of client information.
- Complete implementation outcome assessment tool (ANSA) for adult and older adult System of Care programs that is inclusive of contract providers in addition to directly operated programs.
- As the MHP and Department of Child and Family Services implements the Continuing Care Reform (CCR) project, design and implement data reporting responsibilities that are defined and track services for Foster Care beneficiaries in placement settings.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

ATTACHMENT B—REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Lynda Hutchens, LMFT, Lead Quality Reviewer
 Bill Ullom, Chief Information System Reviewer
 Tilda De Wolfe, Consumer-Family Member, Consultant
 Saumitra Sengupta, Ph.D., Executive Director
 Rob Walton, RN, MPA, Quality Reviewer, Consultant

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

SITES OF MHP REVIEW

MHP SITES

San Bernardino County Department of Behavioral Health
 303 E. Vanderbilt Way San Bernardino, CA 92415-0026

PARTICIPANTS REPRESENTING THE MHP

Name	Position	Agency
Amber Carpenter	Clinical Therapist, Pre-Licensed	ADS-Administration
Andrew Gruchy	Deputy Director	DBH-Regional Operations
Arlene Ferrara		Inland Empire Health Plan
Barbara Knutson	Business Application Manager	DBH-Information Technology
Christina Glassco	Chief Quality Management Officer	DBH-Quality Management
Dianne Sceranka	Clinic Supervisor	DBH-Integrated Services
Dr. Joshua Morgan	Research and Planning Psychologist	DBH-Research & Planning
Imo Momoh	Cultural Competency Officer	DBH
Janeth Tran	Staff Analyst I	DBH
Jason Hill	Business System Analyst III	DBH
Jason Hinkle	Administrative Manager	DBH-Admin/Fiscal
Julie Hale	Clinic Supervisor	DBH-Triage Engagement Services Team
Kim Carson	Administrative Supervisor	DBH
Manuel Ted Rodriguez	Business System Analyst III	DBH
Mariann Ruffolo	Administrative Manager	DBH-Workforce, Education & Training

Name	Position	Agency
Marina Espinosa	Chief Compliance Officer	DBH-Compliance Office
Mark Thomas	Clinic Supervisor	DBH
Megan Daly	Project Manager	DBH-Program Support Services
Melissa Genisauski		Molina Health Plan
Miriam Clark	MH Education Consultant	DBH-Workforce Education & Training
Nancy Olsen	Program Manager II	DBH-CCRT East Valley
Neima Burrell	Automated System Analyst I	DBH
Olga Granillo	Clinic Supervisor	DBH-Quality Management
Patricia Grace	Automated System Technician I	DBH
Sandra Sesma-Ramirez	Staff Analyst II	DBH-Research & Evaluation
Sarah Eberhardt-Rios	Deputy Director	DBH-Program Support Services
Sherwin Farr	Program Manager II	Mesa Counseling Services
Valerie Maybrier	Secretary I	DBH

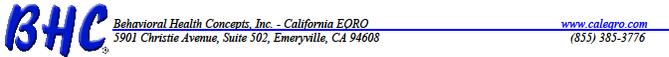
ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

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

ATTACHMENT D—PIP VALIDATION TOOL

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

Clinical PIP:



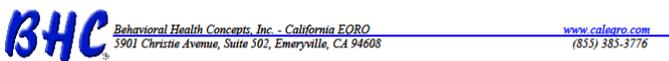
PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: San Bernardino <input checked="" type="checkbox"/> Clinical PIP <input type="checkbox"/> Non-Clinical PIP		
Name of PIP: CHOICE Program Advancing Recovery Collaborative		
Dates in Study Period: October 2013-January 2016		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<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	PIP participants included the Advancing Recovery Collaborative (ARC) team, Choosing Health Options to instill Change and Empowerment (CHOICE) staff, consumers, and other key participants from the mental health and forensic teams.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? <i>Select the category for each PIP:</i> Clinical: <input checked="" 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 checked="" type="checkbox"/> High risk conditions Non-Clinical: <input type="checkbox"/> Process of accessing or delivering care	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Unable to Determine	The PIP team considered existent literature on the topic of treating forensically involved individuals with substance use and mental health disorders. As well, it considered local data on these individuals, to the extent possible. The PIP team acknowledged that the PIP would involve 85% of all forensic MHP consumers; however, this population was limited to approximately 1% of all MHP consumers served. If successful, the impact upon this narrow population may be significant and seemed to the MHP worth exploring. Clearly the risk of relapse is significant with those having a mental illness and/or substance use issue and a history of criminal charges.

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Non-Clinical PIP:



PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: San Bernardino <input type="checkbox"/> Clinical PIP <input checked="" type="checkbox"/> Non-Clinical PIP		
Name of PIP: Hospitalized Patients Linkage and Engagement in Outpatient Clinic Services - Access, Coordination and Enhancement of Services (ACE)		
Dates in Study Period: August 2013 to December 31, 2015		
ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	<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	The focus of this PIP was primarily the engagement and follow-up of post-hospital discharge consumers with aftercare. A related element was tracking the 30-day readmission rate for additional information on these consumers. The topic was selected with the involvement of MHP Clubhouse consumers, of which 67 were surveyed. Consumer input furnished the MHP with a menu of suggested approaches to engaging consumers in follow-up care.

San Bernardino_Non-Clinical-PIP-Validation-Tool_FY15-16_RW_v2

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