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FY 17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

PERFORMANCE IMPROVEMENT PROJECTS

Prepared for:

California Department of Health Care Services (DHCS)

For Site Visits Conducted During:

April - June 2018

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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. County Mental Health Plans (MHPs) are considered PIHPs and are therefore subject to rules governing PIHPs. CMS rules (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid Managed Care programs. These rules require an on-site review or a desk review of each County MHP.

The California Department of Health Care Services (DHCS) contracts with 56 county 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.

A Performance Improvement Project (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." Each PIP is designed to produce beneficiary-focused outcomes. The *Validating Performance Improvement Projects Protocol*[1] specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, or were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway at some time during the twelve months preceding the on-site review.

This report presents a summary of the PIP findings of the on-site reviews conducted by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC). The summary contained in this report pertains to the reviews that were conducted during the fourth quarter of the 2017-18 DHCS fiscal year (FY) (April - June). This report provides summary information to DHCS, MHPs, and other stakeholders regarding the completeness of the PIP submissions received by CalEQRO during the quarter. Each PIP submission is summarized at the end of the report. Any further information about a specific PIP may be obtained by reviewing that MHP's Annual Report.

[1] 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, December 2012. Washington, DC: Author.

This summary report includes data that was analyzed and aggregated by CalEQRO from the EQR activity described below:

VALIDATING PERFORMANCE IMPROVEMENT PROJECTS

Each MHP is required to conduct two PIPs during the 12 months preceding the review. These PIPs must be submitted to CalEQRO for review and scoring in accordance with a Validation Tool developed by BHC (see Appendix B). This Validation Tool was created by CalEQRO to include all required elements of review from the relevant CMS Protocol.[2]

The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by a MHP.

The following MHPs submitted PIPs that were reviewed and scored during on-site reviews conducted by CalEQRO during the months of April to June 2018. The results of these MHP reviews are described in this report.

Table 1. MHPs Reviewed During April – June 2018

Del Norte	**Inyo**	**Lassen**	**Modoc**
Mono	**Napa**	**Plumas**	**Riverside**
San Bernardino	**Santa Barbara**	**Santa Cruz**	**Siskiyou**
Trinity	**Ventura**		

[2] Ibid.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

The following table illustrates the number of PIPs that were submitted for validation through the CalEQRO review by each MHP reviewed in April - June 2018.

Table 2. PIPs Submission Standard

MHP	MHP Size	Number of Clinical PIPs Submitted	Status of Clinical PIPs as determined by CalEQRO	Number of Non-Clinical PIPs Submitted	Status of Non-Clinical PIPs as determined by CalEQRO
Del Norte	Small Rural	1	Active and Ongoing	1	Completed
Inyo	Small Rural	0	Submission Determined Not to be a PIP	1	Active and Ongoing
Lassen	Small Rural	1	Completed	1	Active and Ongoing
Modoc	Small Rural	1	Concept Only, Not Yet Active	1	Concept Only, Not Yet Active
Mono	Small Rural	1	Active and Ongoing	0	Submission Determined Not to be a PIP
Napa	Small	1	Active and Ongoing	0	No PIP Submitted
Plumas	Small Rural	0	No PIP Submitted	0	No PIP Submitted
Riverside	Large	1	Active and Ongoing	1	Active and Ongoing
San Bernardino	Large	1	Completed	1	Completed
Santa Barbara	Medium	1	Completed	1	Completed
Santa Cruz	Medium	1	Completed	1	Active and Ongoing
Siskiyou	Small Rural	1	Concept Only, Not Yet Active	1	Concept Only, Not Yet Active
Trinity	Small Rural	1	Concept Only, Not Yet Active	1	Active and Ongoing
Ventura	Large	1	Completed	1	Completed

Table 3. PIP Status Defined

Active and Ongoing	Baseline established on at least some of the indicators, and at least some interventions have started. Any combination of these is acceptable.
Completed	In the past 12 months or since the prior EQR the work on the PIP has been completed.
Concept Only, Not Yet Active	Baseline may have been established, but interventions have not started. This is NOT an active PIP.
Inactive, Developed in a Prior Year	Rated last year and not rated this year. MHP has done work on it, but it has not yet started, or it has been suspended for some reason. This is NOT an active PIP.
Submission Determined Not to be a PIP	The write-up does not contain a plan, data, and/or indication where data will come from. This is NOT an active PIP.

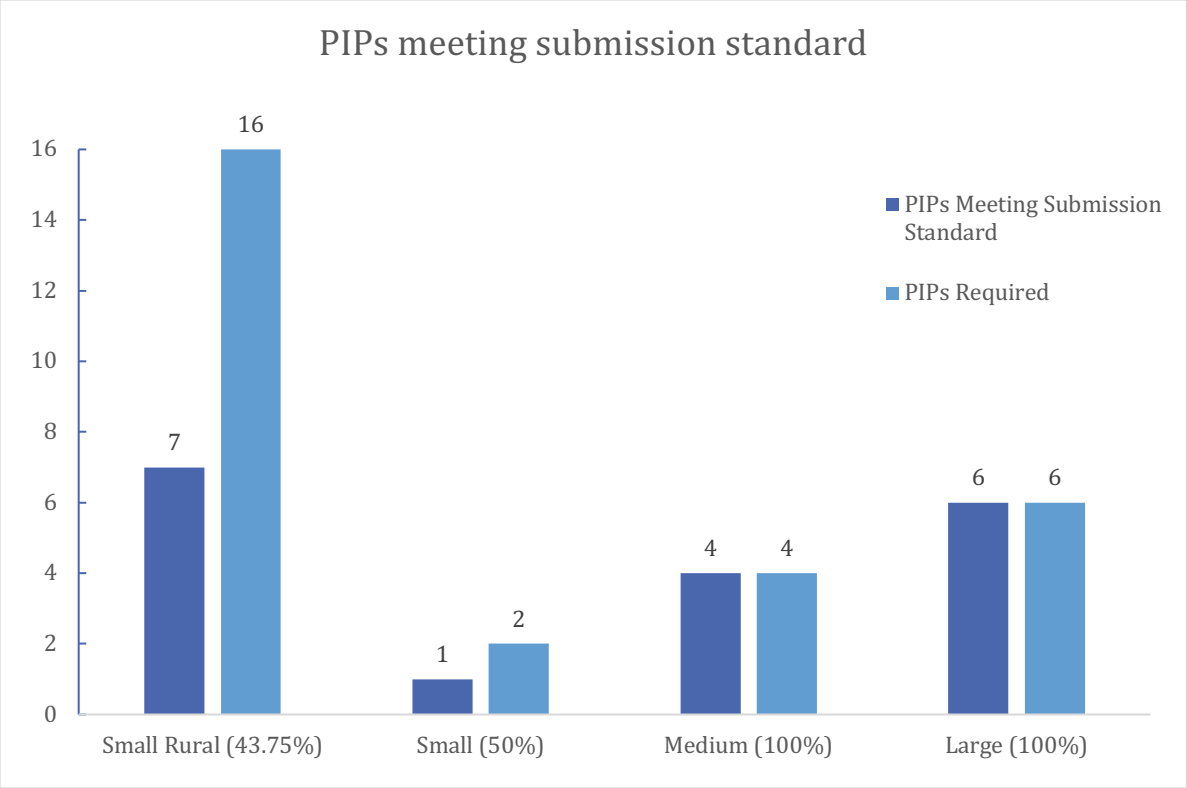
Of the 14 MHPs whose on-site reviews were conducted during the months of April - June 2018, 8 are classified as Small Rural, 1 is classified as Small, 2 are classified as Medium, and 3 are classified as Large.

Thirteen of the 14 MHPs included in this quarter's review submitted some information to be considered for validation of PIPs, however, only 7 MHPs (50 percent) met the submission standard that requires submission of two active or completed PIPs. Of the remaining 7 MHPs:

- Mono and Napa MHPs met the requirement for submission of an active or completed clinical PIP, but did not submit an active or completed non-clinical PIP;
- Inyo and Trinity MHPs met the requirement for submission of an active or completed non-clinical PIP, but did not submit an active or completed clinical PIP;
- Modoc, Plumas and Siskiyou MHPs did not submit any active or completed PIPs.

Modoc, Siskiyou, and Trinity MHPs submitted documentation for PIPs for which interventions had not been initiated at the time of the on-site review; these PIPs are classified as Concept Only, Not Yet Active. Inyo and Mono submitted documentation that was determined not to constitute a PIP. Additionally, Napa did not submit any information for a non-clinical PIP and Plumas did not submit any information for either a clinical or non-clinical PIP.

Figure 1. PIP Submission Rates



Small Rural MHPs

- 7 of 16 required PIPs submitted met submission standards
  - 5 PIPs were rated as Active and Ongoing
  - 5 PIPs were rated as Concept Only, Not Yet Active
  - 2 PIPs were rated as Complete
  - 2 Submissions were rated as Submission Determined Not to be a PIP
  - Nothing was submitted for one Clinical PIP
  - Nothing was submitted for one Non-clinical PIP

Small MHPs

- 1 of 2 required PIPs submitted met submission standards
  - 1 PIP was rated as Active and Ongoing
  - Nothing was submitted for one Non-clinical PIP

Medium MHPs

- 4 of 4 required PIPs submitted met submission standards
  - 1 PIP was rated as Active and Ongoing
  - 3 PIPs were rated as Complete

Large MHPs

- 6 of 6 required PIPs submitted met submission standards
  - 2 PIPs were rated as Active and Ongoing
  - 4 PIPs were rated as Complete

Five PIPs received a rating of 0 percent. One MHP did not submit any information to be considered for either a clinical or a non-clinical PIP, and one MHP did not submit any information for a non-clinical PIP. Two MHPs' submissions were determined not to meet the standards for a PIP. Additionally, five Concept Only, Not Yet Active PIPs were rated for technical assistance (TA) purposes only, and those ratings were not factored into the overall ratings described in this report (see Table 8).

MHPs addressed various topics and issues in the PIPs that were submitted for review. Eighteen PIPs rated as Active and Ongoing or Completed, covered topics that address the following areas: Timeliness of Care, Access to Care, Quality of Care, and Outcomes of Care. A summary of the information provided to CalEQRO for all PIPs is provided at the end of this report.

Table 4. PIP Topics for Active and Completed PIP Submissions

PIP Topics	PIP Titles	Clinical	Non-Clinical
Access to Care	Psychiatry No-Show Study*		**Del Norte**
	Open-Access Scheduling and Kept Appointments		**Lassen**
	Law Enforcement Co-located Triage, Engagement, and Support (TEST) Teams*		**San Bernardino**
	Beneficiary Acuity Index*		**Ventura**
Timeliness of Care	Rapid Connect*	**Santa Cruz**	
	Timeliness to Psychiatric Services*		**Santa Barbara**
	Timeliness of Access to Services		**Santa Cruz**
	Improving Timely Access to Services		**Trinity**
Quality of Care	Improving Treatment: Training, Beneficiary Engagement and Team Based Care*	**Santa Barbara**	
	Smoking Cessation*	**Ventura**	
	Improving Engagement and Retention in Services		**Riverside**
Outcomes of Care	Rehospitalization Rates	**Del Norte**	
	Early Therapeutic Alliance & Retention*	**Lassen**	
	Strengths Model Intervention for Employment Related-Goals	**Mono**	
	Adult Social Engagement	**Napa**	
	Follow-Up After Hospitalization	**Riverside**	
	Complex Care Coordination*	**San Bernardino**	
	Strengths Based Interventions		**Inyo**

*Completed PIPs

Table 5. PIP Topics for Concept Only PIP Submissions

PIP Topics	PIP Titles	Clinical	Non-Clinical
Timeliness of Care	Timeliness Plan		**Modoc**
	Timely Access for Children and Youth		**Siskiyou**
Quality of Care	Improving Beneficiary Outcomes through integrated treatment of Co-Occurring Disorders	**Modoc**	
Outcomes of Care	Initial Engagement and Retention in Children's Services	**Siskiyou**	
	Improving Anxiety Levels of Beneficiaries Diagnosed with an Anxiety Disorder	**Trinity**	

FINDINGS

Many PIPs address similar topics as MHPs are facing the same issues. The findings further illustrate this point. The findings also pertain to MHPs' operation of an effective Managed Care Organization, such as MHPs' processes for ensuring access to and timeliness of services, and processes for improving the quality of care. The details below reflect only those PIPs rated as Active and Ongoing or Completed. For more information regarding the PIPs detailed below, please see Appendix A of this report.

Access to Care

Four non-clinical PIPs focused on improving access to care for beneficiaries.

- Del Norte's and Lassen's non-clinical PIPs focused on improving no-show rates.
- San Bernardino's non-clinical PIP focused on co-locating in law enforcement sites.
- Ventura's non-clinical PIP focused on ensuring that beneficiaries were getting the level of care necessary for their individual needs.

Del Norte increased telepsychiatry to improve no-show rates; however, the reduction in no-show rates was minimal. Lassen implemented open access to improve no-show rates; however, the intervention centered on beneficiaries who kept their appointments rather than ameliorating the barriers for beneficiaries who were not able to keep appointments.

San Bernardino co-located a team of MHP clinical staff with law enforcement staff to provide a more appropriate and (clinically) informed response to law enforcement calls that involve residents who present with mental health concerns. The results demonstrate that co-locating teams led to a reduction in involuntary psychiatric holds at all four police departments used for this project.

Ventura's PIP aimed to ensure that beneficiaries identified as fitting into the categories of high, moderate or low needs were receiving a level of care likely to meet their service needs. The

MHP tested this approach with 12 staff members and ultimately decided to implement it throughout the MHP.

Timeliness of Care

One clinical and three non-clinical PIPs focused on improving timeliness of services for beneficiaries.

- Santa Cruz's clinical PIP focused on ensuring timely follow-up to services for individuals after discharge from the Crisis Stabilization Program (CSP).
- Santa Barbara's non-clinical PIP aimed at reducing the time it takes for new beneficiaries (adult and youth) to have their first appointment with a psychiatrist.
- Santa Cruz's non-clinical PIP focused on improving the timeliness from first contact to first session.
- Trinity's non-clinical PIP was designed to reduce the number of days from claimed assessment to claimed appointment.

Analysis of the clinical PIP from Santa Cruz found that many beneficiaries from the CSP are discharged to inpatient hospitalization services. The EQRO observed that CSPs tend to have the purpose of preventing beneficiaries from inpatient hospitalization, and that does not seem to be working well in Santa Cruz.

Santa Cruz's non-clinical PIP had data analysis issues, as some clinicians were not recording the time of first offered appointment. Additionally, Santa Barbara's non-clinical PIP had six interventions and the MHP found it difficult to measure the effectiveness of them all.

Although Trinity's interim analysis revealed a trend toward decreased time to access services, inconsistencies in collecting the data occurred. Staff were not consistent in documenting the timelines, which impeded standardized data collection.

Quality of Care

Two clinical PIPs and one non-clinical PIP were designed to impact quality of care.

- Santa Barbara developed and completed a clinical PIP that focused on improving beneficiary experience of treatment.
- Ventura implemented a clinical PIP that focused on improving the health status of beneficiaries who use tobacco products. The MHP utilized a smoking cessation program titled Call It Quits (CIQ).
- Riverside implemented a non-clinical PIP with the goal of increasing engagement and retention of children in county-operated specialty mental health outpatient clinics.

Santa Barbara's clinical PIP had only one clinical intervention: Beneficiary engagement in treatment planning, the remaining interventions were non-clinical in nature. The MHP did not track all the interventions they implemented as part of the PIP, however the combined results indicated

improvement or stability in the Child and Adolescent Needs and Strengths (CANS) and Milestones of Recovery Scores (MORS) scores.

Ventura's clinical PIP's results have seen no change in outcomes for beneficiaries. Reliance on CIQ sessions alone, even if embedded in clinics, seems unlikely to produce change unless specific elements are tailored to the MHP's population.

Riverside's non-clinical PIP lists two interventions: Collaborative Assessment and evening availability for services. However, both interventions lacked sufficient details in the PIP narrative and did not include steps/activities that will be taken to implement them. Prior to selecting these interventions, the team appears to have missed the step of determining beneficiaries' reasons for lack of engagement and subsequently dropping out of treatment.

Outcomes of Care

Six clinical PIPs and one non-clinical PIP were designed to impact outcomes of care.

- Del Norte, Riverside and San Bernardino focused clinical PIPs on improving outcomes related to hospitalizations.
- Lassen focused a clinical PIP on improving early therapeutic alliance.
- Mono focused its clinical PIP on improving beneficiaries' employment goals.
- Napa designed a clinical PIP to improve social engagement for its beneficiaries.
- Inyo's non-clinical PIP aims to implement a Strengths-Based approach that incorporates a process of assessment, planning, clinical case review and supervision of staff, and support provided to beneficiaries to achieve identified life-goals.

Del Norte's clinical PIP proposed the use of an assessment by a drug and alcohol counselor within five days of acute psychiatric hospitalization to reduce rehospitalization rates. This approach yielded an 11 percent improvement in their rehospitalization rate. The goal of the PIP is to afford beneficiaries with follow-up services as quickly as possible post hospitalization to prevent the traumatizing effects of rehospitalizations.

Riverside's clinical PIP had the goal of increasing beneficiary engagement in and access to timely outpatient services within seven days following hospital discharge, with focus on unengaged beneficiaries who are not already known by and open to the outpatient mental health system.

San Bernardino's clinical PIP targeted beneficiaries with comorbid somatic conditions who have higher frequency and longer duration of psychiatric hospitalizations compared to the MHP's general adult population. The MHP provided coordinated care that addressed both chronic mental and physical illnesses to reduce the risk, frequency, and duration of psychiatric hospitalization at two programs within the MHP. The project had mixed results in the two programs where it was implemented, both programs saw a reduction in rates of psychiatric hospitalization, but one program saw an increase in risk of hospitalization.

Lassen's clinical PIP is completed and achieved success; however, the problem was originally described as a timeliness problem when it was truly an engagement problem – beneficiaries

dropping out of service. The MHP did not conduct a barrier analysis to determine causes and link interventions to data.

Although Mono described the various aspects of the Strengths Model (SM) approach, including the SM Assessment, Personal Recovery Plan, and group supervision of clinical staff, no specific intervention was described that related to the specific actions of staff with beneficiaries, which would seem to be a key element of this model.

Napa experienced many issues with the implementation and measurement of their clinical PIP. Due to several natural disasters, including a flood and wildfire, the MHP had to postpone several of the intervention activities. Specifically, the measurement of one key indicator proved to be difficult, as it takes approximately six months from its administration to receive the data.

Inyo's non-clinical PIP has the potential to positively affect beneficiary outcomes in areas identified by the beneficiary, including housing, employment, and education. However, the MHP has not completely implemented this PIP yet and outcome measurements are still pending.

CALEQRO RATING OF SUBMITTED PIPS

The table below lists the Validation Items that are rated for each PIP by CalEQRO. All PIPs are rated based on their completeness and compliance with the standard, therefore, PIP submissions that were rated as Concept Only, Not Yet Active (and did not receive ratings for each PIP step) are not included in the tabulations, figures, and tables in this section. All PIPs receiving a rating of 0 percent (i.e., PIPs rated as: Submission Determined Not to be a PIP, Inactive, and No PIP Submitted) are also not included in the tabulations, figures, and tables in this section. As such, there are 22 PIPs represented in the figures and ratings tables.

The standards are found in the CMS PIP Protocol: Validation of Performance Improvement Projects.[3] Within each of the nine PIP "Steps" there are subsections that are rated according to the PIP Validation Tool (see Appendix B).

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

Table 6. PIP Rating Steps

Step	PIP Section
1	Selected Study Topics
2	Study Question
3	Study Population
4	Study Indicators
5	Improvement Strategies
6	Data Collection Procedures
7	Analysis and Interpretation of Study Results
8	Review Assessment of PIP Outcomes
9	Validity of Improvement

All PIP sub-sections receive a rating of *Met; Partially Met; Not Met; Not Applicable; or Unable to Determine.*

Table 7. PIP Ratings Defined

Met	Credible, reliable, and valid methods for the item were documented.
Partially Met	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met	Errors in logic were noted or contradictory information was presented or interpreted erroneously.
Not Applicable	Only to be used in Steps 7-9 when the study period was underway for the first year.
Unable to Determine	The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

A rating of Met or Partially Met weighs positively into the Overall Average Rating received by the PIP. Each Met item receives two points, while each Partially Met item receives one point. The Overall Average Rating for each PIP is calculated with the following formula:

$$\frac{(Number\ Met\ \times\ 2) + (Number\ Partially\ Met)}{Number\ of\ Applicable\ Items\ \times 2}$$

CalEQRO used the formula referenced above to calculate a rating for each of the nine Steps in the PIP Validation. Then an overall rating was given to each PIP and then divided by the Total Applicable PIP steps. PIP submissions that were rated as Concept Only, Not Yet Active, and therefore did not receive ratings for each PIP step, are not included in the tabulations in the tables in this section. All PIPs receiving a rating of 0 percent (i.e., PIPs rated as: Submission Determined Not to be a PIP, Inactive, and No PIP Submitted) are represented in the denominator of the tabulations.

The MHPs reviewed during April to June 2018 received the following overall ratings:

Table 8. Average PIP Ratings by MHP Size

MHP Size	Clinical	Non-Clinical
Small Rural	70.45%	62.21%
Small	52.63%	NA
Medium	77%	76%
Large	70.95%	67.65%

The average ratings received by Medium MHP's clinical PIPs are higher than those received by all other MHPs.

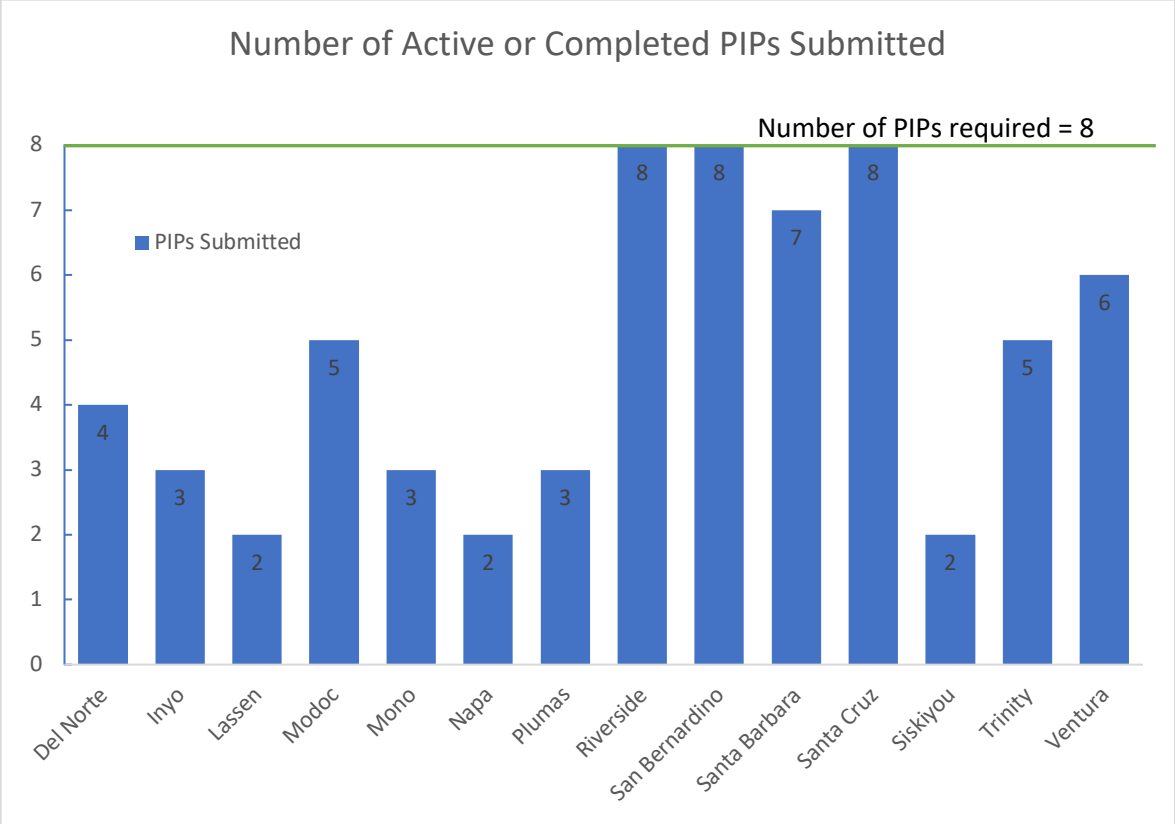
- The PIP ratings for Medium MHPs were higher than the ratings for all other sized MHPs.
- Due to the ratings being an average, the PIP ratings for Small MHPs only reflects the one MHP of that size that had an on-site review during this period.

HISTORY OF PIP SUBMISSIONS BY MHP

CalEQRO has been validating PIP submissions from Medi-Cal MHPs since FY 2014-15. CalEQRO has provided subject-based TA on-site, via email, telephone, video, and webinar. However, numerous MHPs have submitted PIPs that did not meet the submission standard of having two Active and Ongoing or Completed PIPs for each review year. Although these MHPs are contractually required to meet the submission standards, they continue to cite staffing issues, competing priorities, and limited resources as reasons for not meeting this requirement.

The figure below illustrates the submission history of each MHP represented in this report:

Figure 2. PIP Submission History (FY 2014-15 to FY 2017-18)



The specifics of the submissions received by the MHPs represented in this report are as follows:

Table 9. Clinical PIP Submissions by Small Rural MHPs

MHP	FY 2014-15 Clinical	FY 2015-16 Clinical	FY 2016-17 Clinical	FY 2017-18 Clinical
Del Norte	Active and Ongoing	Concept Only, Not Yet Active	Concept Only, Not Yet Active	Active and Ongoing
Inyo	No PIP Submitted	No PIP Submitted	Submission Determined Not to be a PIP	Submission Determined Not to be a PIP
Lassen	No PIP Submitted	No PIP Submitted	Submission Determined Not to be a PIP	Completed
Modoc	Active and Ongoing	Active and Ongoing	Completed	Concept Only, Not Yet Active
Mono	Active and Ongoing	Concept Only, Not Yet Active	Concept Only, Not Yet Active	Active and Ongoing
Plumas	No PIP submitted	No PIP submitted	Active and Ongoing	No PIP Submitted
Siskiyou	No PIP Submitted	Active and Ongoing	Concept Only, Not Yet Active	Concept Only, Not Yet Active
Trinity	Active and Ongoing	Concept Only, Not Yet Active	Concept Only, Not Yet Active	Concept Only, Not Yet Active

Table 10. Non-Clinical PIP Submissions by Small Rural MHPs

MHP	FY 2014-15 Non-Clinical	FY 2015-16 Non-Clinical	FY 2016-17 Non-Clinical	FY 2017-18 Non-Clinical
Del Norte	Active and Ongoing	Submission Determined Not to be a PIP	Submission Determined Not to be a PIP	Completed
Inyo	Active and Ongoing	Submission Determined Not to be a PIP	Completed	Active and Ongoing
Lassen	No PIP Submitted	Concept Only, Not Yet Active	Submission Determined Not to be a PIP	Active and Ongoing
Modoc	Active and Ongoing	Concept Only, Not Yet Active	Active and Ongoing	Concept Only, Not Yet Active
Mono	Active and Ongoing	Submission Determined Not to be a PIP	Concept Only, Not Yet Active	Submission Determined Not to be a PIP
Plumas	Active and Ongoing	Completed	No PIP Submitted	No PIP Submitted
Siskiyou	No PIP Submitted	Active and Ongoing	Submission Determined Not to be a PIP	Concept Only, Not Yet Active
Trinity	Active and Ongoing	Active and Ongoing	Active and Ongoing	Active and Ongoing

Table 11. Clinical PIP Submissions by Small MHPs

MHP	FY 2014-15 Clinical	FY 2015-16 Clinical	FY 2016-17 Clinical	FY 2017-18 Clinical
Napa	No PIP submitted	Concept Only, Not Yet Active	Concept Only, Not Yet Active	Active and Ongoing

Table 12. Non-Clinical PIP Submissions by Small MHPs

MHP	FY 2014-15 Non-Clinical	FY 2015-16 Non-Clinical	FY 2016-17 Non-Clinical	FY 2017-18 Non-Clinical
Napa	Concept Only, Not Yet Active	Concept Only, Not Yet Active	Active and Ongoing	No PIP Submitted

Table 13. Clinical PIP Submissions by Medium MHPs

MHP	FY 2014-15 Clinical	FY 2015-16 Clinical	FY 2016-17 Clinical	FY 2017-18 Clinical
Santa Barbara	Active and Ongoing	Concept Only, Not Yet Active	Active and Ongoing	Completed
Santa Cruz	Active and Ongoing	Active and Ongoing	Active and Ongoing	Completed

Table 14. Non-Clinical PIP Submissions by Medium MHPs

MHP	FY 2014-15 Non-Clinical	FY 2015-16 Non-Clinical	FY 2016-17 Non-Clinical	FY 2017-18 Non-Clinical
Santa Barbara	Active and Ongoing	Active and Ongoing	Active and Ongoing	Completed
Santa Cruz	Active and Ongoing	Active and Ongoing	Completed	Active and Ongoing

Table 15. Clinical PIP Submissions by Large MHPs

MHP	FY 2014-15 Clinical	FY 2015-16 Clinical	FY 2016-17 Clinical	FY 2017-18 Clinical
Riverside	Active and Ongoing	Completed	Active and Ongoing	Active and Ongoing
San Bernardino	Active and Ongoing	Completed	Active and Ongoing	Completed
Ventura	Active and Ongoing	Completed	Concept Only, Not Yet Active	Completed

Table 16. Non-Clinical PIP Submissions by Large MHPs

MHP	FY 2014-15 Non-Clinical	FY 2015-16 Non-Clinical	FY 2016-17 Non-Clinical	FY 2017-18 Non-Clinical
Riverside	Active and Ongoing	Completed	Active and Ongoing	Active and Ongoing
San Bernardino	Active and Ongoing	Completed	Active and Ongoing	Completed
Ventura	Active and Ongoing	Active and Ongoing	Inactive, Developed in a Prior Year	Completed

CONCLUSIONS/RECOMMENDATIONS

During the FY 2017-18 annual reviews, CalEQRO found strengths in MHP programs and practices 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.

PIP TOPICS

CalEQRO observed that 7 of the 18 (39 percent) PIPs rated as Active and Ongoing or Completed, focused on Outcomes of Care issues.

PIP DESIGN/IMPLEMENTATION

Areas for Improvement

- 47 percent of the submissions (16 of 34) requested by CalEQRO for the April - June 2018 on-site reviews did not meet the Active and Ongoing or Completed standard as required for PIP submissions.

    - Five of those submissions were rated as Concept Only, Not Yet Active and were in various stages of implementation. Once interventions are implemented, the PIPs will be considered Active and Ongoing.
    - One MHP did not submit documentation for one of the required PIPs.
    - One MHP did not submit documentation for both required PIPs.
    - Two submissions did not meet the minimum requirements and were rated as Submission Determined Not to be a PIP.
- Eight PIPs were rated as Completed. BHC emphasized the need for continued PIP development. MHPs should not limit themselves to developing new PIPs when previous ones are completed; they should consider PIP development from a continuous quality improvement process perspective.
- 41 percent of the submissions (46 of 112) requested by CalEQRO for each of the prior four FYs did not meet the Active and Ongoing or Completed standard as required for PIP submissions.
    - 21 submissions were rated as Concept Only, Not Yet Active.
    - 14 PIPs were not submitted.
    - 10 submissions were Determined Not to be a PIP.
    - 1 PIP was rated as Inactive, Developed in a Prior Year.
- Three MHPs (Lassen, Napa, and Siskiyou) submitted only two PIPs that have met the Active and Ongoing or Completed standard during the past four review years.
- Three MHPs (Inyo, Mono, and Plumas) submitted only three PIPs that have met the Active and Ongoing or Completed standard during the past four review years.

Recommendations to MHPs

- CalEQRO continues to recommend that MHPs foster a culture of continuous quality improvement throughout their organizations.
    - PIP ideas should be generated from ongoing efforts to improve beneficiary outcomes, as MHPs should focus on beneficiary outcomes versus organizational improvements.
    - PIP ideas should come from any area of the MHP that directly impacts beneficiaries.
    - MHPs should consider areas in which to develop PIPs on a continuous basis. If an issue that requires improvement has a potential impact on beneficiary outcomes, the MHP should consider how a PIP could be developed to improve the issue.
- MHPs should develop a plan and put it into action. Active and Ongoing PIPs are the standard by which the MHPs are evaluated.
    - PIPs should have mechanisms for collecting data quarterly, at a minimum, and should have new activities occurring on a regular basis.
    - The CMS protocol requires at least one new intervention every year if an unsuccessful PIP is to continue.
- PIPs should involve beneficiary feedback as much as possible; beneficiaries' input can be valuable in determining the direction and interventions of PIPs.
    - MHPs should develop PIP teams that are specific to the issues they are addressing, including subject matter experts and beneficiaries as appropriate.
- MHPs should ensure that they have a solid foundation on which to design a PIP. To do so requires background data and analysis of barriers prior to the implementation of a PIP.

- It is imperative that the MHPs participate in TA from CalEQRO to improve their ability to collect, analyze, and use data that help establish the need for a PIP and develop a measurable study question.
    - PIP Clinics are offered to all MHPs on a quarterly basis.
    - Resources are available on the CalEQRO website, including:
        - PIP instructional videos[4]
        - PIP Library[5]
        - Instructions for Completing PIP Validation Tool[6]
- MHPs should contact CalEQRO for assistance in developing PIPs; TA is available for all MHPs outside of the on-site review.

Technical Assistance to MHPs

CalEQRO worked individually with each MHP while onsite to provide TA in the development and progression of their PIPs. Additional TA was provided at the request of MHPs. Phone sessions were conducted with MHPs prior to and following on-site reviews as requested. These phone sessions are specific for each MHP but include: assistance with defining a problem with local data; aid in writing a PIP study question; and help with finding appropriate interventions, outcomes and indicators.

CalEQRO presented a PIP Clinic on June 21, 2018 that addressed tips for successful PIPs and reviewed common topic selection, indicators and interventions. Question and answer sessions were conducted during this presentation. All MHPs were invited and encouraged to participate in the presentation. The recording of this webinar and the presentation materials used are available on CalEQRO's website.

CalEQRO has recorded three PIP instructional videos and has collected successful PIPs in a PIP Library that is available on our website at www.caleqro.com .

[4] http://www.caleqro.com/data/california_eqro_resources/PIP%20Library/YouTube%20-%20BHC%20PIP%20101%20-%201%20-%20California%20Drug%20MediCal%20-%20Bringing%20Ideas%20to%20Successful%20PIP%20Concept.html

[5] http://caleqro.com/#!california_eqro_resources/PIP%20Library

[6] http://www.caleqro.com/data/california_eqro_resources/PIP%20Library/Instructions%20for%20Completing%20PIP%20Validation%20Tool-PUBLIC_v.3.docx

APPENDICES

Appendix A: Summary of PIPs submitted by MHPs

Appendix B: CalEQRO PIP Validation Tool

CLINICAL PIP TOPICS SUBMITTED

Of the 14 Clinical PIPs required for submission, 3 were considered Active and Ongoing and 5 were Completed. Three were rated as Concept Only and did not have interventions implemented at the time of the on-site review. One submission was determined not to be a PIP. One PIP was not submitted by the MHP. All the PIPs submitted are summarized here in this Appendix.

Timeliness of Care PIPs

- Rapid Connect (Completed)

Santa Cruz

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"To what extent will the implementation of Rapid Connect, which includes direct contact with beneficiaries/families (for youth) seen at the Crisis Stabilization Program (CSP) or immediate phone contact after discharge, reduce the number of readmissions to the CSP within 30 days?"	Santa Cruz's clinical PIP focused on ensuring timely follow-up to services for individuals after discharge from the CSP. It involves Rapid Connect, a service to facilitate rapid follow-up for beneficiaries who were admitted to CSP. Mobile Emergency Response Team (MERT) members or staff from County Access will contact the individual within one business day post CSP stay to determine treatment needs and link them to services.	The rewritten study question still lacks specificity that would be useful in measuring outcomes. A second intervention was not added in the past review year, as recommended by EQRO in the FY16-17 review. The goal of indicator number one is 75 percent, and for indicator number two 10 percent. The study began November 2016 and the MHP considers this PIP to be complete as of November 2017. EQRO agreed with the MHP staff presenting the PIP that the clinical PIP has the necessary components and can be considered completed.	The following items were discussed with the MHP: Rewrite the study question to make it measurable and specific. Expand upon the description of the interventions, which were not described sufficiently in the write-up within the section in the PIP Development Tool marked "describe the intervention". Change the percentage improvement for each quarter in Rapid Connect contacts so it references the percent of baseline rather than the percent of the targeted goal amount.

Clinical PIP topics submitted

			Redo the calculation method for change in percent of readmissions so the last-quarter comparison does not include those to immediately be hospitalized following discharge from the CSP. The intervention was only for those discharged from the CSP to the community, and these were a minority of those discharged. Clearly articulate in significant detail all the interventions that will be implemented. Additional interventions are needed to improve clinical outcomes and answer the study question as related to benefit to beneficiaries. Add outcome measures at key events to strengthen this PIP. Determine what the threshold is for frequency of administering the CANS and monitor for improvement in the data over time. Consider additional interventions that might include linkages with post hospitalization follow-up activities and staff.

Clinical PIP topics submitted

Quality of Care PIPs

- Improving Treatment: Training, Beneficiary Engagement and Team Based Care (Completed)

Santa Barbara

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Are beneficiary outcomes, as measured by the Consumer Perception Survey (CPS), CANS and MORS, improved by implementing: 1) training for clinical staff, 2) the team-based care model and tools and 3) improved MIS treatment related reports (for managers and supervisors)?"	This PIP focused on improving beneficiary experience of treatment in terms of: a) ensuring that all beneficiaries have high quality current/active treatment plans; b) implementing team based care; and c) improving beneficiary engagement. The hypothesis was that improved experience of treatment will result in: improvements in specific outcomes as measured by the CPS, CANS (Youth) and MORS (Adult) scores.	The only clinical interventions presented by the MHP were beneficiary engagement in treatment planning and team-based care training (which in and of itself is not an intervention). Not all the interventions were tracked as part of the PIP, but the combined results indicated improvement or stability in the CANS and MORS scores. Elements of the CPS were also reviewed, but this data was not well linked to the interventions in this PIP.	The TA provided to the MHP by CalEQRO, meant to address areas for opportunity and future PIPs, consisted of suggestions to validate assumptions about the cause of problems through a review of the relevant literature and more thorough barrier analysis; to assure that all persons impacted, especially line staff and beneficiary/family members are a part of the PIP active stakeholder group; and to identify variables not part of the PIP study that could impact the changes in beneficiary outcomes being tracked.

Clinical PIP topics submitted

- Integrating Smoking Cessation Programs into a Behavioral Health System (Completed)

Ventura

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will integration of smoking cessation services within VCBH decrease the proportion of beneficiaries who describe themselves as active tobacco users. Addendum (5/7/2017): Will integration of smoking cessation services within VCBH result in the percentage of tobacco users remaining quit for 3 mos., 6 mos. and 12 mos. after completing a Call It Quits (CIQ) program be least 25%, 15% and 10% respectively?"	Beginning in June 2016, the MHP focused on improving the health status of beneficiaries who use tobacco products. The national data on smoking prevalence was supported by a sample survey of adult beneficiaries across all sites. The survey validated high tobacco use (46 percent), three-quarters of whom wanted to stop smoking.	The broad, positive impacts of this activity to date include the MHP's development of a process to routinely ask beneficiaries about tobacco use, encourage and support smoking cessation, and collection of that data about smoking within the electronic health record (EHR). The successful screening of smoking status for 71 percent of the adult population is an accomplishment. The development of a referral process, coupled with effective interventions for this population, followed by tracking of results, is important. It must be acknowledged that current results show no change for beneficiaries. Reliance on CIQ sessions alone, even if embedded in clinics, seems unlikely to produce change unless specific elements are tailored to the MHP's population.	The TA provided to the MHP by CalEQRO consisted of discussions about the limited number of beneficiaries impacted by this improvement activity and the absence of positive results. That said, the screening aspect has been very successful. Strong consideration was given to termination of this PIP and exploring another issue that could have greater impact. However, this is an important topic, involving a large percentage of MHP adult beneficiaries. There remains a strong rationale for continuation, if the MHP adjusts its intervention strategy to improve efficacy for its unique population. The MHP may consider further literature review for proven strategies that could involve specific supportive approaches to smoking cessation not currently utilized.

Clinical PIP topics submitted

Outcomes of Care PIPs

- Rehospitalization Rates (Active and Ongoing)

Del Norte

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will an assessment by a drug and alcohol counselor within five days of acute psychiatric hospitalization reduce the rehospitalization rate within a year for Del Norte County from 12 percent to 7 percent?"	The PIP addresses the issue of the rehospitalization rate for Medi-Cal beneficiaries in Del Norte County. This rate is higher than the state average per data from CalEQRO. The goal of this PIP is to reduce the number of rehospitalization admittances to the state average or lower. The MHP acknowledges how traumatizing and stigmatizing psychiatric hospitalizations can be, even just one time, and the goal of the PIP is to improve outcomes from the first discharge of hospitalization and reduce the need for a second hospitalization.	The MHP presented a statistically significant decrease using the common p-value of five percent. However, this calculation was using the given 18.8 percent improvement, which was determined to be inaccurate. The actual improvement is 11 percent. More information is expected and will be available as the study continues. There is no complete analysis of findings currently. The PIP will be continued, and an additional intervention will be added. Discussion onsite looked at what the new intervention might be, although no conclusion was reached.	The TA provided to the MHP by CalEQRO consisted of onsite discussion of findings of the PIP. CalEQRO pointed out that there is a need for more data to be entered into the study and more analyzation of the findings. No external threats to validity were discussed in the written study. The PIP findings need to be analyzed on a quarterly basis at a minimum.

Clinical PIP topics submitted

- Early Therapeutic Alliance & Retention (Completed)

Lassen

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will early therapeutic alliance improve beneficiary retention by 25 percent as measured by the percentage of individuals retained from assessment to initial therapy appointment?"	To address the identified delay of therapeutic alliance and its impact on retention, the MHP looked at barriers to early therapeutic alliance. In a review of beneficiary retention in 2016, the MHP found a 54 percent dropout rate from clinical assessment to initial therapy appointment. One barrier, identified by beneficiaries and clinicians, was therapist impermanence.	Improving beneficiary retention in services through better therapeutic alliance will improve quality of care. However, continued retention in ongoing services will be dependent on other factors. These include, but are not limited to, the frequency of ongoing services and if wait times between appointments are not lengthy.	The TA provided to the MHP by CalEQRO consisted of a discussion on general PIP development. While this PIP is completed and achieved success, it was a resubmission based upon onsite questions during the review. For example, how did the MHP make the decision to select the intervention? Was there research into the possible causes of the problem? How did the MHP determine sample size when evaluating the problem? Onsite discussion clarified that the problem, originally described as a timeliness problem, was truly an engagement problem – beneficiaries dropping out of service. CalEQRO discussed the usefulness of barrier analysis to determine causes and link interventions to data. Data related to the problem should be quantified in terms of scope and size and should be gathered before implementing interventions. The MHP was advised to use the most current PIP submission form (they had submitted current PIPs on last year's form).

Clinical PIP topics submitted

- Strengths Model Intervention for Employment Related- Goals (Active and Ongoing)

Mono

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will using the Strengths Model help beneficiaries make progress toward their employment-related goals, as measured by the achievement of their employment-related goals as recorded in the Strengths Assessment over the two-year study period?"	The MHP developed this PIP from community survey data in which members of the community, including some current and past beneficiaries, identified life domain goals in which support was desired. The MHP utilized the SM assessment with 14 high need beneficiaries and discovered that 11 had employment or economic goals for life improvement.	The MHP described the various aspects of the SM approach, including the SM Assessment, Personal Recovery Plan, and group supervision of clinical staff. No specific intervention was described that related to the specific actions of staff with beneficiaries, which would seem to be a key element of this model. The study question did not provide the anticipated quantifiable improvement goal, as required for a PIP. The study indicator includes achievement of employment-related goals. However, the data table breaks out separate numerators for those who achieve employment goals and decline to set another goal from those who achieve the listed goal and then set a new goal. Since achievement of employment seems to be the goal of this activity, the meeting of this goal would seem sufficient.	The TA provided to the MHP by CalEQRO consisted of discussion of needed elements to add to the PIP and resubmission of the update. CalEQRO shared how the lack of baseline data, lack of specificity of what defines inclusion in the study group by way of being "stuck" or "high need" is problematic. Over the course of this next review period the MHP needs to add data elements such as the service utilization level of these "high-need" individuals. The inclusion of beneficiaries seems to lack specific, defined quantifiable parameters that would support replication.

- Adult Social Engagement (Active and Ongoing)

Napa

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"If Napa County Mental Health introduces a series of social engagement activities, particularly targeting the most isolated beneficiaries, will it increase the number of actively engaged individuals?"	The MHP determined through its analysis of its CPS data that one challenging area reported by the respondents is social isolation or lack of social engagement. Based on this finding, the MHP launched this PIP to reduce social isolation and improve social engagement. The primary interventions have consisted of increased social activities specifically targeted for the chronically socially isolated individuals.	Due to several natural disasters in the past 16 months, flood and wildfire, the MHP had to postpone several of the intervention activities. In addition, one key indicator obtained from CPS is delayed as it takes approximately six months from its administration in November for the MHP to receive the data. Consequently, the MHP was not able to provide any outcomes from the activities that indeed took place in 2017. CalEQRO has therefore found many of the PIP validation items to be not applicable at this time.	Onsite TA and CalEQRO feedback consisted of the following: PIP Question: The MHP was informed that the PIP question should outline and link the intervention and the intended outcomes. Following the onsite review, the MHP submitted a revised PIP question that met the standards. Indicators and validity of future findings: CalEQRO advised the MHP that the study methodology should have the power to detect the changes among the intended beneficiaries. Currently, the CPS methodology is more generic, and the sample reflects the overall adult beneficiaries. CalEQRO recommends that the MHP consider more frequent administration of CPS among the target beneficiaries.

- Follow-Up After Hospitalization (Active and Ongoing)

Clinical PIP topics submitted

Riverside

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will the implementation of navigation strategies with inpatient treatment facility (ITF) discharge teams increase the percentage of unengaged beneficiaries who receive an outpatient follow-up service within seven days of discharge?"	The goal of this clinical PIP is to increase beneficiary engagement in and access to timely outpatient services within seven days following hospital discharge, with focus on unengaged beneficiaries who are not already known by and open to the outpatient mental health system. The intervention uses peer specialists through the peer-run navigation center to engage these beneficiaries and link them to services including therapy, case management, medication management, housing, detox, and other supports.	The study question would be strengthened by adding a measurable target. The indicator goals are too low to demonstrate statistically significant change, and therefore any change measured cannot be attributed to this intervention alone. The current intervention requires a more detailed explanation of the clinical activities that will take place to engage and provide services to the target population of unengaged beneficiaries newly discharged from an inpatient facility.	The TA provided to the MHP by CalEQRO consisted of a discussion on the differences between clinical and non-clinical PIPs, and suggestions for strengthening this clinical PIP. As discussed onsite, it would be helpful to add a description of how the engagement activities provide a direct link to clinical services and include the composition of the ITF discharge team (clinical and non-clinical staff: peer specialists, therapists, case managers, psychiatrists and nurses, etc.). During the onsite discussion the MHP did provide additional clinical information and justification which CalEQRO agrees with. The MHP has agreed to rewrite the PIP Development Outline and will be engaging in further consultation with CalEQRO in the coming months.

- Complex Care Coordination (Completed)

Clinical PIP topics submitted

San Bernardino

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will complex care coordination reduce the risk, frequency, and duration of psychiatric hospitalizations by 20 percent for psychiatrically and medically complex beneficiaries who require the most intensive care coordination services?"	The MHP has identified a population of beneficiaries with comorbid somatic conditions who have higher frequency and longer duration of psychiatric hospitalizations compared to the MHP's general adult population. The goal of this PIP is to provide coordinated care that addresses both the chronic mental and physical illnesses to reduce the risk, frequency, and duration of psychiatric hospitalization.	The PIP team provided indicators (which were the same as their outcome measures) that were objective and measurable. However, there were no indicators to address the performance of the team in applying them. Indicators are needed that compare: • actual home/field visits to needed home/field visits • actual accompaniment to medical/pharmacy appointments needed accompaniment • frequency of inquiry into medication compliance • and others	The TA provided to the MHP by CalEQRO consisted of the recommendation to operationalize the components of complex care coordination and to articulate the differences in the project from one year to the next, which the MHP did. CalEQRO and the MHP discussed the MHP's plans for a future clinical PIP—reducing polypharmacy through examination of antipsychotic prescriptions and improving continuity of care by improving communication between inpatient and outpatient practitioners.

NON-CLINICAL PIP TOPICS SUBMITTED

Of the 14 non-clinical PIPs required for submission, 5 were rated as Active and Ongoing; 4 were rated as Completed; 2 were rated as Concept Only, Not Yet Active and did not have interventions implemented at the time of the on-site review. Additionally, one submission was Determined Not to be a PIP and two PIPs were not submitted.

Access to Care PIPs

- Psychiatry No-Show Study (Completed)

Del Norte

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will no-show rates decrease for beneficiaries from FY2015-16 to FY2016-17 with a change from locum psychiatry (e.g., a new doctor every three months) to telepsychiatry (i.e., the same doctor for patient for at least one year)?"	After increasing psychiatry services in 2016 through locum psychiatrists, it was found that no-show rates and formal grievances against psychiatry services increased. The previous telepsychiatrists were still in place and neither no-shows nor formal grievances showed an increase for those providers. The MHP decided to end the contract with locum psychiatry and increase telepsychiatry. The goal presented by the MHP was to achieve consistency in service provision, as "consistent psychiatry leads to better patient outcomes and less no-shows or beneficiary cancellation." The results of that change are the focus of this PIP.	The MHP hypothesis includes that when beneficiaries do not get the care they need, especially with psychiatry, negative outcomes are predicted to occur, including symptoms worsening and possible need for higher levels of care (e.g. psychiatric hospitalizations). The intervention would be to increase the hours of psychiatry with Kings View telepsychiatry using doctors who will be around for a year or more.	The TA provided to the MHP by CalEQRO consisted of discussion of the need to do a thorough barrier analysis before designing a PIP. CalEQRO also noted that measuring results once a quarter at a minimum would be useful to see if the PIP needs any adjustments moving forward. The MHP plans to monitor no-show rates for all services monthly and will track this intervention and adjust accordingly. Issues with calculating percent versus percentage points were pointed out. The MHP was offered ongoing TA for creating a new PIP; this PIP is considered complete. The MHP was encouraged to consult with EQRO early and often during PIP formulation for its next non-clinical PIP.

Submission determined not to be a PIP

- Open-Access Scheduling and Kept Appointments (Active and Ongoing)

Lassen

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Does implementing open access scheduling for outpatient services improve kept appointment rates by ten percent as measured by attendance?"	The MHP focused its non-clinical PIP on addressing the no-show rate for scheduled initial and follow-up appointments through walk-in access and open access scheduling. The MHP identified open scheduling as a viable intervention through a literature review. Open scheduling allows for the scheduling of next visit appointments only, rather than booking several appointments, which results in leaving no space for other beneficiaries. The percentage of missed appointments affects other important system and beneficiary-centered factors.	The MHP did not provide an explanation for the disconnection between the intervention and the problem. The PIP attempts to solve the problem of no-shows with open access scheduling but does not inquire in depth the reasons for no-shows. The intervention centered on beneficiaries who kept their appointments rather than ameliorating the barriers for beneficiaries who were not able to keep appointments. A barrier analysis would have led to a more impactful intervention.	The TA provided to the MHP by CalEQRO consisted of discussions on how to better develop PIP topics and improve the success of interventions. In this case, a barrier analysis on reasons for no-shows would better inform interventions. To ensure both validity and reliability, the data collection plan should specify the data to be collected, sources, collection methods including personnel, and the instruments used. There were also elements to the PIP which were under-developed due to the MHP using the incorrect PIP submission tool.

Submission determined not to be a PIP

- Law Enforcement Co-located Triage, Engagement, and Support (TEST) Teams (Completed)

San Bernardino

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will co-locating Triage, Engagement, and Support Teams (TEST) at law enforcement agencies decrease involuntary holds written by law enforcement and received by ARMC by 15 percent, while also decreasing psychiatric hospitalizations for beneficiaries served by the TEST staff by 20 percent and increasing routine outpatient psychiatric care by 25 percent?"	This is the second year of the MHP's project on TEST, a team of MHP clinical staff who are co-located with law enforcement. The goal of the PIP was to use TEST to provide a more appropriate and (clinically) informed response to law enforcement calls that involve residents who present with mental health concerns.	The results of the study show that the TEST was successful in reducing 5150s by the Fontana (by 54.55 percent) and Rialto police departments (by 28.00 percent), the two departments in urban communities. The TEST decreased 5150s by the Mountain Region police department by 12.14 percent. The TEST decreased 5150s in Victorville only marginally (by 0.84 percent), to which the MHP partially attributed to new deputies joining the law enforcement agencies. Following the TEST encounter, beneficiary hospitalizations decreased, and outpatient services increased overall.	The TA provided to the MHP by CalEQRO consisted of recommendation to adjust the pre- and post-measurement period (from six months to four months) to enable the MHP to have complete data to compare for this review, which the MHP did. CalEQRO and the MHP discussed the MHP's plans for future non-clinical PIPs. The MHP discussed their intentions to address the low rate of 7-day follow-ups post hospitalization.

Submission determined not to be a PIP

- Beneficiary Acuity Index (Completed)

Ventura

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will an acuity index derived from the nature/extent of past psychiatric hospitalization(s) provide staff with a practical and effective guide to service delivery? Will providing staff with reference to an objective measure of acuity, along with associated services delivery expectations, increase productivity and caseload coverage thereby reducing psychiatric hospital admissions in the long-term?"	The aim of this PIP was to ensure that beneficiaries identified as fitting into one of the categories of high, moderate, low, or uncategorized, were receiving a level of care likely to meet their service needs. The MHP then developed a minimum service level which was paired to the need categories. The MHP also established mechanisms for the beneficiary and staff to provide feedback to the service levels and scoring.	The MHP determined to discontinue this PIP in January of 2018. The MHP believes it is prepared to make system decisions based on this brief test process (11 months). The addition of a level of care instrument to support a comprehensive process guiding service delivery across all levels of need and helping determine a consumer flow into recovery would improve this PIP. Furthermore, approximately 50 percent of the MHP's adult consumers are uncategorized due to lack of recent hospitalization history, which may limit the application of this approach.	The TA provided to the MHP by CalEQRO consisted of onsite encouragement, suggesting that the use of tested and validated level of care tools would provide additional data to augment the current approach. The use of instruments such as MORS, LOCUS, and ANSA provide broad applicability. The uncategorized beneficiaries, for whom the MHP lacks a specific service analytic strategy. For many MHPs, the larger challenge is developing standards for satisfactory level of improvement for stepping down service levels. This PIP was more basic in its approach, seeking to assure high level need beneficiaries are so identified and receive a minimum level.

Submission determined not to be a PIP

Timeliness of Care PIPs

- Timeliness to Psychiatric Services (Completed)

Santa Barbara

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will implementing the six (6) interventions of the PIP: 1) appointment reminder calls; 2) team-based appointment management; 3) increased clinical/peer contacts prior to psychiatric assessment; 4) implementation of a singular, standardized appointment scheduling system throughout the county; 5) enhanced recruitment of psychiatrists and physician assistants; and 6) incentivizing psychiatrists' productivity, result in: a) a reduction in beneficiary no-show rates and b) a reduction in wait time between admission and first psychiatric appointment in the adult and children's systems of care?"	This PIP is trying to reduce the time it takes for new beneficiaries (adult and youth) to have their first appointment with a psychiatrist. The PIP tests several strategies to determine which is the most effective. The interventions include: appointment reminder calls, team-based appointment management, increased clinical/peer contact prior to the first psychiatric appointment, implementation of a singular, standardized appointment scheduling system throughout the county, enhanced recruitment efforts for psychiatrists and physician assistants, and incentivizing psychiatrists' productivity.	This non-clinical PIP had originally planned an intervention to implement an electronic scheduler. This was not put in place due to vacancies in IT staff and some staff resistance. The electronic scheduler implementation would improve future tracking of no-shows and increase provider capacity.	The TA provided to the MHP by CalEQRO, meant to address current opportunities and future PIPs, consisted of suggestions to stagger interventions to better understand the impact of any specific intervention; limit the focus and number of interventions in PIPs, and assure that all the persons impacted, especially line staff and beneficiary/family members, are a part of the PIP active stakeholder group.

Submission determined not to be a PIP

- Timeliness of Access to Services (Active and Ongoing)

Santa Cruz

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will dissemination of accurate timeliness data and system wide availability of resources assist MHP to insure beneficiaries receive timely services upon initial request?"	The PIP is focused on improving the timeliness from first contact to first session. The rationale is that timeliness will reduce adverse events to beneficiaries who are suffering and in need of treatment and hasten their road to recovery.	As stated the study question does not specifically address a beneficiary benefit of more timely response to request for services or accurate timeliness data dissemination. It was found that some clinicians were not recording time of first offered appointment. The PIP study team decided that a single measure could encompass both. They surmised that the time of first offered appointment would sometimes be sooner than first actual appointment, and at the latest would coincide with the date of first actual appointment. Therefore, by taking the earlier of first offered appointment (when the data is available) or first actual appointment, timeliness would be sufficiently measured.	The TA provided to the MHP by CalEQRO consisted of the following feedback: The change in methods to reduce wait lists is likely helpful but is not in itself a measure. The PIP must measure the impact of timeliness on the beneficiaries studied. This means it is necessary to measure what was the change in time from first contact to first offered appointment, and from first contact to first actual appointment? CalEQRO did not recommend blending the measures of first offered appointment and actual appointment dates. It is recommended they are kept separate. CalEQRO also recommended analyzing for patterns the frequency of missing data for date of first offered appointment. In that way, the MHP can ascertain what treatment programs have the most missing data and can conduct targeted training so the numbers decrease.

Submission determined not to be a PIP

- Improving Timely Access to Services (Completed)

Trinity

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will changing the internal "access meeting" process for approval, and modifying the setting and tracking of clinician appointments result in an improvement of timeliness of services for actual claimed assessment to actual clinical appointment (assessment to clinical appointment) from an average of 21 days to an average of 12 days, a 43 percent reduction?"	The goal of this non-clinical PIP is to reduce the number of days from actual claimed assessment to actual claimed appointment from an average of 21 days to an average of 12 days, a 43 percent reduction. The PIP will evaluate all the various steps in the workflow, identify areas of bottlenecks or delays and implement interventions to improve the timeliness.	Interim analysis revealed that although there was a trend toward decreased time to access services inconsistencies in collecting the data occurred. Staff were not consistent in documenting the timelines and standardization was not achieved that impacted data. The MHP indicated a need to continue its efforts to collect additional data and a more robust review. There is concern that the MHP collected small numbers in its on-going data collection. This should have been addressed to eradicate the problem and to determine the effects of the improvement intended. The reliability in documenting the steps amongst provider staff is also a question that the MHP will need to address.	The TA provided to the MHP by CalEQRO consisted of encouraging the MHP to compete the actions identified for data collection, and continue to make improvements, and was encouraged to seek this early into its concept and to continue to seek support in its write-ups. However, since this is the second year of submitting this PIP with limited activities and data provided, the MHP is advised to initiate a new PIP for the next review cycle for rating. CalEQRO also discussed the timelines of PIP activities, encouraging the MHP to identify its PIP early in the process, implement interventions, and collect and analyze the relevant date to identify necessary adjustments so that the rating for the PIP is accepted as active. The MHP was offered ongoing TA and the MHP followed up with an email update and indicated consultation will be scheduled in the upcoming months.

Submission determined not to be a PIP

Quality of Care PIPs

- Improving Engagement and Retention Services (Active and Ongoing)

Riverside

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Does the use of a collaborative assessment process decrease no show rates by 25 percent and increase by 20 percent continued engagement in services following the initial assessment with continued engagement defined as at least two services within 30 days of the initial assessment?"	The goal of this non-clinical PIP is to increase engagement and retention of children in county-operated specialty mental health outpatient clinics by demonstrating that the interventions (collaborative assessment, and availability of evening hours) work in one clinic, and then scaling them up to other clinics. The data used for this PIP included the percentage of beneficiaries with fewer than five services, and the average approved claims per beneficiary which showed a pattern of fewer services per beneficiary than other large counties and that statewide.	The PIP lists two interventions, collaborative assessment and evening availability for services. Both lack a detailed discussion and steps/activities that will be taken to implement them. Prior to selecting these interventions, the team appears to have missed the step of determining beneficiaries' reasons for lack of engagement and subsequently dropping out of treatment. Interventions should be selected based on this information to fully address the barriers beneficiaries are experiencing.	The TA provided to the MHP by CalEQRO consisted of a discussion on the differences between clinical and non-clinical PIPs, and suggestions for strengthening this non-clinical PIP. As discussed onsite, the MHP has agreed to review the feedback in the PIP Validation Tool and update their PIP Development Outline in the coming months to reflect the feedback and their quarterly data analyses and changes made to the interventions. The MHP will seek further consultation with CalEQRO after this report has been finalized.

Submission determined not to be a PIP

Outcomes of Care PIPs

- Strengths Based Interventions (Active and Ongoing)

Inyo

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will improving the content & structure of group supervision sessions utilizing the University of Kansas Strengths Model group supervision tools and methodology result in more beneficiaries achieving their self-identified goals related to living arrangements, vocational status, educational status, hospitalizations, or successful completion and exit from services?"	The MHP has engaged with a three county, Eastern Sierra, collaborative project implementing the Strengths-Based Model, which is out of the University of Kansas and supported by the California Institute of Behavioral Health (CIBH). The MHP determined it lacked a clear process that identified and tracked beneficiary progress towards identified life goals, including those aspects that were outside of pure clinical indicator progress. The MHP further explored the aspect of personal life goals through a review of beneficiary records and discovered that very few had identified or made progress with improved housing, employment, education, emergency room visits, psychiatric hospitalizations, and graduation from services.	The study question as written does not clearly and succinctly identify what is being done differently with beneficiaries, as required in a PIP, the details of that interaction, and does not propose how much of a change is expected. The list of interventions relates to use of the strength's model assessment, supervision, and use of report to track potential beneficiary gains. As written, this would be difficult to replicate, for the PIP does not specify the 'what and how' interventions are being done with beneficiaries through the lens of this model, and how the staff-beneficiary interaction is being changed to improve likelihood of beneficiary attainment of goal. These elements are critical to correct going forward.	The TA provided to the MHP by CalEQRO consisted of onsite and pre/post interactions speaking to how this PIP and the clinical PIP utilized the same topic – Strength-Based Model – and were duplicative. The non-clinical PIP appears to have broader intervention elements and focus that would support utilization for several review cycles so long as the focus and interventions continued to grow and change over time. The study question requires the addition of a quantifiable element, and the interventions require specific information regarding the specific interventions used in the clinician/beneficiary interaction to accomplish change.

Submission determined not to be a PIP

CONCEPT ONLY, NOT YET ACTIVE PIP TOPICS SUBMITTED

Timeliness of Care PIPs

- Timeliness Plan (Concept Only, Not Yet Active)

Modoc – Non-clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will designating "access" clinicians decrease beneficiary wait time for behavioral health non-urgent initial contact and first assessment as measured by timeliness measures?"	The PIP focuses on timeliness for non-urgent appointments. Reasons identified for delayed timely access to services included lack of sufficient clinicians and large caseload distributions, both of which are addressed through the proposed intervention of appointing "access" clinicians. Access clinicians will be poised to accept non-urgent call-ins or walk-ins as they present at the main clinic. The current baseline for access is 11 business days. The MHP's standard is ten business days.	As written, the MHP is planning to begin their intervention in 2019. However, that would mean a gap of ten months without an active PIP. In discussion, the MHP said they would likely be starting earlier once they implement a new screening and triage system. Also discussed was that while working towards the goal of complying with a mandated measure, PIPs should be approached in terms of beneficiary benefit. A thorough barrier analysis should be completed so patterns can be identified (i.e., specific staff or clinic) to determine what types of targeted interventions are needed.	The TA provided to the MHP by CalEQRO consisted of discussion regarding the requirement to have two active PIPs and reviewing the criteria for active PIPs (having active/new interventions each year for unsuccessful PIPs). Given that the baseline for timely access is 11 business days, and close to the standard of 10 business days, continuation of this PIP is dependent on the barrier analysis and whether it uncovers a barrier that potentially affects many beneficiaries. Data should be analyzed at least quarterly, though more often is recommended to implement changes before the end of a year.

Submission determined not to be a PIP

- Timely Access for Children and Youth (Concept Only, Not Yet Active)

Siskiyou – Non-Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Can scheduling with contracted provider Remi Vista anytime there is not an available MHP appointment slot within 10 days result in: • **An increase in the proportion of beneficiaries being offered an assessment within 10 business days from 42 percent to a goal of 90 percent;** • **A reduction in the average number of days between referral and actual assessment from 19.4 to 12.0; and ultimately; and** • **An increase in the percentage of child/youth beneficiaries who attend an assessment from a baseline of 80 percent to a goal of 95 percent?"**	The PIP intends to offer assessment appointments within ten days of contact and to track the average number of business days between referral and assessment. To comply with the ten-day standard, the MHP will refer youth to its organizational provider, Remi Vista, for the assessment to be completed. This PIP is designed to improve timely assessment rates for children and youth who are new or returning to services.	Although the MHP has submitted this as a non-clinical PIP, the project is at the concept only stage. The interventions have not been applied and data have not been collected. The MHP will need to implement interventions, provide the follow up data, and analyze the data to support its premise that improved timeliness to assessments occurred. Since the MHP discusses both the timeliness and engagement strategies for both PIPs for the same age group, it is critical to collect data for different interventions. The MHP was advised to continue to define separate elements for each PIP to distinguish the two. The MHP will also need to define what it expects to achieve for beneficiary benefit which appears to be identified as reduced wait times even if the option to refer to Remi Vista is not utilized.	The TA provided to the MHP by CalEQRO consisted of pre-site telephone discussion and the on-site discussion of the elements that would help in accelerating the activities of the PIP process. Post review phone calls were made as well for TA. Elements of the PIP process that were emphasized consisted of the need for the interventions, the data collection plan, and the benefit to beneficiaries, all to be measurable. The MHP was encouraged to consult with CalEQRO early and often during PIP formulations and the MHP recognized this option. Further TA has been scheduled.

Submission determined not to be a PIP

Quality of Care PIPs

- Improving Beneficiary Outcomes through integrated treatment of Co-Occurring Disorders (Concept Only, Not Yet Active)

Modoc - Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will implementation of the Drug Use Screening Quick Inventory (revised) (DUSI-R) improve quality of care and accuracy of diagnoses as measured by co-occurring diagnosis rates and beneficiary retention rates?"	The MHP reported a co-occurring diagnosis rate of 6 percent during the FY16-17 review. Retrospectively they were unable to duplicate the low rate, but instead calculated the rate at 21.03 percent. The MHP's goal remains to increase the co-occurring reporting rate so that it is more in line with national standards.	The MHP was advised to conduct a barrier analysis to discover what led to the low rate of co-occurring disorders and inaccurate diagnoses. The MHP plans to use an assessment tool for SUD and mental health to capture co-occurring diagnoses. However, the overarching goal should be to accurately diagnose beneficiaries. Otherwise, a goal of increasing the identification and documentation of co-occurring disorders could lead to over diagnosing co-occurring disorders.	The TA provided to the MHP by CalEQRO consisted of discussion on ways to insure validity and reliability of their efforts. The data collection plan should specify the data to be collected; the data sources; how and when the data are to be collected; who will collect the data; and instruments used to collect the data. The MHP stated that they had recently provided additional training for staff in data collection. As a result, the MHP was advised to see if there are current issues with reporting of diagnoses and consider the possibility that current data may not indicate a problem warranting a PIP.

Submission determined not to be a PIP

Outcomes of Care PIPs

- Initial Engagement and Retention in Children's Services (Concept Only, Not Yet Active)

Siskiyou - Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
Can the following result in an increase in the percentage of children and youth who receive at least one clinical treatment after assessment, from a baseline of 71 percent to a goal of 90 percent (i.e., reduce the percentage of child and youth beneficiaries discharged after only one service from 29 percent to 10 percent)? • **Training in and implementation of FIT, which involves collecting feedback from beneficiaries and using that feedback to improve listening, engagement, rapport and trust with beneficiaries;** • **Immediate follow-up appointment scheduling by the clinician; and** • **Providing telephone and/or home visits by behavioral health specialists between the assessment and follow-up treatment appointments?"**	The goal of this PIP is to increase the proportion of children and youth who are retained beyond their first service encounter identified as the assessment.	Although the MHP submitted detailed and thoughtful indicators and explained the interventions, it has not proceeded beyond the concept only stage. The interventions have not been applied, and data have not been collected.	The TA provided to the MHP by CalEQRO consisted of phone calls prior to the on-site review and following the review. Since then, the MHP has developed a concept for their clinical PIP, although as mentioned, the MHP has not implemented the interventions. The on-site discussions during the review included encouraging the MHP to collect and report on data monthly and compare data quarterly. The PIP must identify and measure the benefit to the beneficiary as well. At any point during the data review, the MHP is encouraged to contact CalEQRO regarding contingencies or training needed to reach its goals.

Submission determined not to be a PIP

- Improving Anxiety Levels of Beneficiaries Diagnosed with an Anxiety Disorder (Concept Only, Not Yet Active)

Trinity - Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will creation of an intervention group for treating anxiety reduce the average aggregate level of anxiety by the beneficiary population from 2.2 to 2.0 (on a scale of 1-3) as measured by the ANSA tool?"	The overall goal of this clinical PIP is to improve the outcomes of beneficiaries diagnosed with an anxiety disorder as measured by the ANSA tool. Addressing the issue is expected to impact any beneficiary with an anxiety diagnosis, as much as 27 percent of the beneficiaries, as well as those with anxiety symptoms. The goal of this PIP is to improve and to reduce the severity of anxiety experienced by the beneficiaries, potentially leading to earlier engagement with the addition of a group focused on coping strategies.	The MHP will offer and conduct a group focused on strategies to improve coping with a Mindfulness-based Stress Reduction syllabus. The introduction of the Mindfulness-based Stress Reduction technique is hoped to lead to an improvement in the level of anxiety experienced by adult beneficiaries by providing coping skills to lessen symptoms. This is in the planning phase now, an initial syllabus has been drafted, and is intended to support the beneficiary in dealing with and reducing levels of anxiety. The MHP also believes that beneficiaries who use improved coping skills may be able to focus on other behavioral health issues that are currently superseded by their focus on anxiety. An improvement may also be in assuring a more accurate diagnosis and more frequent updating of diagnoses, with corresponding treatment plans for beneficiaries in this category.	The TA provided to the MHP by CalEQRO consisted of discussing the timelines of PIP activities, encouraging the MHP to identify its PIP early, implement interventions, and collect and analyze the relevant data to identify necessary adjustments so that the rating for the PIP is accepted as active. The study question, although measurable could be reviewed since it suggests a marginal improvement goal (from 2.2 percent to 2.0 percent) and to review the language in the study question with the suggestion to change the wording to "Will providing the…" The MHP was offered on-going TA. No further consults have been scheduled.

Submission determined not to be a PIP

SUBMISSION DETERMINED NOT TO BE A PIP

- Strengths-Based Learning Collaborative: Strengths Model Group Supervision for Employment-Related Goals (Submission Determined Not to be a PIP)

Mono – Non-Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will using SMGS (Strengths Model Group Supervision) help beneficiaries make progress toward their employment-related goals, as measured by the achievement of and/or change in employment-related goals over the two-year study period as reported on the Strengths Assessment?"	The MHP has identified fulfillment of life goals of beneficiaries as not well supported by the usual clinical focus of staff, which tends to align with symptoms and impairments of illness. The existence of life domain areas that are unfulfilled, such as housing, education and employment, has brought the MHP to focus on an approach geared to support other successes. The Strengths Model is associated with a specific assessment approach, the development of a personal recovery plan and supported by a specific focus in group supervision. Likely this is associated with changes in approach by clinical staff, but these interventions are not described within this PIP.	This PIP is very similar to the clinical PIP but with a slightly different focus. The overlap is sufficient to conclude that both cannot be accepted as active PIPs for this MHP.	The TA provided to the MHP by CalEQRO consisted of discussion of the duplicative aspects of this PIP, and identification of potential alternate PIP topics. One topic that was discussed was that of telepsychiatry appointment no-shows, which the MHP has been tracking.

- Strengths Assessment (Submission Determined Not to be a PIP)

Inyo – Clinical

Study Question (as presented by MHP)	Focus of PIP	Areas for Improvement	TA Provided by CalEQRO
"Will the implementation of the Strengths Assessment tool from the Strengths Model help move eight ICBH beneficiaries formerly mired in repetitive service utilization towards their highest level of recovery in the self-identified goal areas of housing?"	In alignment with the MHP's non-clinical PIP, this activity focused on correcting for the deficit that emanates from clinically-focused treatment planning, a narrow focus on symptoms and impairments of mental illness. Positive achievement of beneficiary life goals can be missed if the MHP is not oriented to the rehabilitative services model. This PIP narrowly focused on the eight beneficiaries who through the Strengths Assessment had identified improved housing as a key area for personal improvement.	The Strengths Assessment PIP, submitted to meet the clinical requirement, essentially duplicates a narrow aspect of the non-clinical Strengths Model PIP, with the caveat that it was focused on beneficiaries who have identified highest priority life goals in the housing domain. However, that narrow activity appropriately belongs integrated with the non-clinical PIP.	The TA provided to the MHP by CalEQRO consisted of onsite discussion and post-review follow-up, providing the MHP with the opportunity to amend the non-clinical PIP. This clinical PIP could be a first phase of the strengths model implementation of the non-clinical PIP. Further guidance to include the direct interventions of staff with beneficiaries was also provided. Additional guidance provided by email after the review, including encouragement to develop a new clinical PIP topic.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION	
MHP: ☐ Clinical PIP ☐ Non-Clinical PIP	
PIP Title:	
Start Date (MM/DD/YYYY) _____ **Projected Study Period** (#of Months) _____ Completed: _____ Yes _____ No Dates of On-Site Review: _____(MM/DD/YYY) Name of Reviewer: _____	**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
Brief Description of PIP:	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions	*Non-Clinical:* ☐ Process of accessing or delivering care	
1.3 Did the Plan's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? *Include study question as stated in narrative:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* <Text>	☐ Met ☐ Partially Met ☐Not Met ☐ Unable to Determine	

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? Are long-term outcomes implied? ☐ Yes ☐ No Or are long-term outcomes clearly stated? ☐ Yes ☐ No ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ 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?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? Instruments used: ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

6.6 Were qualified staff and personnel used to collect the data? Project leader: Name: <Text> Title: <Text> Role:<Text> Other team members: Names: <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	<#> Met <#> Partially Met <#> Not Met <#> UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *<Text>*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** NA **<#>** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

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? Indicate the time periods of measurements:_____ Indicate the statistical analysis used:_____ Indicate the statistical significance level or confidence level if available/known:_____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
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? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** NA **<#>** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used, when measurement was repeated? *Ask: Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
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? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** NA **<#>** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified upon repeat measurement?	☐ Yes ☐ No	○

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: <Text>		
Recommendations: <Text>		
Check one:	☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible