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FY17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

INYO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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INYO MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 358

MHP Threshold Language(s) — Spanish

MHP Size — Small-Rural

MHP Region — Central

MHP Location — Bishop

MHP County Seat — Independence

Introduction

Inyo is one of the smaller counties in California by population and is categorized for this review process as a small-rural Mental Health Plan (MHP). By population density, approximately two people per square mile, it is considered a frontier county (threshold: six people per square mile) and it is the second largest by area. These categories reflect the challenges found in creating systems of care and delivering services, in both the location of clinic sites and provision of services, and as well in difficulties with recruiting and hiring of mental health professionals.

Access

Ranging from Death Valley to Bishop and up the I-395 corridor, Inyo County Behavioral Health (ICBH) serves a large and sparsely populated region. Challenges are persistent in the recruitment and hiring of licensed professional staff. In the southeastern area, the MHP utilizes a contractor in Pahrump, Nevada, for services when needed. Telemedicine and teletherapy are used to extend the reach of the MHP into remote areas. The MHP has linked with Kern County to the south in this last year and is in the early stages of navigating a contract for crisis stabilization services with that county. The lack of non-profit resources results in the MHP usually having to directly develop programs.

Timeliness

The MHP was unable to report on timeliness metrics for this review cycle. To its credit, the MHP has identified and adopted timeliness standards, but reporting on the various elements is not yet possible. In FY16-17 the Avatar system was adopted, and the switchover unearthed methodological and reporting issues that have yet to be resolved for efficient automated reporting to occur. Also, the lack of exclusive dedicated analyst resources to assist the MHP during the long transition period further impairs progress.

Quality

For many years, the MHP utilized part of a clinician's full-time availability to help with quality improvement and assurance, including providing staff trainings and helping with utilization review. In the past several years the MHP has shifted this work to a number of analysts who are part-time dedicated to ICBH and shared with other divisions of Inyo County Health and Human Services Department (ICHHS). The apportioning of their time between agency divisions prevents a comprehensive focus on MHP issues. A recently hired bilingual clinician is splitting time between direct clinical work and quality improvement (QI) work. The fragmentation of support for quality and compliance has potential to disrupt claiming fidelity and progress.

Outcomes

The MHP is in the process of preparing to adopt the Child, Adolescent Needs and Strengths (CANS) instrument, and has incorporated the Milestones of Recovery Scale (MORS) in the treatment process of adults. Neither is integrated in the electronic health record (EHR), although the MHP reports entering the MORS score in the EHR. As to direct consumer outcomes, the MHP has established two part-time Health and Human Services Specialist I positions for individuals with lived experience.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care 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 State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan.

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

This report presents the FY17-18 findings of an EQR of the Inyo MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

Validation of Performance Measures[1]

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

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);

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

[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

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

MHP Health Information System Capabilities[4]

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

Validation of State and County Consumer Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Key Recommendations from FY16-17

Recommendation #1: Pursue activities that lead to recruitment of candidates for vacant positions, as well as anticipating those that are expected to be vacated in the near future. Particularly critical are the difficult to fill licensed clinical positions, and even more challenging are those who are bilingual Spanish speakers. The MHP should also explore possibilities of augmenting onsite staff with telemedicine and teletherapy services should difficulties continue with filling permanent positions.

Status: Met

- The MHP started implementation of telepsychiatry furnished by Kings View during this last year, and is also contracting with a physician recruiter to assist with filling the upcoming vacancy. The MHP plans to have sufficient psychiatric capacity available before the retirement of the onsite psychiatrist during the coming summer.
- A clinician from out of the area was hired to fill the children's system of care director role. Several individuals who are post-masters and needing supervised hours were hired and are progressing towards licensure. Analysts have been hired who function in a shared role with other Health Service Agency (HSA) divisions.

- The MHP has established a contract with a psychologist to provide neuro-feedback teletherapy treatment as part of its Mental Health Services Act (MHSA) Community Services and Supports funded services.

- Also discussed onsite, the MHP has sought to attract licensed personnel with advertisements in various outdoor activity magazines, posting flyers at the local outdoor equipment stores and other venues. Their conclusion is that individuals coming to the Inyo County area do so only if a significant other is also drawn to the region for their own or shared reasons.

Recommendation #2: Fill vacant data analyst positions so as to be able to implement the remaining CCBH modules and ensure all users are trained in use of the EHR.

Status: Partially Met

- The current structure of data analytics staffing is similar to that for other entities like this MHP who are part of an overarching health agency where resources may be shared. Unfortunately, shared resources, unless appropriately managed and allocated provide for a sub-optimal implementation of complex software systems like the MHP's relatively new EHR, as appears to be the case for this MHP.

- This review found that while attempting to meet its mandates, the MHP does not have adequate access to the dedicated QI staffing or the clinical analysts required to develop subject matter expertise and perform routine robust clinical analytics. Following adoption of a new EHR, as is the MHP's circumstances, the first decade of operation requires a significant commitment of fulltime resources.

Recommendation #3: Train clinicians/staff to screen for co-occurring substance use disorders (SUDs), include these secondary diagnoses in the Assessment/Treatment Plan and track the co-occurring disorder rate.

Status: Not Met

- The MHP does not currently have sufficient dedicated staffing to accomplish regular and routine QI activities to accomplish this recommendation. The development of reporting of co-occurring diagnosis requires work with Kings View to generate the needed system outputs.

Recommendation #4: Join the Kings View User Group to take advantage of collaborative activities and information sharing this forum would provide.

Status: Not Met

- Despite an existing robust Kings View user group that regularly holds meetings and trainings across the state, the MHP continues to have communication issues with its vendor and has not been able to leverage this resource.

- This recommendation will be carried over to the current year.

Recommendation #5: Explore and identify the issues around lower foster care penetration rates.

Status: Met

- Discussions with MHP and Child Welfare Services (CWS) staff demonstrated that the MHP is clearly serving larger percentages of beneficiaries than it is credited with from FC service coding, due to the non-Medi-Cal delivery stream that serve a segment of this population. Policy decisions may well be revisited by the new Chief of Children's Services at the MHP which would provide enhanced revenue opportunities to the MHP and materially improve FC penetration rates in the future.

Recommendation #6: Continue efforts to identify and begin to implement within the EHR outcome and level of care instruments that are used with all children and all adults.

Status: Met

- The MHP implemented the MORS in its adult system of care this year and is actively engaged in implementing the CANS tool for its youth population. Neither of these tools have currently been integrated fully into the EHR workflow but the MHP is investigating this enhancement.

- The MHP has also implemented another outcome tool, the Patient Health Questionnaire (PHQ-9), which quantifies the degree of depression severity to enhance diagnostic functionality. The MHP continues to evaluate targeted outcomes tools for implementation as the need presents itself.

- It is unclear when the MHP will link the use of outcome tools to an outcome analysis system, including aggregation and larger scale analysis. This is partially due to the lack of adequately staffed clinical data analysts at the MHP, and secondarily due to the small size of the consumer population.

Changes in the MHP Environment and Within the MHP—Impact and Implications

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

Access to Care

- The telemedicine implementation began during this past year with Kings View as the provider, to date serving 20 consumers, and has had mixed responses from consumers.
- Development of access to a crisis stabilization unit (CSU) operated by Telecare for Kern County in Ridgecrest occurred during this last year. This will improve the depth of services available to Inyo County eligibles, particularly for those needs that exceed the capabilities of Progress House.
- The MHP is exploring the possibility of providing medication assisted treatment in the absence of SUD-ODS waiver.
- The MHP is in the early phases of exploring cognitive behavioral therapy (CBT) apps and other technology developments that support provision of services to remote areas.

Timeliness of Services

- The MHP has been unable to report on timeliness of service during the last year due to adoption of a new EHR and methodologic reporting issues. It has also faced challenges in participation and support with the user group. The MHP does set standards and is of small enough scale to create manual tracking.

Quality of Care

- The Strengths Model of the University of Kansas was adopted during this past year, and utilized in a PIP, to improve the achievement of personally identified outcomes of consumers.
- The MHP reports efforts to obtain administrative burden relief from the DHCS. Considerations include reduced reporting frequency, or possibly joint reporting of MHSA and Medi-Cal services, and possibly regional reporting.
- The MHP has added neuro-therapy to its services, delivered by a contracted psychologist.

- The MHP continues to develop the implementation of Continuum of Care Reform (CCR).
- The MHP's services have been impacted by staff turnover, including retirement of the Child and Family Program Chief. Sixty five percent of the staff have less than three years in their positions, and requiring time, supervision and experience to become fully versed in their roles.

Consumer Outcomes

- The MHP is preparing for the implementation of No Place Like Home, a housing initiative through the California Department of Housing and Community Development. Funds exist for unneeded technical assistance (TA) but are not available to use on the actual acquisition of housing.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

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

HIPAA Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Inyo MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	2,615	44.8%	203	56.7%
Latino/Hispanic	1,745	29.9%	76	21.2%
African-American	38	0.7%	*	n/a
Asian/Pacific Islander	70	1.2%	*	n/a
Native American	1,107	19.0%	38	10.6%
Other	258	4.4%	37	10.3%
Total	**5,831**	**100%**	**358**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

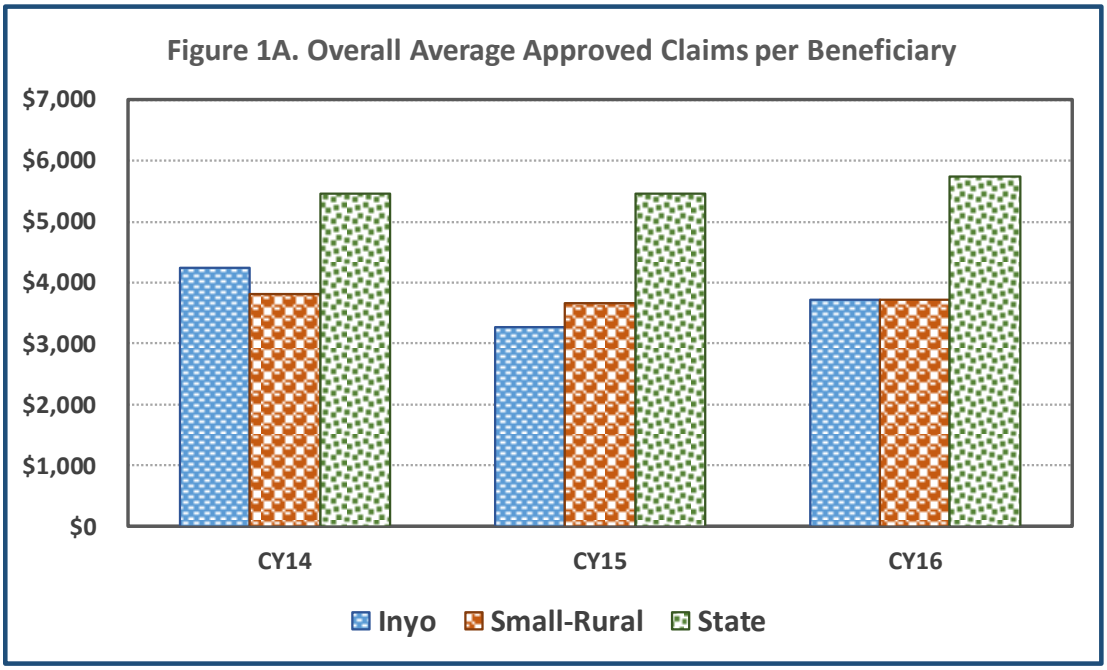
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

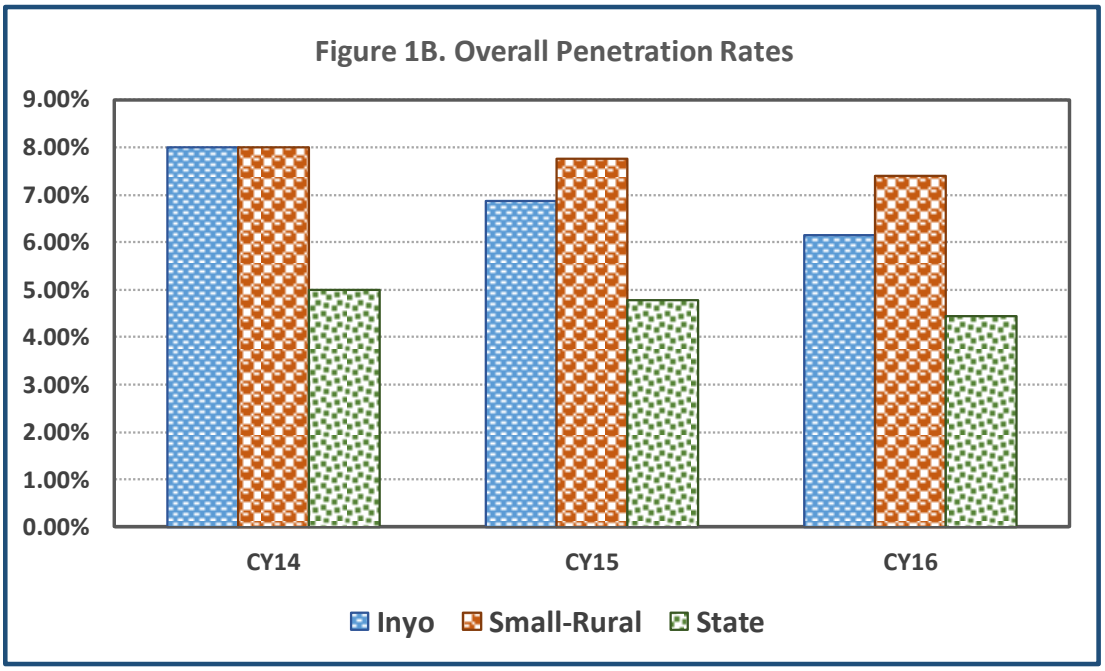
Penetration Rates and Approved Claim Dollars per Beneficiary

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

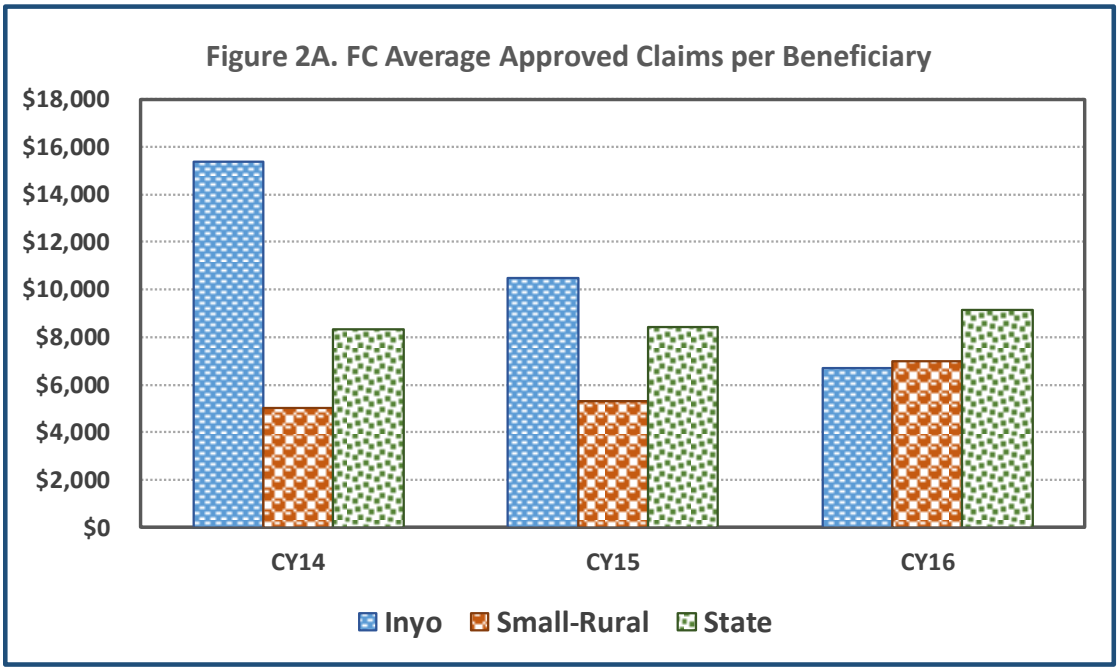
Regarding calculation of penetration rates, the Inyo MHP uses a different method than that used by CalEQRO.

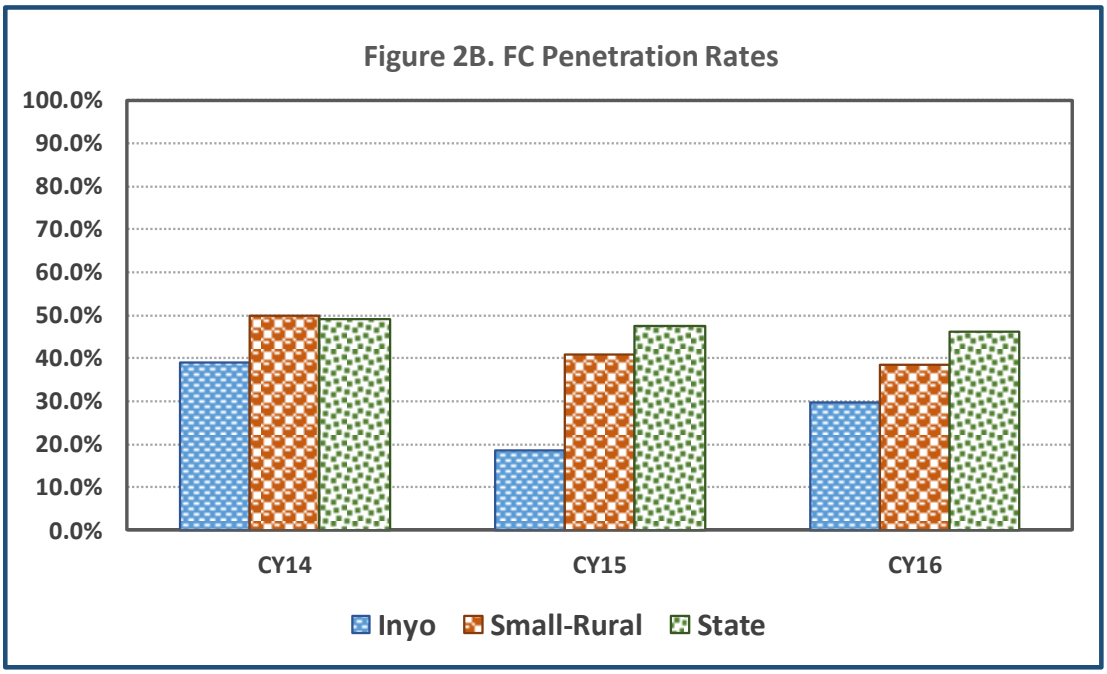
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small-rural MHPs.



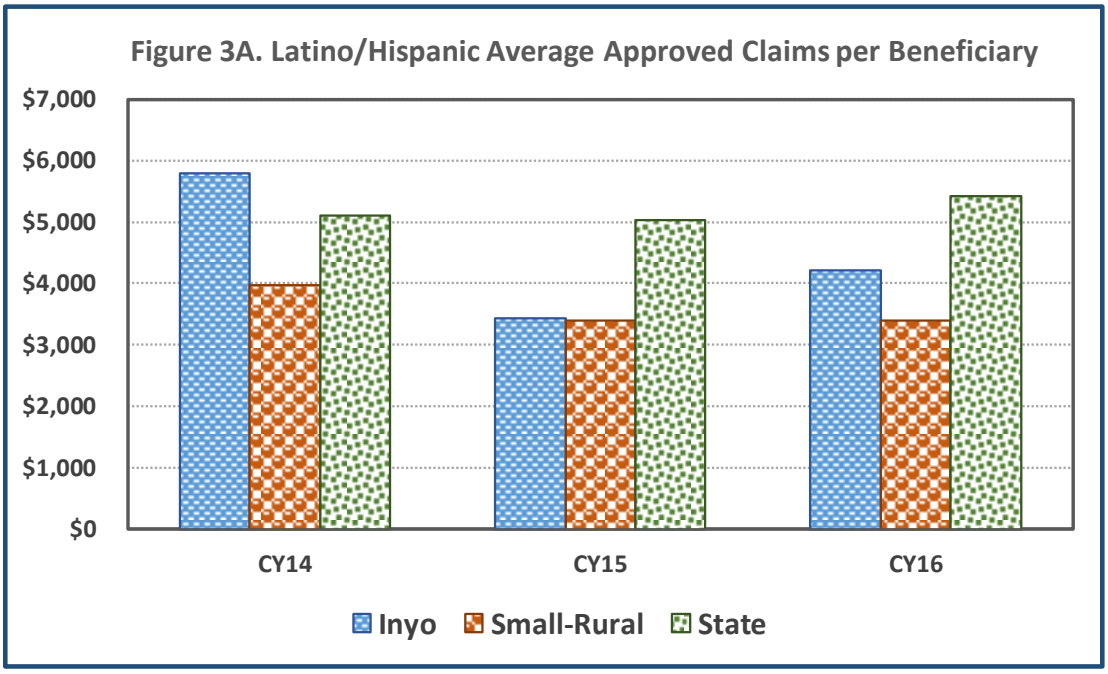


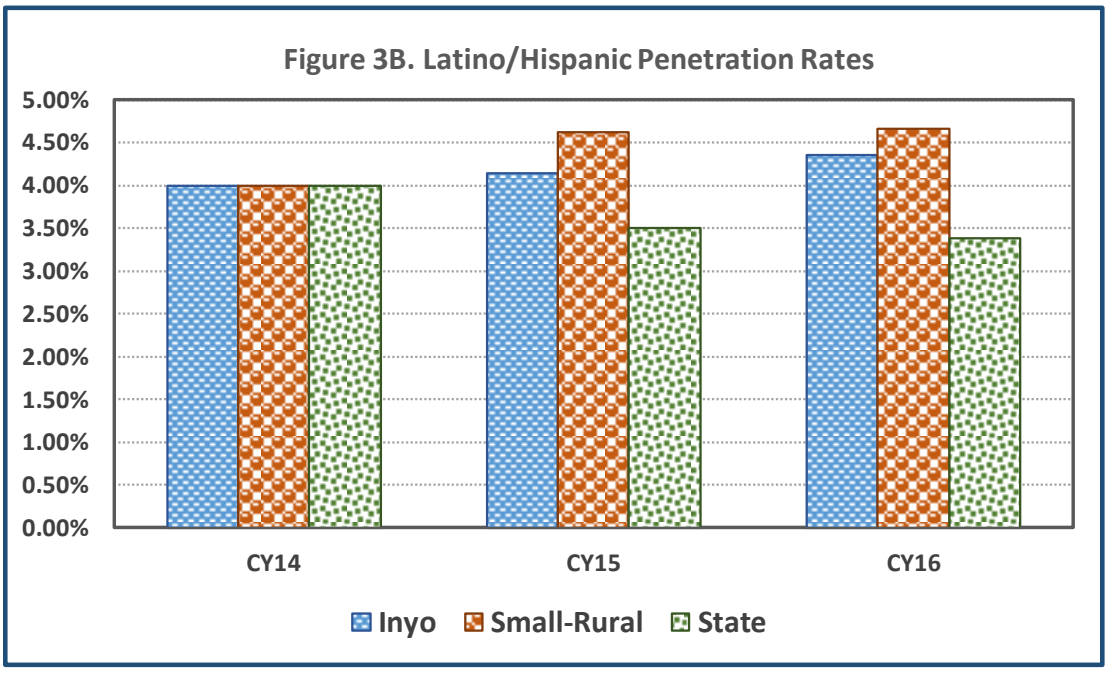
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small-rural MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small-rural MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

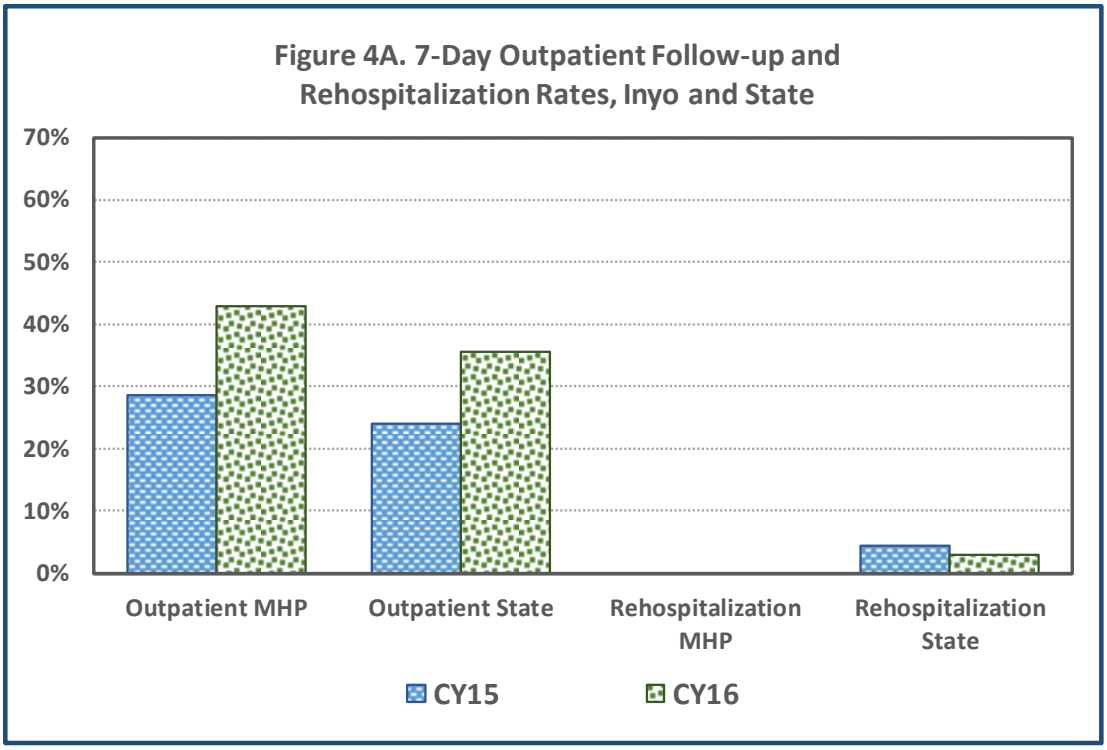
Table 2: Inyo MHP High-Cost Beneficiaries

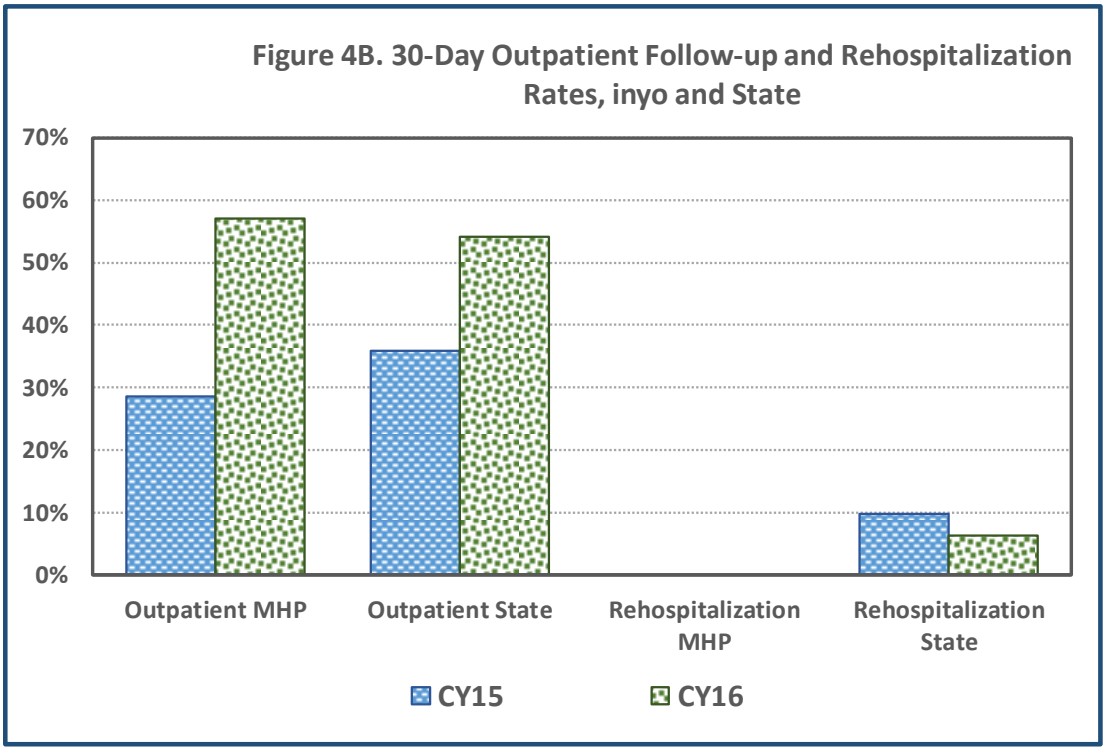
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	19,019	609,608	3.12%	$53,215	$1,012,099,960	28.90%
Inyo	CY16	*	358	n/a	-	-	n/a
	CY15	*	392	n/a	-	-	n/a
	CY14	*	334	n/a	$59,284	-	n/a

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000; and those above $30,000.

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

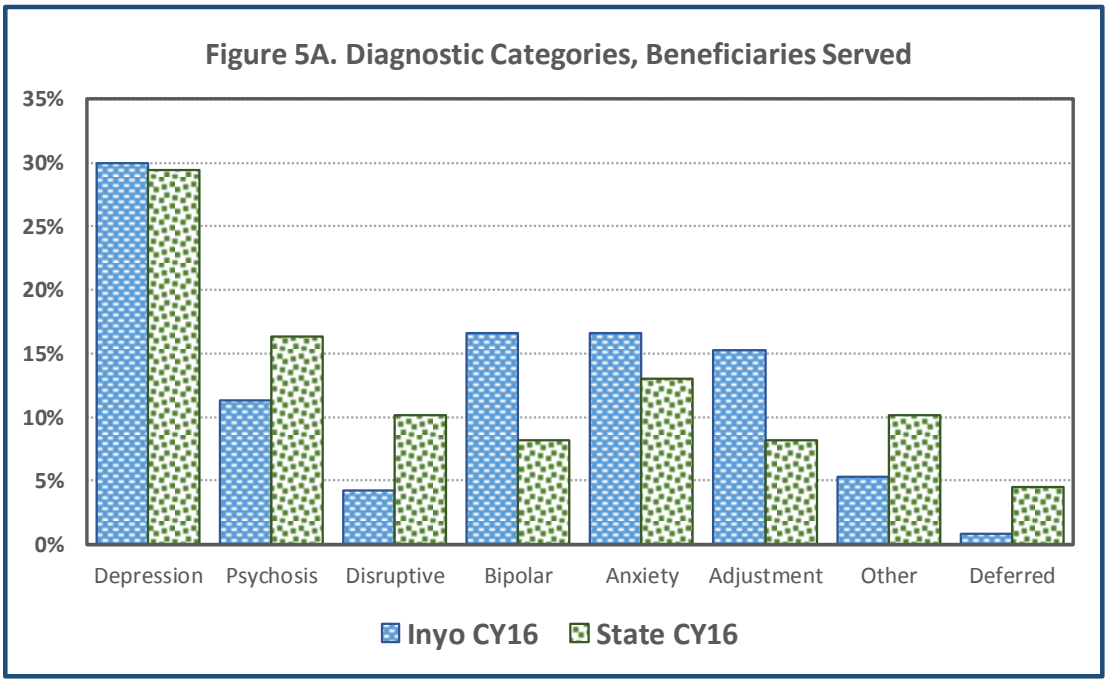


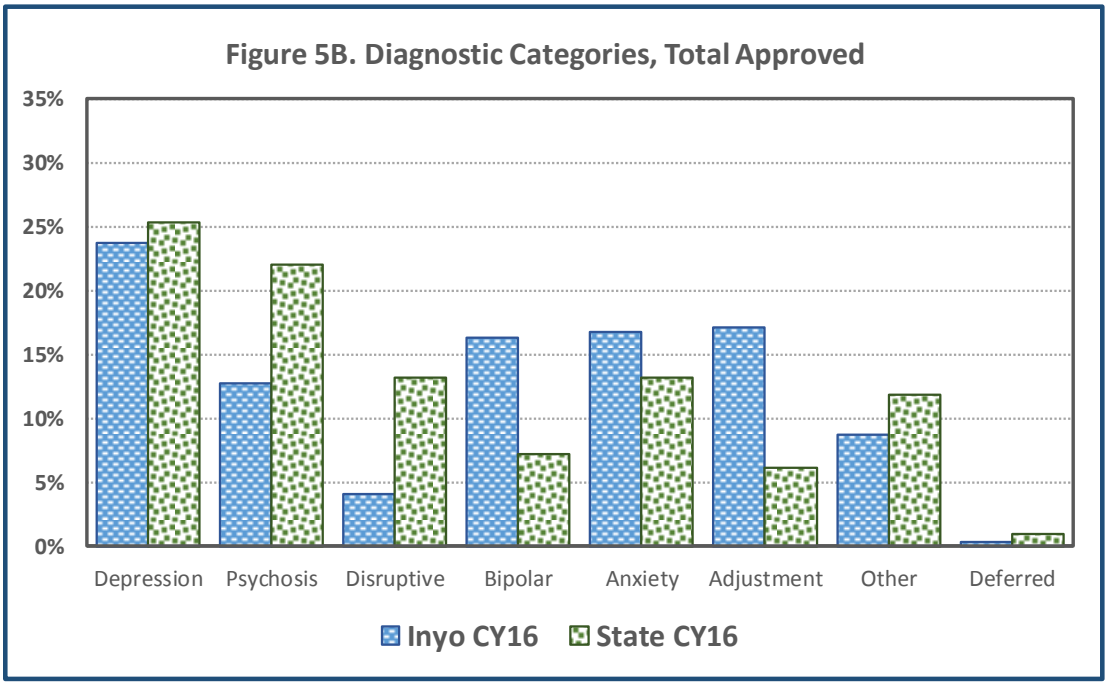


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

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





Performance Measures Findings—Impact and Implications

Access to Care

- While the MHP's number of eligibles increased slightly from CY15 to CY16, beneficiaries served dropped. However, even with this slight decrease, the MHP's CY16 overall penetration rate is substantially more than the statewide average.
- After a decline in FC penetration rate from CY14 to CY15, the penetration rate increased substantially from CY15 to CY16. The MHP's FC penetration rate remains significantly below both small-rural MHP and statewide averages. Onsite discussion suggests this may be related to the application of MHSA/non-Medi-Cal services to a segment of the FC population.
- While the MHP's Hispanic penetration rate increased from the CY14 and CY15 experience, it is comparable to the small-rural average and exceeds the statewide.

Timeliness of Services

- In CY16, the MHP's 7-day outpatient follow-up rate after discharge from a psychiatric inpatient episode improved when compared to the corresponding CY15 rate and remains above the statewide average. The MHP's 30-day follow-up rate increased from CY15 and is slightly above the statewide average.

Quality of Care

- The MHP's average overall approved claims per beneficiary has remained relatively stable, but declining slightly, from CY14 to CY16. It is approximately equal to the small-rural average and significantly lower than the statewide average in CY16.
- The MHP's average FC approved claims per beneficiary continued a significant downward trend from CY14 to CY16. It is now about equal to the small-rural average and less than the statewide average in CY16.
- The MHP's average Hispanic approved claims per beneficiary increased from CY15 to CY16 and has increased to be slightly more than the small-rural average and is less than the statewide average in CY16.
- Consistent with the statewide diagnostic distribution, primary diagnoses of depressive disorders accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a notably lower rate of psychosis and disruptive disorders and a higher rate of anxiety, adjustment and bipolar disorders. The use of deferred diagnosis is low when compared to statewide averages.
- Corresponding with the MHP's diagnostic patterns, the percentage of total approved claims for individuals tracked well with the MHP's diagnostic experience.

Consumer Outcomes

- The MHP had no 7-day or 30-day rehospitalizations in CY16.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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." The Validating Performance Improvement Projects Protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year.

Inyo MHP PIPs Identified for Validation

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

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Inyo MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Strengths Assessment
Non-clinical PIP	1	Strength-Based Interventions

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review

				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	M
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	PM
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	PM
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	PM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	M
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NA
		5.2	Valid sampling techniques that protected against bias were employed	NR	NA
		5.3	Sample contained sufficient number of enrollees	NR	NA
6	Data Collection Procedures	6.1	Clear specification of data	NR	M
		6.2	Clear specification of sources of data	NR	M
		6.3	Systematic collection of reliable and valid data for the study population	NR	M
		6.4	Plan for consistent and accurate data collection	NR	NM
		6.5	Prospective data analysis plan including contingencies	NR	M
		6.6	Qualified data collection personnel	NR	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NA
		8.2	PIP results and findings presented clearly and accurately	NR	NA
		8.3	Threats to comparability, internal and external validity	NR	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NA
		9.3	Improvement in performance linked to the PIP	NR	NA
		9.4	Statistical evidence of true improvement	NR	NA
		9.5	Sustained improvement demonstrated through repeated measures	NR	NA

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	0	10
Number Partially Met	0	5
Number Not Met	0	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	0	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**0%**	**78.12%**

Clinical PIP—Strengths Assessment

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

"Will the implementation of the Strengths Assessment tool from the Strengths Model help move eight ICBH consumers formerly mired in repetitive service utilization towards their highest level of recovery in the self-identified goal areas of housing?"

Date PIP began: 2/1/18

Status of PIP: Submission determined not to be a PIP (not rated)

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 consumers who have identified highest priority life goals in the housing domain. However, that narrow activity appropriately belongs integrated with the non-clinical PIP.

In alignment with the 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 consumer life goals can be missed if the MHP is not oriented to the rehabilitative services model.

This PIP narrowly focused on the eight consumers who through the Strengths Assessment had identified improved housing as a key area for personal improvement.

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

The technical assistance provided to the MHP by CalEQRO consisted of 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 consumers was also provided. Additional guidance provided by email after the review, including encouragement to develop a new clinical PIP topic.

Non-clinical PIP—Strength-Based Interventions

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

"Will improving the content & structure of group supervision sessions utilizing the University of Kansas Strengths Model group supervision tools and methodology result in more clients achieving their self-identified goals related to living arrangements, vocational status, educational status, hospitalizations, or successful completion and exit from services?"

Date PIP began: 1/3/2018

Status of PIP: Active and ongoing

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 consumer 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 consumer 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 Strengths-Based approach incorporates a process of assessment, planning, clinical case review and supervision of staff, and support provided to consumers to achieve identified life-goals. In the initial phase of this project the majority of consumers identified improvement of housing as a key issue, wanting more independence and for some, obtaining housing and not being homeless.

It must be noted that the study question as written does not clearly and succinctly identify what is being done differently with consumers, 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 client gains. As written, this would be difficult to replicate, for the PIP does not specify the 'what and how' interventions are being done with consumers through the lens of this model, and how the staff-consumer interaction is being changed to improve likelihood of consumer attainment of goal. These elements are critical to correct going forward.

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

The technical assistance provided to the MHP by CalEQRO consisted of 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 addition of a quantifiable element, and the interventions require specific information regarding the specific interventions used in the clinician/consumer interaction to accomplish change.

PIP Findings—Impact and Implications

Access to Care

- No access issues were identified.

Timeliness of Services

- No timeliness issues were identified.

Quality of Care

- The Strengths-Based Model works with the consumer on the identification of life domain areas in which positive change is desired and provides support to the staff and the consumer on the achievement of those outcomes.

Consumer Outcomes

- The non-clinical PIP has the potential to positively affect consumer outcomes in areas identified by the consumer, albeit in housing, employment, education, or other areas.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 6: Access to Care Components

	Component	Quality Rating
1A	Service accessibility and availability are reflective of cultural competence principles and practices	M

The MHP has a current Cultural Competence Plan (CCP) in which the MHP identifies the chief constituent groups of its served population, including Native Americans, and Hispanics. Spanish is the threshold language. Review input indicates more training on Culturally and Linguistically Appropriate Services (CLAS) standards is desired by staff.

Locally, the MHP lacks the intensive high-level services such as formal crisis stabilization and crisis residential programming. Acute care access is challenging for the consumers of ICBHS. When and if a psychiatric inpatient bed can be identified, then challenges with transportation to that facility arise. Stakeholders suggest that the multiple transportation options be developed to support of the limited ambulance availability that exists, such as shield equipped county vehicles.

As already mentioned, penetration rates for FC consumers are low, and reflect the MHP's use of MHSA services to provide non-Medi-Cal services to a segment of the population.

Considering the challenges in recruiting and hiring licensed staff the MHP might wish to consider developing roles for paraprofessional staff to augment crisis response with the proper consultation and support.

The MHP is reviewing the Kings View penetration rate report monthly to evaluate effectiveness of outreach and engagement activities. The MHP is being furnished with the language and ethnicity of its consumers.		
1B	Manages and adapts its capacity to meet consumer service needs	M
The MHP's efforts to adapt capacity is reflected in the contract with a teletherapy practitioner who provides neuro-feedback. The exploration with Kern County of acquiring access to crisis stabilization beds in Ridgecrest offers alternatives to those who may require a higher level that can be provided at Progress House. In addition, Ridgecrest is much closer than the inpatient resources typically utilized. The addition and expansion of telepsychiatry are other adaptive mechanisms of the MHP that address that challenges of locally hiring needed professionals. The implementation of the telepsychiatry pilot is focused on new consumers, with the eventual plan to transition all consumers to that modality if an onsite psychiatrist cannot be obtained. Current acceptance of this approach by consumers is mixed, as evidenced by feedback in focus groups and other sessions. Currently only 20 individuals have been served through this mechanism.		
1C	Integration and/or collaboration with community-based services to improve access	M
Locally, there are no significant opportunities to collaborate with community-based organizations. The MHP has an ongoing relationship with the local emergency department, including psychiatric consultation and staff response to that locale for mental health evaluations. The existence of effective and responsive interagency protocols was not presented or evident during the review. Interface with the educational system, child welfare and other governmental entities is routine. The challenges for the mild-to-moderate provider, Anthem, to maintain a viable and responsive provider network in this area may result in the MHP functionally assuming the role of primary treating entity for this segment of the population.		

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components

	Component	Quality Rating
2A	Tracks and trends access data from initial contact to first appointment	NM

The MHP utilizes a 7-day standard but was unable to develop any reports during this last year due to reporting and methodologic issues. This standard is listed in the MHP's QI Work Plan and in the EQRO Timeliness Self-Assessment (TSA).		
2B	Tracks and trends access data from initial contact to first psychiatric appointment	NM
The MHP was unable to develop any reports during this last year due to reporting and methodologic issues. However, review of a Kings View data report dated May of 2017 indicates a goal of 14 working days from request to authorization, followed by a 30-day goal from authorization to treatment. These two standards would appear to have been completely replaced by the current QI Work Plan (FY17-18) goal of 30 working days, which also is accompanied by a statement that 75 percent are conducted within 10 working days, both reported out quarterly.		
2C	Tracks and trends access data for timely appointments for urgent conditions	NM
The MHP reports a one-hour standard for urgent services and an overall 40 percent meeting of this standard. The data that supports this was unavailable for reporting purposes. The MHP relies upon operational procedures to ensure adequate consumer response.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	NM
The MHP's QI Work Plan indicates a two-day standard for post-hospital discharge follow-up, a higher standard than the 7-day HEDIS metric. But the submitted TSA document does not reflect any data from this last year. The CY16 data, which does not align with the current review, indicates six hospitalization events. It would seem likely the MHP continues to face reporting challenges in this area as well.		
2E	Tracks and trends data on rehospitalizations	NM
The MHP's current QI Work Plan states a goal of no more than 10 percent readmissions within 30 days, with quarterly reporting and review. The TSA submitted for this review indicated inability to currently track. The scale would seem sufficiently small to enable manual tracking and reporting until the EHR and Kings View are able to furnish this information.		
2F	Tracks and trends no-shows	NM
The MHP's QI Work Plan states psychiatry no-show goals of: cancellation – 5 percent; no-show – 10 percent, supported by monthly reporting. In the TSA, the MHP indicated no current tracking due to reporting challenges. One data report from January through March 2017 indicated no-shows for psychiatry but did not indicate the standard at that time.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components

Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	PM
The MHP submitted a QI Work Plan for FY17-18. The evaluation of the FY16-17 results was scheduled to occur in September 2017, but no documentation of this process was submitted as requested. There were QIC minutes and limited data provided throughout the year. The participation of leadership in the QI process is clear, and the interface with other divisions is apparent operationally. However, the basic structure of the QI section is clearly under-resourced. It requires commitment of consistent clinical time and devoted analytic support. Additionally, engagement of Kings View in the development of reporting that fits the MHP's needs is essential and currently incomplete.		
3B	Data are used to inform management and guide decisions	PM
The appearance of reports that reflect quality elements that are essential appears in the data run of May 2017, covering January through March. In preparation for the review, the MHP had not submitted the QI Work Plan evaluation and related data. The reporting and data evident for this review reflects the identified challenges in obtaining the relevant reports for review likely related to the lack of tailored Cerner/Kings View EHR reporting functionality and dedicated QI staffing.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	M
As a small-rural MHP much of the communication is organic, occurring in regular staff meetings, and conveyed by supervisors. Review sessions confirmed the effectiveness of the MHP's communication with line staff, and consumers. Other partner agencies, such as emergency departments, were not available for input. These entities will be considered for participation in future quality reviews. In larger MHPs the communication with contract providers is a		

Table 8: Quality of Care Components		
Component		**Quality Rating**
significant element, but within ICBH, 99 percent of services are directly provided, and contractors are not a usual participant.		
3D	Evidence of a systematic clinical continuum of care	PM
The MHP lacks ease of access to acute psychiatric inpatient care, crisis stabilization, and crisis residential. The promise of an arrangement with Kern county, which seems willing to offer use of slots in the recently opened Telecare operated CSU and possible back-up by acute inpatient beds within Kern County will improve access for Inyo County beneficiaries. Within the mild-to-moderate level, Anthem is responsible for the provider network. In this remote area that can mean long delays and limited provider availability. Reportedly, this results in the MHP needing to intervene and provide services in order to prevent further deterioration. Other MHPs in similar circumstances have sought to develop a contract with the managed care organization to provide the MTM services integrated with their SMHS care. This improves access and provides added funding to the MHP to manage service delivery to the full Medi-Cal population. The MHP may wish to explore this area going forward.		
3E	Evidence of consumer and family member employment in key roles throughout the system	M
Individuals with lived experience are employed at the wellness center and to a lesser extent Progress House. The wellness center has some supervisory positions for consumers. The system lacks the comprehensive scale of many medium and large MHPs, but reports from consumers indicate that the employment meets their needs without threatening Supplemental Security Income (SSI) eligibility.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	M
During this review, visits were conducted at the wellness center and the Progress House. Informal consumer conversations yielded positive reactions to the environment and programs in place. Consumer feedback indicates improvements in programming and opportunities to work and/or earn gift cards for productive onsite contributions.		
3G	Measures clinical and/or functional outcomes of consumers served	M
The MHP has implemented the Adult Needs and Strengths Assessment (ANSA) during this last year and is preparing to start up the CANS survey in the fall. The ANSA is used on an individual basis, with the entry of the score into the EHR. It is not integrated as of yet. Aggregation of data has not occurred.		

Table 8: Quality of Care Components		
Component		**Quality Rating**
3H	Utilizes information from Consumer Satisfaction Surveys	NM
The MHP indicates participation in the statewide consumer perception survey process but did not furnish any reporting on consumer satisfaction for this review.		

Key Components Findings—Impact and Implications

Access to Care

- The MHP utilizes a CCP that includes a comprehensive analysis of culture and language issues relevant to the beneficiary population.
- Challenges exist for beneficiary access to high-level services such as acute inpatient care and crisis programming. For many, the locally developed Progress House serves as an option when acute care is not essential. Efforts to gain access to Kern County's CSU offer positive and improved options for consumers.
- The limited availability of clinicians who contract with the mild-to-moderate provider, Anthem, results in the MHP serving many of these individuals due to risk. The MHP needs to evaluate if negotiating a contract with Anthem would be fiscally viable and provide uniform access to all Medi-Cal beneficiaries.

Timeliness of Services

- The MHP reported an initial access 7-day standard but was unable to provide data for the last year. Methodologic and reporting challenges remain unresolved with the Cerner/Kings View system.
- Reporting of initial psychiatric visits faced the same challenges as that of initial access.
- Generally, the MHP was unable to report timeliness data. It seems this may be related to of lack of close collaboration with the Kings View/Cerner team. Furthermore, the analyst staff involved in supporting the data reporting are not fulltime and are split between other departments.

Quality of Care

- The MHP submitted a QI Work Plan for this review and was scheduled to have a meeting to discuss and review the FY16-17 work plan results in September of 2017. No report of the work plan results or analysis was provided.
- The May 2017 quarterly data summary from Kings View/Cerner indicates the MHP's plan for regular quarterly review of key performance data. For an MHP of such small scale, the planned undertaking and data elements to be reviewed regularly was impressive. However, the Kings View/Cerner application apparently does not use a treatment and reporting paradigm that easily aligns with the MHP's work in this area. The MHP has been seeking to resolve the treatment concepts and reporting inclusion/exclusion data procedures with Kings View.

- ICBHS's communication efforts are largely within the department, the larger community and some limited partner agencies, including child welfare. From various reporters, interactions with the local emergency department are significant. There are challenges with locating appropriate inpatient facilities and also in the provision of transportation for consumers requiring involuntary hospitalization. Emergency department input was not available to this review and would be wise to consider including in the future.

- Locally, the MHP has long been challenged to provide a full and comprehensive system of care to its consumers. The higher-level programs such as acute care and the various crisis programs are simply beyond the reach of any of the small-rural Easter Sierra counties. The MHP has long utilized its Progress House as a resource for those who need observation and care but do not require inpatient psychiatric treatment.

Consumer Outcomes

- The MHP's adoption of the Strengths Model has the promise of targeting consumer personal life domain area outcomes, such as work, education, and housing, among others.

- The MHP has started using the ANSA as an adult instrument and is also preparing to begin use of the CANS in the fall of 2018. These instruments will provide the MHP with standardized information as to the progress of consumers. The ANSA score is entered into the EHR thereby providing staff reference information when performing a re-assessment.

CONSUMER AND FAMILY MEMBER FOCUS GROUP

CalEQRO conducted one 90-minute focus group with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 8 to 10 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group 1

The requested focus group consisted of 8-10 culturally diverse adult beneficiaries representing both high and low utilizers of service, held at Group Room 1, at the MHP's offices at 162 J Grove Street, Bishop California, 93514.

Number of participants: Four

The participant who entered services within the past year described his experiences as the following:

- Initial access occurred in less than one month.
- Therapy began within one month.
- Initial psychiatry access occurred within one month.
- Generally, the consumer was pleased that the MHP was available when needed.
- Access occurred when consumer's relative was provided the phone number.
- No obstacles to treatment were identified.

General comments regarding service delivery that were mentioned included the following:

- Half of the participants receive individual therapy from the MHP. Those who do not receive individual therapy either are followed by the Rural Health Center or therapy is not part of treatment by their choice.
- Frequency of contact is monthly or every four months.

- The majority of participants attend wellness center group activities, which also provides assistance to the homeless, with showers and laundry facilities. An element of the consumer population camp out nearby. All housing and shelter requires money, and without there is nowhere to stay. Participants characterized Progress House as a place for those with severe mental illness or addiction.

- Information about the wellness center was obtained from a variety of sources: psychiatry referral, on the bus from Lancaster, and another by a rural health clinic referral.

- Half of the participants receive psychiatric care around every four months. Lab work is also part of the process. All who receive this service feel it is adequate to meet their needs. Participants are either in the process of changing to telepsychiatry or are aware that it will soon be occurring due to retirement of the current practitioner.

- Urgent care needs, in addition to routine services, are available to consumers when requested. All participants knew whom to contact and how to make the request. While the response to this request was characterized as less than one month, others noted that if you are in need staff will make the time to help.

- All participants feel their input is sought out and utilized in the development of the plan of care. One individual also has a self-determination plan, which is similar to a Wellness and Recovery Action Plan.

- Participants acknowledged receiving written information about medication, including some whose relative also was also provided information. A small number of consumers were aware of information sharing between their psychiatrist and primary care, mostly involving lab results.

- No changes in service levels or availability were identified as occurring in this last year.

- Transportation is assisted by the ICBH wellness center, which has four vans that can transport individuals to programming. Local transit system vouchers can be obtained from ICBH when needed.

- All participants have been queried for feedback on improving services, including those who started within the last year. There are also monthly stakeholder meetings.

- The MHP's services are praised by focus group participants.

Recommendations for improving care included the following:

- Expand wellness center hours to 24/7/365.

- Reduce regulatory requirements, which stifle the development of creative solutions and services for consumers.

- Create a "control hub" one-stop where all agencies and services are available and coordinated with behavioral health.
- The wellness center needs more telephone lines.
- Regular, predictable scheduled presence for nurses at the wellness center.
- wellness center to accept all walk-ins.

Interpreter used for focus group 1: No

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Consumer experiences regarding access was positive and absent of any identified barriers.
- Participants were not receiving psychotherapy with regular frequency.
- Frequency of psychiatry services ranged from every one to four months.
- Participants actively used the wellness center.

Timeliness of Services

- The experience with recent initial access was extremely limited. The overall group experience with initial access, spanning both recent and long-term consumers, was greater than the 14 days identified as a standard in the May 2017 data, and the seven days of the timeliness self-assessment.
- Initial psychiatric service timeliness was insufficient to report findings with recent access.

Quality of Care

- Consumers did not identify any issues with the quality of care or adequacy of care.
- The MHP has solicited input on care from all of the focus group participants, via either survey or stakeholder meetings.

Consumer Outcomes

- No outcomes were reported.

INFORMATION SYSTEMS REVIEW

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

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

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

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

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	99%
Contract providers	<1%
Network providers	<1%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): **1%**

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another County department
☒ Combination of MHP control and another County department or Agency

MHP currently provides services to consumers using a telepsychiatry application:

☐ Yes ☐ No ☒ In pilot phase

- The MHP has very recently engaged with a telepsychiatry pilot that is currently supporting approximately 20 consumers. It is too early to gain material intelligence on the direction that this pilot will take but the MHP is hopeful that it will augment and enhance its efforts and capabilities to improve the wellness of its beneficiaries.

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
1	0	0	0

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
5	0	4	3

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

- Technology and Analyst staffing is provided to the MHP by the Health and Human Services agency for the County. In this shared resource environment, there does not appear to be a viable, industry standard framework in use for the optimal assignment of resources.
- During the review it became clear that the MHP is not able to obtain sufficient clinical data analytics staffing that is appropriate to the MHP's stage of implementation of its new EHR. This is manifesting itself primarily in current available staffing being subsumed in mandated reporting activities for the state rather than the development of ongoing subject matter competence that would lead to a robust and sustainable clinical analytics capability for normal MHP operations.

Current Operations

- The MHP continues to implement the Cerner Community Behavioral Health (CCBH) EHR in Application Service Provider (ASP) mode. It is hosted and supported by Kings View corporation who provides technical support to the MHP.

- The MHP is endeavoring to implement enhancements and additional functionality to the system as resources become available.
- The MHP appears to be having issues communicating its needs to Kings View. Due to the relative newness of the system to staff they are often unable to frame requests adequate to address MHP needs. Kings View does not appear to be making the process easier for the MHP.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide EHR functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third-party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Cerner Community Behavioral Health	EHR	Cerner/Kings View	<2	Kings View

Priorities for the Coming Year

- Complete implementation of Kings View product to finalize CalOMs and Sure Script
- Expand reports capabilities and set up system to review reports on a regular basis
- Fully implement client signature capability
- Develop cross system outcomes
- Train new staff on E.H.R. as needed

Major Changes Since Prior Year

- Implementation of Kings View product as of 7-1-16
- Initiated the work on the goals above

Other Significant Issues

- The current implementation of the EHR seems to be impeded by difficult communications between the MHP and Kings View. Beyond improving communications with the vendor, the MHP needs to engage with peer MHPs to gain intelligence on how to effectively deal with these issues. The MHP's biggest challenge, at this point in the implementation, is that it doesn't know what or how to ask for enhanced assistance on.

This is especially true concerning in the area of reporting and analytics where both parties appear to be talking past one another. The MHP also seems to be having difficulty connecting with the Kings View User Group for regular communications and ongoing training.

Plans for Information Systems Change

- The MHP has an implementation in progress and is working diligently with its vendor, Kings View, to debug and enhance system capabilities as warranted.
- The MHP appears to be having communications issues with Kings View.

Current Electronic Health Record Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH/Kings View	x			
Assessments	CCBH/Kings View	x			
Care Coordination					x
Document imaging/storage	CCBH/Kings View	x			
Electronic signature—consumer	CCBH/Kings View	x			
Laboratory results (eLab)				x	
Level of Care/Level of Service				x	
Outcomes			x		
Prescriptions (eRx)				x	
Progress notes	CCBH/Kings View	x			
Referral Management					x
Treatment plans	CCBH/Kings View	x			
Summary Totals for EHR Functionality:		6	1	3	2

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

- While the MHP is embarking on a telepsychiatry pilot project it does not, as yet, appear to have fully functional electronic lab (eLab) or electronic prescribing tools (eRx) functionality built into this phase of EHR deployment. These appear to be future

projects. The telepsychiatry project appears unable to enter consumer data directly in the MHP's EHR.

- Scoring for the MORS outcomes tool is now present in the EHR but none of the current outcomes tools have yet to be built into and integrated into the EHR workflow for clinical staff. This will be a future enhancement that should benefit clinical quality activities.
- The MHP is beginning its efforts to implement the CANS toolset for it children's system of care. Trainings begin in May and will proceed until staff are qualified for use of the tool.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☐ Within the next year
☐ Within the next two years	☒ Longer than 2 years

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Kings View

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Inyo MHP Summary of CY16 Short Doyle/Medi-Cal Claims							
Number Submitted	**Gross Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Gross Dollars Adjudicated**	**Claim Adjustments**	**Gross Dollars Approved**
5,344	$1,236,595	**149**	$43,715	3.54%	$1,192,880	$44,258	$1,148,622
Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017. The statewide average denial rate for CY2016 was 4.48 percent. Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.							

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Inyo MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Invalid procedure code and modfier combination	58	$21,782	50%
Other coverage must be billed prior to submission of this claim	43	$10,224	23%
Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y"	35	$9,401	22%
Total Denied Claims	149	$43,715	100%

- Denied claim transactions with reason codes as listed in Table15 are generally re-billable within the State guidelines.

Information Systems Review Findings—Implications

Access to Care

- The MHP has begun a pilot telepsychiatry project which has the strong potential to expand and broaden the system of care's access to qualified professionals.

Timeliness of Services

- The MHP does not appear to have sufficient access to clinical analyst/analytics resources to develop the subject matter expertise necessary for robust and routine timeliness reporting.

Quality of Care

- The MHP lacks adequate policies and procedures for the telepsychiatry pilot project to ensure high quality of consumer care and appropriate risk management strategies for the MHP.

- The MHP has yet to implement eRx, eLabs, and real time telepsychiatry notes within ICBH's own EHR that would simplify the clinical/medical workflows and improve consumer care.

Consumer Outcomes

- While the MHP is implementing outcomes tools it has not, as yet, integrated them into the EHR workflow which would enhance reporting capabilities and streamline use for clinical staff.

- The MHP is implementing the CANS outcome tool and training its staff in appropriate usage.

SITE REVIEW PROCESS BARRIERS

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

- No site review process barriers were identified.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- The telepsychiatry pilot project has the potential to expand and broaden the system of care's access to qualified psychiatric practitioners.
- The MHP began efforts to contract with Kern County for Ridgecrest crisis stabilization unit use, and possible inpatient acute bed access.
- A neurofeedback teletherapy contract was created to augment local capacity.
- The MHP is exploring implementation of medication assisted treatment in the absence of adopting the SUD-ODS waiver.
- The MHP's Hispanic penetration rate is similar to the small-rural average and exceeds the statewide number.
- Hispanic average approved claims per beneficiary have continued to increase slightly and is greater than the small-rural average.

Opportunities:

- The MHP's FC penetration rates remain slightly under the small-rural and statewide averages, and is likely associated with the circumstances that rely on some FC programming as MHSA/non-Medi-Cal. It is possible these services would be eligible for Medi-Cal claiming.
- Improved reporting of co-occurring diagnosis will assist the MHP in tracking need and determining the level of resources committed to this important segment of consumer population.
- With a very limited number of licensed clinical staff, the MHP needs to consider the development of mechanisms for greater use of trained unlicensed staff in crisis response, with suitable consultation and support available.

Timeliness of Services

Strengths:

- While experiencing very low acute admission numbers, the MHP's 7-day and 30-day follow-up rates are slightly higher than the statewide and small-rural averages.
- There were no 7-day or 30-day rehospitalizations for CY16.

Opportunities:

- The MHP does not appear to have sufficient access to clinical analyst/analytics resources to develop the subject matter expertise necessary for routine timeliness reporting.

Quality of Care

Strengths:

- The MHP's PIP focused on the University of Kansas Strengths-Based Model has the promise of providing greater support to consumers who have targeted achievement of life goals, such as better housing, education, and employment.
- The MHP has adopted the ANSA and is implementing the CANS for children and youth.
- The MHP's updated CCP included review of data elements and changes over time, providing a resource for the determination of current and future needs.

Opportunities:

- While the MHP scheduled a meeting to perform the analysis of results of the prior QI Work Plan, a summary of that analysis was not available for the current review.
- The telepsychiatry physician information is not directly entered into the MHP's Kings View/Cerner system, which creates barriers to effective medical communication and duplication of effort.
- The MHP EHR reporting functionality currently does not support regular reporting of important timeliness and other related data elements.
- The MHP lacks a fulltime QI coordinator and dedicated fulltime analysts to manage and execute the MHP's QI Plan.
- The MHP does not currently have a formally adopted telepsychiatry pilot project protocol to ensure high quality of consumer care and appropriate risk management strategies for the MHP.

- Completion of a comprehensive analysis of the extent to which the MHP is serving mild-to-moderate individuals is necessary for determining if a clinical and business case can be made for negotiations with Anthem to assume formal responsibility and reimbursement for this population.

Consumer Outcomes

Strengths:

- The MHP is implementing the CANS outcome tool and training its staff in appropriate usage to better serve consumers. The ANSA implementation has occurred, which will be informing re-assessment determinations at least annually.
- The MHP is preparing implementation of No Place Like Home, while facing challenges created by separate funds allocations for technical assistance that could better be used on resource acquisition.

Opportunities:

- As the MHP outcomes tools are not currently integrated into the EHR workflow, challenges are created for aggregation and analysis.

Recommendations

- Establish the position of a full-time QI coordinator, supported by dedicated full-time data analyst positions, augmented by EHR reporting and timeliness functionality. [Continuation and clarification of FY16-17 recommendation.]
- Join the Kings View User Group and identify peer MHPs who are Kings View users to take advantage of collaborative activities and information sharing these forums would provide. [Continuation of FY16-17 recommendation.]
- Develop formal training on the identification of co-occurring disorders, supported by a reporting system that produces information regarding prevalence and ensures review on a regular basis throughout the year. [Continuation of FY16-17 recommendation.]
- Provide regular review of timeliness data, at least quarterly, throughout the year. This requires that methodologic and reporting barriers be resolved.
- Pursue implementation of eRx, eLabs, and real time telepsychiatry notes within the MHP's EHR to simplify clinical/medical workflows and improve consumer care.
- Perform an analysis of services to the mild-to-moderate population and consider if a business and clinical case can be made for negotiating a contract for this population with Anthem.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Inyo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Clinical Line Staff Group Interview
Consumer Family Member Focus Group(s)
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
Wellness Center Site Visit
Site Visit to Innovative Clinical Programs: Progress House, Crisis Alternative

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Quality Reviewer, Consultant
Duane Henderson, IS Reviewer, Consultant
Janyce Leathers, Consumer-Family Member, Consultant

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

Sites of MHP Review

MHP Sites

Inyo County Behavioral Health
162 "J" Grove Street
Bishop, CA 92514

Progress House
536 North 2nd Street
Bishop, CA 92514

Wellness Center
586 Central Street
Bishop, CA 92514

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Beall	Miquela	Admin Analyst	Inyo HHS
Blackwell	Pamela	(Former) Prog Chief Child & Family	ICBH
Bowman	Robert	Psychotherapist	Inyo County BH
Cataldo	Ralph	Admin Sec II	Inyo HHS
DeVincent	Holly	CPS Social Worker Sup	Inyo Co HHS/CPS
Dixon	Cindy	BH RN	ICBH
Dote	Carla	Psychotherapist	ICBH
Howell	Michelle	Social Worker	ICBH
Kent	Janelle	SWIV	ICBH
Mattovich	DB	Human Services Supervisor	ICBH
Rathburn	Karen	Current Program Chief	ICBH
Spoonhunter	Topah	Admin Analyst	Inyo HHS
Tanksley	Stephanie	Admin Analyst	Inyo HHS
Veenker	Jody	Mngmt Analyst	Inyo HHS
Zwier	Gail	HHS Dep Dir BH	Inyo HHS

Attachment C—Approved Claims Source Data

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

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Inyo MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	141,926	3.86%	$611,752,899	$4,310
Small-Rural	30,196	2,135	7.07%	$5,865,681	$2,747
Inyo	1,606	76	4.73%	$193,121	$2,541

Table C2 shows the distribution of the MHP beneficiaries served by approved claims per beneficiary range for three cost categories: under $20,000; $20,000 to $30,000, and those above $30,000.

Table C2: Inyo MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	354	98.88%	94.05%	$1,163,137	$3,286	$3,612	87.30%	59.13%
>$20K - $30K	*	n/a	2.83%	-	-	$24,282	n/a	11.98%
>$30K	*	n/a	3.12%	-	-	$53,215	n/a	28.90%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Inyo	
PIP Title: Strengths Assessment	
Start Date (MM/DD/YY): 2/1/2018 **Completion Date** (MM/DD/YY): N/A **Projected Study Period** (#of Months): N/A **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 4/24/18 **Name of Reviewer**: Rob Walton	**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 – Duplication of topic ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP has utilized treatment plans that focused on the clinical issues presented by the consumer, symptoms and impairments of the illness. Progress towards larger recovery-oriented life goals, such as better housing,	

employment, education, was not a key aspect of services. Nor were these issues addressed in a consistent manner. Furthermore, staff have developed an approach of doing things for consumers, without a clear skillset as how to support consumers in doing for themselves.

The Strengths Model is a product of the University of Kansas and includes a number of elements. Among these elements are the strengths assessment, relationship and engagement, goal planning, resource acquisition, personal recovery plan, and group supervision. The MHP's staff attended a training on the Strengths Model, which was provided by the California Institute of Behavioral Health. Out of that training, the MHP first administered the Strengths Assessment, selecting 11 consumers who were at what the MHP considered to be the correct point in treatment to benefit from a focus on achievement of life domain goals. Of the 11 consumers, eight identified improving independent housing as a desired area of focus, and three identified education. The MHP cites literature that demonstrates the effectiveness of this model. In this clinical PIP, the MHP thought to focus on those eight consumers who identified improved housing as a life goal.

It must be noted that both this clinical PIP and the non-clinical PIP focus on the Strengths Model, with the clinical having a narrower focus. Both elements would appropriately fit within the scope of a single PIP. They differentiate only through focusing on different aspects of the Strengths Model. The broader PIP is the non-clinical, which is scored and included for this review period.

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	The use of the Strengths Model occurred through participation in the Eastern Sierra Learning Collaborative, which involved the three MHPs of Alpine, Inyo and Mono Counties, in a training by the University of Kansas, sponsored by CIBHS. The selection of this training topic did not have the input of consumers; whereas the choice of the specific focus on housing was derived from the strengths assessment results.

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	The MHP did not present data on the overall number and percent of its consumers that were "stuck" and making no progress in achieving life goals. The MHP considered the data reported by the University of Kansas team which created this practice. No specific data elements were identified and considered that related to the selected 11 consumers. The narrative described the selected individuals as having been staffed on multiple occasions and struggling to find an approach that would help them successfully transition to a more fulfilling life and disengagement from services. The identification process appears to have been a generally subjective assessment.
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 PIP, 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	This activity narrowly focuses on the use or application of the Strengths Model assessment. This tool serves to identify the life domain which is most relevant and of greatest concern to the consumer. There are no details presented as to what they are the nature of the interventions and/or approach that is used with the consumer. In this case, it seems the focused goal is improving housing.
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	The PIP is unclear what specific elements were considered that identified the 11 consumers who were the initial focus of this PIP, and then winnowed down to the eight with housing concerns.
	Totals	**0** Met **2** Partially Met **2** Not Met **0** UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the implementation of the Strengths Assessment tool from the Strengths Model help move 8 ICBH consumers formerly mired in repetitive service utilization towards their highest level of recovery in the self-identified goal areas of housing?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The Strengths Model Assessment appears to have been utilized to identify the life domain area which has the greatest important for consumers. The PIP identifies eight with housing concerns and three with educational goals. There is nothing described about the assessment that could be construed as helping to move the consumer further towards the preferred goals.
Totals		**0** Met **0** Partially Met **1** Not Met **0** 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	Eleven consumers were identified by the clinical team because they were determined to be "stuck" and not making the hoped-for recovery progress. It is clear that these 11 were identified but the specific characteristics, such as level of care instrument scores, or other metrics that would indicate stability, were not offered other than being "stuck" and in treatment with significant progress.
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: Treatment team determination, stuck, long-term, little progress.	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	Consumers identified through a general clinical team evaluation without any aspects that could be easily replicated.
Totals		**0** Met **0** Partially Met **2** Not Met **0** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Housing Goal Attainment	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP identified attainment of housing goal 50 percent, would result in four of eight obtaining desired housing.
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☒ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While not a specific clinical outcome, the attainment of independent housing is a functional achievement closely connected with satisfaction. Attainment and sustaining independent housing is commonly, but not always, associated with improved clinical status.
Totals		**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP did not use any specific sampling technique, but instead provided a clinical review of consumers and used that approach to select 11 consumers, later winnowing down to those eight who had a focus on independent housing. There is no replicable process described that would enable another MHP or entity to apply this approach to its own population with any certainty.

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 ☒ Not Applicable ☐ 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 ☒ Not Applicable ☐ Unable to Determine	
	Totals	**0** Met **0** Partially Met **0 N**ot Met **3** NA **0** UTD

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? • Data will include progress, or regress if applicable, towards achieving housing goals identified by the Strengths Assessment. • Data will be collected monthly during group supervision. ICBH will report on what progress was made by the consumer to achieve their goal. • Each consumer will be tracked using a Monthly Outcomes Status Report. This report will track the progress of the consumers in relation to their Strengths Assessment. This will also include staff input as they will report on consumer progress. • The Monthly Outcomes Status Report for the 8 identified consumers will be reviewed at monthly meetings. These, along with reports from ICBH staff, will help us track the progress of these consumers. This will also give staff the opportunity to discuss barriers and solutions for these consumers and make any necessary adjustments. • Staff will include ICBH clinicians and case workers assigned to work with these 8 consumers along with administrative analyst team members.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP specified data collection in the bullets to the left. While it is clearly stated that progress, or not, will be reported monthly, it is not clear what variables are included in the reporting process. This would include lack of specifics regarding how detailed the progress reporting will be.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☒ Provider ☒ Other: Outcome Status Report	☒ 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	There is no population reporting occurring. This described PIP more accurately fits the parameters of a PDSA process, testing the strengths model on a very limited sample identified by the clinical team and narrowly focused on housing. With such a small number it is difficult to understand why those who selected education were excluded from this phase. The overall numbers are small and including those with education goals might provide some valuable feedback as to effectiveness of this approach.
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: N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	No data available as of the review. The PIP was initiated one month earlier.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	No data analysis plan described.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* No specifically identified individuals were detailed.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Staff will include ICBH clinicians and case workers assigned to work with these 8 consumers along with administrative analyst team members.
	Totals	**1** Met **3** Partially Met **2** Not Met **0** 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:* *No interventions listed*	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP's SQ asks if the S-B Assessment will result in this change, however it is not mentioned in the intervention section. Nor would it be, itself, an intervention to produce change.
	Totals	**0** Met **0** Partially Met **1** Not Met **0** 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? *Monthly Outcomes Status Report for the 8 identified consumers will be reviewed at monthly meetings. These, along with reports from ICBH staff, will help us track the progress of these consumers. This will also give staff the opportunity to discuss barriers and solutions for these consumers and make any necessary adjustments.*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	This review occurred a little over one month post the initiation of the PIP, and there was no data available to review.
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	Too early.

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		**0** Met **0** Partially Met **1** Not Met **3** NA **0** 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: At what interval(s) was the data measurement repeated?* *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	**0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	No findings presented – too early.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: Duplication of non-clinical PIP		
Recommendations: Create separate topic for each clinical and nonclinical PIPs.		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☒ Confidence in PIP results cannot be determined at this time	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Inyo	
PIP Title: Strength Based Interventions	
Start Date (MM/DD/YY): 1/3/2018 **Completion Date** (MM/DD/YY): N/A **Projected Study Period** (#of Months): N/A **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 4/24/18 **Name of Reviewer**: Rob Walton **MHP PIP Team:** Rick Goscha; Matthew Blankers, & Karin Kalk from the University of Kansas and CIBHS; Gail Zwier, Deputy Director of Inyo County HHS Behavioral Health; D.B. Mattovich; Lisa Trunnell; Pete Charley; and Vanessa Ruggerio - Wellness Center; Gina MacKenzie - Progress House; Robert Bowman, Janelle Kent, & Carla Orieta - Adult Service clinicians; Jody Veenker & Topah Spoonhunter - ICHHS analysts; Tim Toppass – Inyo County Employment & Eligibility	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The non-clinical PIP also focuses on the Strength-Based Model (SBM) developed by the University of Kansas. The aspect of the SBM emphasized is the supervision format for staff. The data considered for this PIP to establish a rationale for an improvement activity focused on the use of the strengths-based assessment (SBA) tool results, SBM plan development, SBM group supervision, and SBM interventions with consumers (specifics not described in the PIP). Of 66 adult consumers and the extent to which they were reviewed in March 2018, 8 percent were involved with education, 44 percent had no vocational activity, 26 percent were homeless, institutionalized or in a group home situation, 27 percent had received emergency department health care in the prior month, 6 percent were hospitalized for psychiatric reasons. The MHP believes these indicators suggest a targeted effort should occur that focuses on identification of attainment of life goals. A fidelity review of the MHP's practices in group supervision indicated a very low use of SBM principles.

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	There was no discussion of stakeholders input or participation prior to the decision to focus on the SBA. The MHP has identified a team comprised of SBA experts/developers and MHP staff. This occurred following the decision to adopt and test the SBA, starting with the SBM assessment after which consumer input was obtained.
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	While limited to a single point in time, the MHP performed a chart review of 66 adult consumers. The MHP concluded that it lacks the structure to capture functional goals in major life domain areas. Analysis of recently closed cases, such as within the prior year, to ascertain the prevalence of achieving positive life goals without a structured treatment process such as SB. In addition, during late October 2017, there was a review of 19 consumer care plans, that scored out a 1.9 on a 1-5 scale on the SBA. The MHP determined that the group supervision process was lacking.

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 PIP, 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	The MHP asserts that the typical clinical approach used in serving consumers does not focus on improvements in functional life domain areas – such as housing, education, employment, vocational, etc. – but is limited to clinical issues such as symptoms. While this may be a local trend, statewide this seems unusual considering the focus on wellness and recovery and history of incorporation of the Rehab Model many years ago in California. Perhaps over time the MHP's focused narrowly was limited to clinical issues.
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	All ICBH adult consumers, between 25 to 65+, about 161 in total. The PIP initially targets 40 long-term consumers from Progress House, the wellness center and other SMI adults attending outpatient services.
	Totals	**2** Met **2** Partially Met **0** Not Met **0** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* *Will improving the content & structure of group supervision sessions utilizing the University of Kansas Strengths Model group supervision tools and methodology result in more clients achieving their self-identified goals related to living arrangements, vocational status, educational status, hospitalizations, or successful completion and exit from services?*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study question (SQ) does not provide the amount of improvement, as required, when constructing a PIP. The SQ includes details about life domain areas expected to become priorities of services and expected to improve. The intervention description appears to be focused on SB supervision techniques, whereas it would seem that this approach is reliant on information from the assessment process, the SB planning process, staff supervision process, and actual unique approaches in the interventions utilized by MHP staff. These are not itemized or identified.

	Totals	**0** Met **1** Partially Met **0** Not Met **0** 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	Initially 40 identified, with eventually reaching 161 adult consumers.
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	The MHP appears to be limiting its data collection to those who are the initial focus of this approach (40) with the balance of the 161 brought into the intervention with time.
	Totals	**1** Met **1** Partially Met **0** Not Met **0** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* *# and % of adult service clients making progress toward independent living* *# and % of adult service clients progressing toward competitive employment* *# and % of adult service clients attaining an educational goal* *# and % of adult service clients admitted to the ER per month* *# and % of adult service clients admitted to a psychiatric hospital per month* *# and % of adult service clients discharged from the program for successful completion*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Each of the domains contains variables that offer rating from high to low, better to worse categorization.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The information tracked did not include any indicator of clinical status
	Totals	**2** Met **0** Partially Met **0** Not Met **0** UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ 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 ☒ Not Applicable ☐ 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 ☒ Not Applicable ☐ Unable to Determine	

	Totals	**0** Met **0** Partially Met **3** Not App. **0** 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	Each life domain area has numerous options that would indicate for success or challenge in that area.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: SBM Outcomes Survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Yes, the SBA rating tool.
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	At least monthly determination of status with relevant indicators.
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	At the time of the review the PIP had been active for approximately one month and the data did not exist in the table.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	As 2018 and 2019 progress, the IHHS team will aggregate the monthly outcomes data and report it back to staff once a month. Over time the MHP will be able to see what has changed from the initial intervention application date month by month and observe if there a trend of appreciable gains in any or all areas.

6.6 Were qualified staff and personnel used to collect the data? Patrick Goscha, Matthew Blankers, & Karin Kalk from the University of Kansas and CIBHS Gail Zwier, Deputy Director of Inyo County HHS Behavioral Health D.B. Mattovich, Lisa Trunnell, Pete Charley, and Vanessa Ruggerio - Wellness Center Gina MacKenzie - Progress House Robert Bowman, Janelle Kent, & Carla Orieta - Adult Service clinicians Jody Veenker & Topah Spoonhunter - ICHHS analysts Tim Toppass – Inyo County Employment & Eligibility Project leader	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not specifically identify those involved in data collection, but the list of PIP team participants clearly includes all involved in the collection and the analytic process.
	Totals	**5** Met **0** Partially Met **1** Not Met **0** 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:* Using Strengths Assessment and sharing the results in group supervision for brainstorming Stating the client goal in group supervision Identifying next steps in group supervision Using monthly outcomes status report to track potential client gains	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the interventions listed are comprehensive, detailing of the actual specific nature of staff-consumer interaction is important and is not stated in the intervention set presented. The implication of the PIP is that the supervision process itself will direct the proximate consumer interventions and support. However, it remains unstated and would be useful in the replication process to state the unique aspects of clinician/consumer interactions in the PIP.
	Totals	**0** Met **1** Partially Met **0** Not Met **0** NA **0** 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	The PIP is just starting and there is no granular baseline data nor subsequent post-intervention data to provide analysis.
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	**0** Met **0** Partially Met **0** Not Met **4** NA **0** 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: At what interval(s) was the data measurement repeated?* *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		**0** Met **0** Partially Met **0** Not Met **5** NA **0** UTD

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

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

Conclusions:

Results are not reported at this time.

Recommendations:

The specific nature and type of SBM interventions utilized in the clinician/consumer interactions needs to be described and added to intervention list.

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