FY16-17

Medi-Cal Specialty Mental Health

External Quality Review

MHP Final Report

INYO

Conducted on

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Introduction

Inyo is one of the smallest counties in California by population (18, 546 in 2010), and is considered a Small-Rural MHP, with a population density of 1.8 per square mile, which is the lowest density of all California counties. However, it is second largest in square miles. Total Medi-Cal eligibles, including those added under the Affordable Care Act, number 5,274, (CY15) resulting in 30% of the population being Medi-Cal eligible.

Access

The MHP's service needs are geographically widely disbursed, and to meet these needs a variety of approaches are utilized, including a Health and Human Services Community Center in Tecopa, in the far southeastern area of Inyo county, where behavioral health services, including medication assessments can occur via teleconferencing equipment. The MHP has a contract with Pahrump Counseling Services, in Nevada, for those individuals residing in the border region. The MHP has other part-time coverage arrangements that include Lone Pine. The MHP also faces challenges with the service needs of Spanish-preferred consumers, having very limited bilingual licensed clinician capacity. Maintaining clinical capacity is an ongoing issue for this MHP due to its remoteness and challenges with recruitment and hiring of licensed staff.

Timeliness

While utilizing a unique approach to the tracking of timeliness, the MHP has been able to produce relatively quick access times. Timeliness results are typically associated with the maintenance of clinical capacity, which the MHP faces some upcoming challenges in maintaining.

Quality

Amid transitioning to a new electronic health record, the MHP has managed to generate and review performance data that is relevant to its Quality Improvement Work Plan. In addition, the MHP has utilized quality improvement data findings as the foundation for Performance Improvement

Projects (PIPs) The MHP has increased its regular review of performance data in its Quality Improvement Committee function.

Outcomes

The MHP does not yet have outcome instruments for adults and children implemented for general use.

INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with 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 FY16-17 findings of an EQR of the Name of County MHP by the California EQRO (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

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

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

[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) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

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

(3) MHP HEALTH INFORMATION SYSTEM CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

- 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 serves to inform the evaluation of MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website www.caleqro.com.

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

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

PRIOR YEAR REVIEW FINDINGS, FY15-16

In this section the status of last year's (FY15-16) recommendations are presented, as well as changes within the MHP's environment since its last review.

STATUS OF FY15-16 REVIEW RECOMMENDATIONS

In the FY15-16 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY16-17 site visit, CalEQRO and MHP staff discussed the status of those FY15-16 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed is assigned when the identified issue has been resolved:
  - resolved the identified issue
- Partially addressed is assigned when the MHP has either:
  - made clear plans, and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY15-16

- Recommendation #1: Expand the scope of work for the newly formed quality improvement unit to develop a data driven system of care, including data collection, reporting and analysis. Utilize data which reflects quality and consumer outcomes, to make system changes through monthly reporting and analysis on established baselines and time bound goals, tracking measurable progress to goals.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The Quality Improvement (QI) team assumed the duties of timeliness data collection and analysis during the last year. The Cerner Community Behavioral Health (CCBH) Kings View, as an Application Service Provider (ASP), enables direct system queries for easier analysis.
  - QI continually works with division directors and staff to create data collection and tracking methods. This activity includes evaluation of consumer surveys throughout the year. QI is present at meetings of the Behavioral Health Advisory Committee, Business Analysis Meetings, the Quality Improvement

Committee meetings, and is the active recipient of improvements suggestions from stakeholders at large.

- The transition to the new Electronic Health Record (EHR) occurred on July 1, 2016. There is a learning curve for QI staff to understand the Cerner terminology and methodology of presenting data. However, progress is being made and involves continued work with the Kings View staff to enable more performance measures to be reported directly from the system.

- Recommendation #2: Automate timeliness tracking for all measures: (1) establish and publish the numerator and denominator used for all calculations; and (2) calculate measures for full annual periods. Establish time of consumers' initial request for services at Access as being the start date in determining the time to initial appointment.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - Since implementation on July 2016, the CCBH system MHP QI staff have been producing some reports and learning how to fully utilize the Cerner system. The quality and comprehensiveness of data is improving. Currently, reporting of routine timeliness of access, and psychiatry no-shows are automated. Clinician no-shows are not yet reported. Under development is reporting of initial access to psychiatry services.
  - The MHP publishes its methodologies in the annual Quality Improvement Work Plan (QIWP) and quarterly Quality Improvement Committee (QIC) minutes.
  - Treatment Authorization Requests (TARs) for inpatient stay remain tracked in a paper log, while urgent/emergent requests are maintained in an Excel spreadsheet. Challenges exist in standardizing Access Call log use for urgent/emergent services, and also in tracking hospital discharges for follow-up aftercare.

- Recommendation #3: Utilize MHP staff's new capability to download the MMEF Medi-Cal enrollment file to begin tracking penetration rates for Medi-Cal demographic groups in order to determine underserved population groups.

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - Within the last year, MHP staff learned how to obtain downloads of the Medi-Cal Monthly Extract File (MMEF) from the county Social Services Department.
  - Kings View, as the MHP's ASP, now downloads the monthly MMEF and calculates Medi-Cal penetration rates (PR). The MHP included in the January 2017 QIC minutes the overall Medi-Cal PR, and PR by age, gender, race/ethnicity.

- Recommendation #4: During the Cerner EHR system project planning phase, investigate implementing electronic consumer signature as this function will reduce or greatly eliminate the need for paper medical record charts.

  ☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The MHP attempted implementation of the electronic signature pads with the CCBH implementation, but had to halt the process temporarily. There have been challenges with the signature pads having consistent functionality, which the MHP is in the process of resolving before full use of this technology can be attained.

- Recommendation #5: Explore training opportunities through the Copeland Center's regarding the evidence based practice of the Wellness Recovery Action Plan (WRAP), a self-designed wellness tool for consumers. Consider designating point persons, i.e. staff and peer employee, to become WRAP certified and provide WRAP groups at the Wellness Center.

  ☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP has found that demands on training and planning have been dominated by Continuing Care Reform issues. As such, the MHP has focused its efforts on Triple P Parenting, and Child and Family Team facilitation. The MHP has joined a collaborative process with Mono and Alpine Counties to explore the feasibility of an Eastern Sierra Strengths Model Learning Collaborative for the support of the adult services team.
  - At the present time, the MHP has not had the resources to directly target the WRAP process.

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

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

- Access to Care
  - Succession planning is under way to replace retiring clinical staff, including the onsite psychiatrist who has been an integral key provider for Inyo County. It will be hard to replace this individual who has dedicated her career to serving consumers, including visits to the local jail, flexing her schedule to see individuals who need to be seen immediately. Four or more licensed clinical staff are also retiring in the upcoming year. The organizational chart reflects five additional approved positions for this year, which remain unfilled.
  - Turnover has been significant in front office positions with 50% vacancy rate. These positions are key to answering all business hour Access calls and entry of business and after-hours access call information into the log.
  - The Inyo County area lacks the presence of any Foster Family Agencies, which is a necessary component of Continuing Care Reform and the establishment of

Therapeutic Foster Care (TFC). A CCR Coordinator has been hired, whose duties will include focusing on the Foster Family Agency issue and related changes. There is a strong possibility that the County will become an FFA in order to fulfill the requirements.

- The MHP's Wellness Center relocated to a larger facility in Bishop, and was able to expand capacity and implement a Transitional Age Youth (TAY) Wellness program.

- Timeliness of Services
  - The MHP tracks time from admission (as the initial contact) to first progress note, and Psychiatrist "no-shows" in the CCBH EHR. The MHP does not track Clinician "no-shows."
  - The MHP is working with Kings View to track time to psychiatric appointments in the EHR. The MHP must manually track time to urgent/emergent appointments, follow-up services after hospital discharge, and rehospitalizations, with unreliability noted of these measures.
- Quality of Care
  - The MHP transitioned from the ECHO ShareCare product to the CCBH EHR supported by Kings View on an ASP model. The billing or practice management system is operational, but the implementation of assessment, treatment plan, progress notes, consumer signatures, and e-prescribing remain incomplete.
  - The MHP does not routinely identify or include secondary diagnosis codes in the assessment or treatment plan, and is unable to determine the rate of co-occurring substance use disorders (SUD) and other conditions among its consumers.
  - The QI Coordinator, a licensed MFT, who also functioned in a clinician role half-time, retired several months ago. Adaption to this change includes training staff who may lack a clinical background on the parameters and rationale for the quality indicators. The MHP leadership has requested that an additional analyst be assigned to the department; also, an additional clinician is joining the department at the end of May, who will have some QI related duties.
- Consumer Outcomes
  - Peer support positions have recently been developed by the MHP. Previously, consumers were provided with gift cards as rewards for their volunteer work. The MHP, with the support of county HR, has developed part-time Peer Support Specialist positions. Interviews were recently conducted with candidates for the two positions currently allotted. The intent is to provide work that utilizes lived experience, and income levels that will not threaten the SSI and Medi-Cal benefits.

- The MHP does not administer outcome tools to all consumers in any MHP system of care (e.g., older adults, adults, youth, children, or for all consumers in specific diagnosis or treatment-groups).
- The local juvenile center (Juvenile Justice) has progressively experienced declining utilization, and resulting in the center being closed during the week and open only during weekends.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following performance measures 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 four percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Rehospitalization Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day SMHS Follow-Up Service Rates
- High Cost Beneficiaries ($30,000 or higher)

TOTAL BENEFICIARIES SERVED

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

Table 1—Inyo MHP Medi-Cal Enrollees and Beneficiaries Served in CY15 by Race/Ethnicity

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	% Enrollees	Unduplicated Annual Count of Beneficiaries Served	% Served
White	1,793	41.6%	190	59.6%
Hispanic	1,463	34.0%	67	21.0%
African-American	29	0.7%	N≤11	N/A
Asian/Pacific Islander	49	1.1%	N≤11	N/A
Native American	763	17.7%	34	10.7%
Other	209	4.9%	26	8.2%
Total	4,305	100%	319	100%

The total is not a direct sum of the averages above it. The averages are calculated separately.
The actual counts are suppressed for cells containing n ≤11.

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.

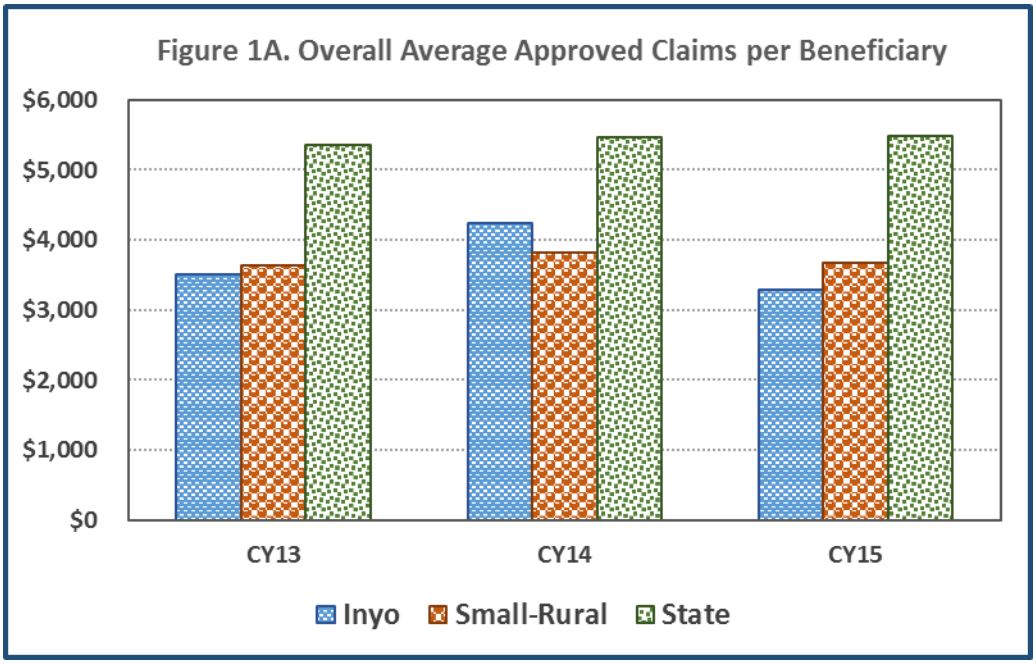
Regarding calculation of penetration rates, the Inyo MHP:

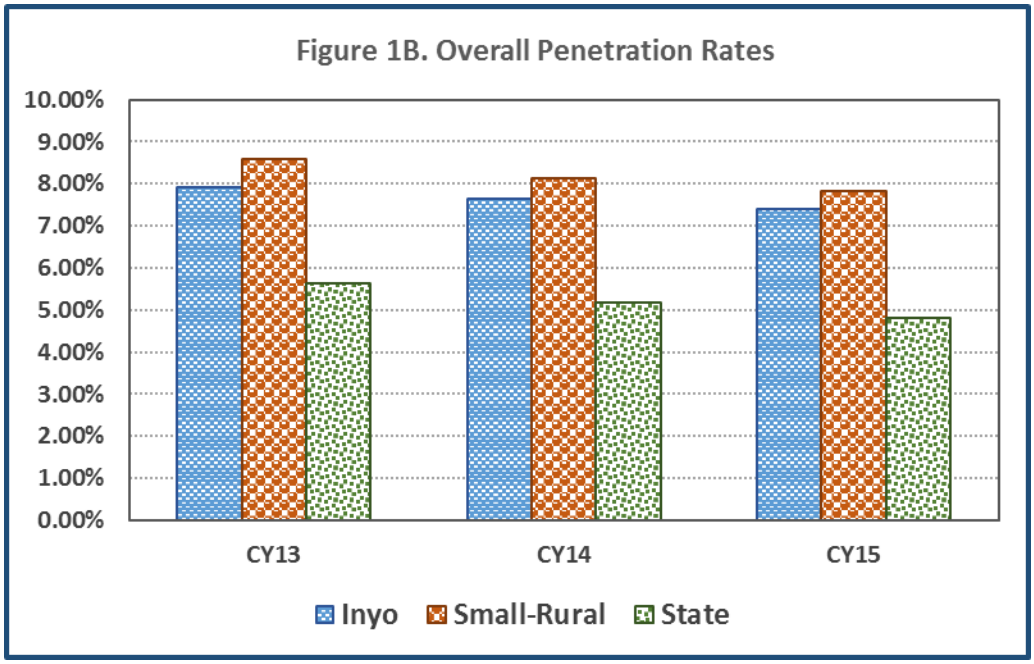
☒ Uses the same method as used by the EQRO.

☐ Uses a different method.

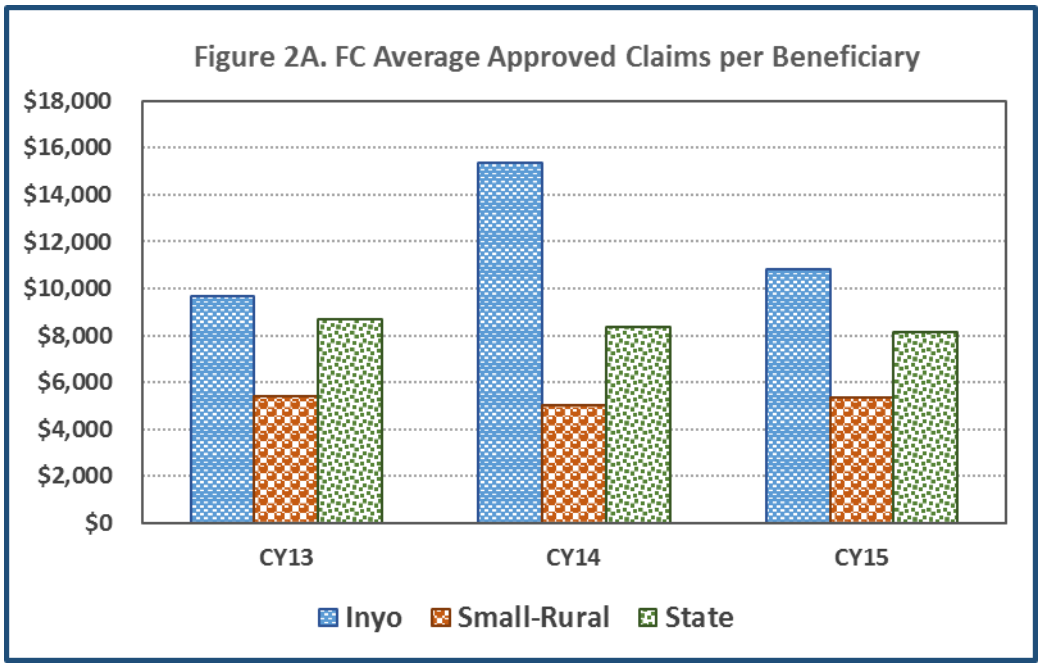
☐ Does not calculate its penetration rate.

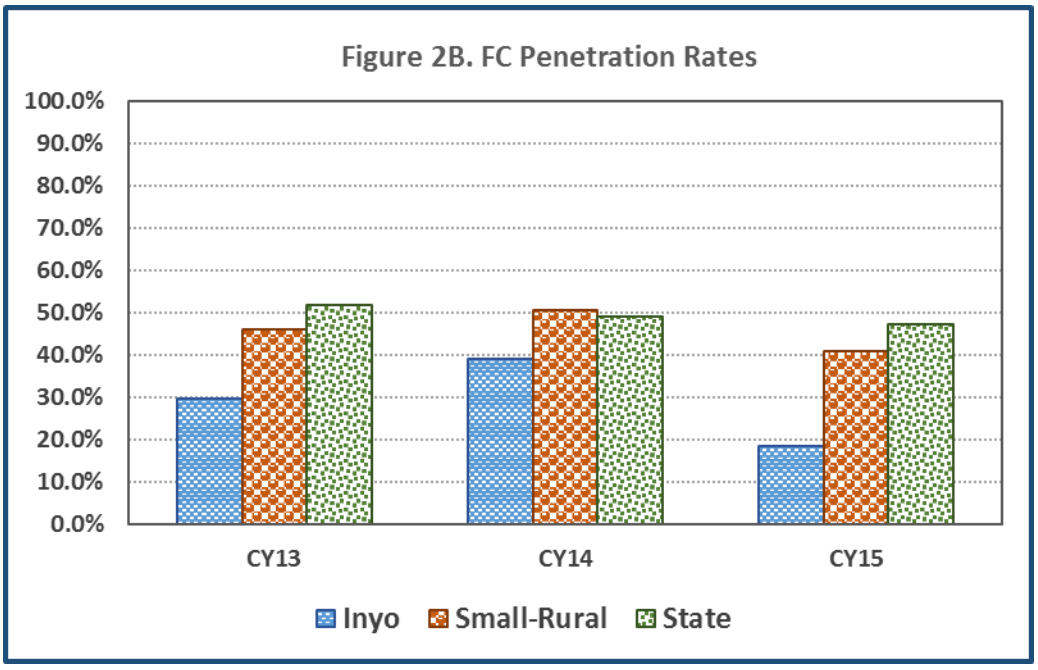
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for size category MHPs.



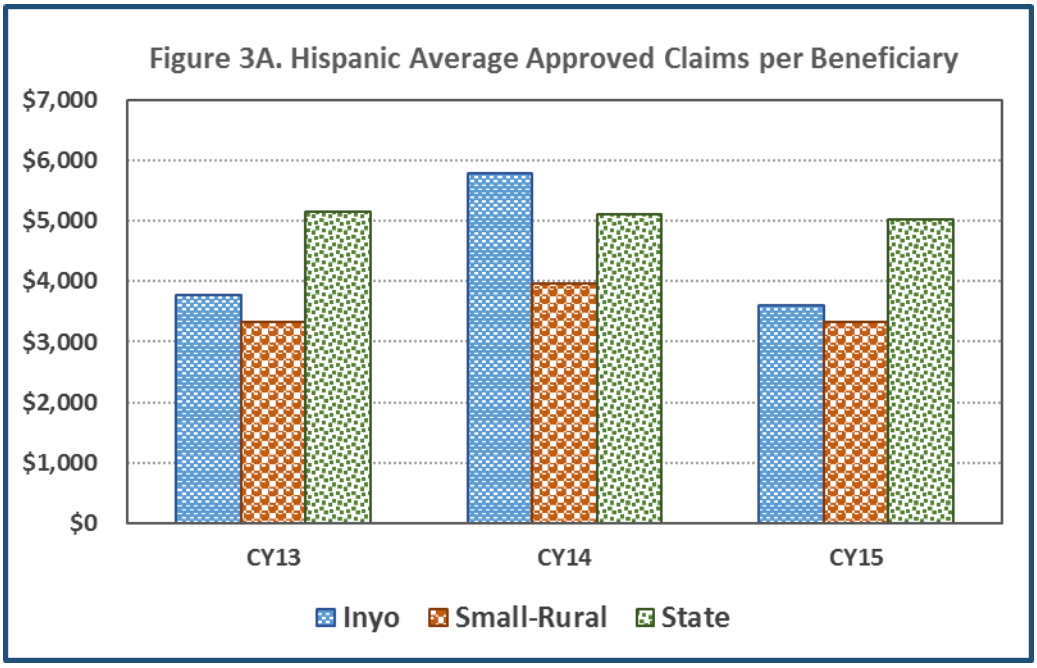


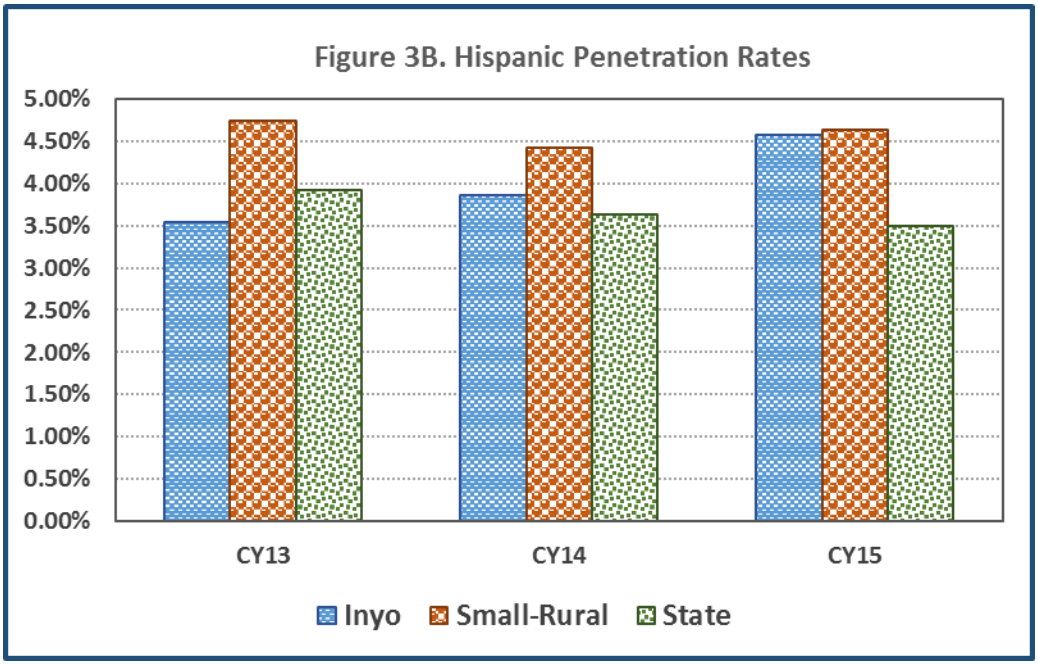
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for size category MHPs.





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





See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary.

HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY15 with the MHP's data for CY15, as well as the prior two years. HCB in this table are identified as those with approved claims of more than $30,000 in a year.

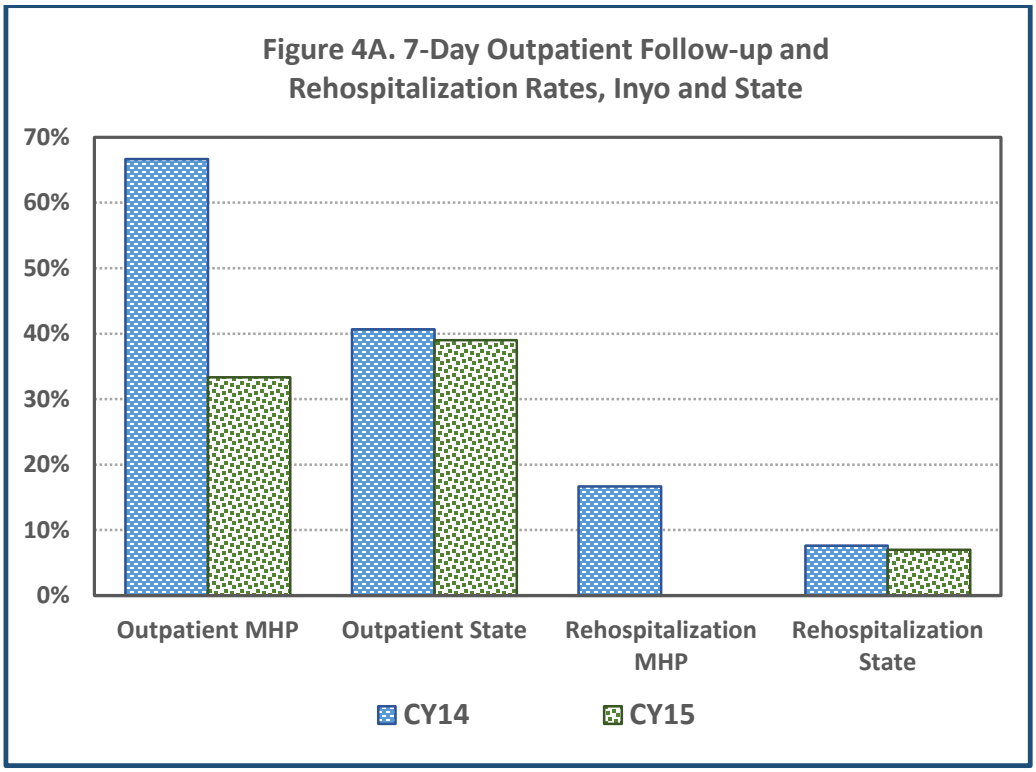
Table 2—High-Cost Beneficiaries

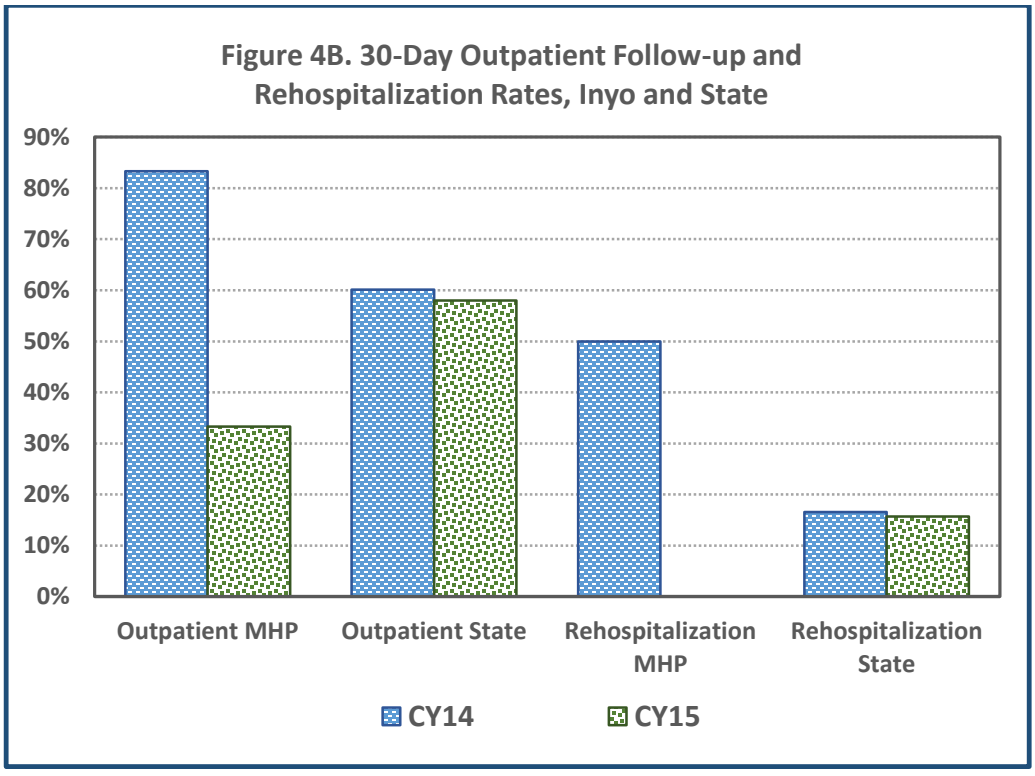
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY15	13,851	483,793	2.86%	$51,635	$715,196,184	26.96%
Inyo	CY15	0	319	0.00%	$0	$0	0.00%
	CY14	≤11	334	N/A	$59,284	$118,569	N/A
	CY13	≤11	314	N/A	$30,454	$30,454	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 CY14 and CY15.

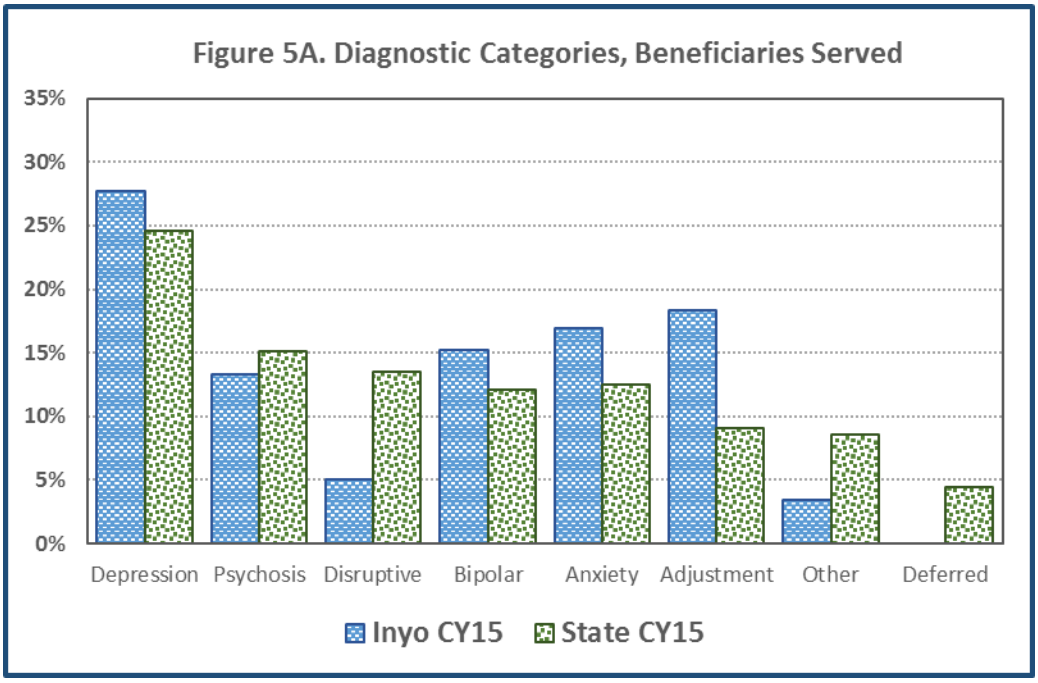


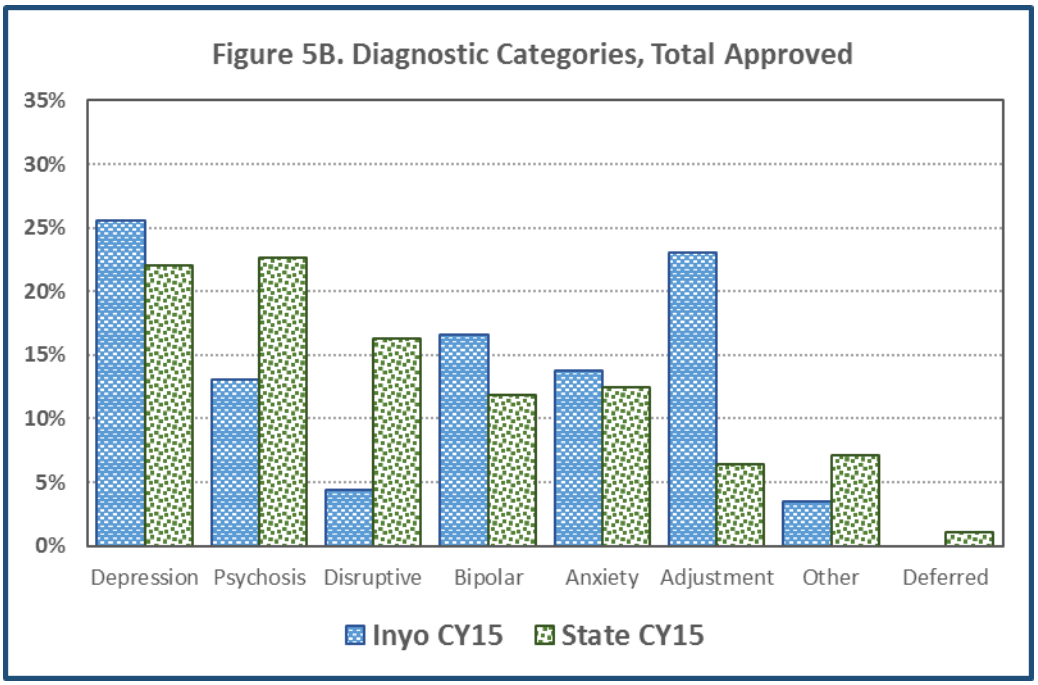


DIAGNOSTIC CATEGORIES

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 CY15.

- 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
    - The MHP's Calendar Year 2015 (CY15) overall penetration rate (PR) slightly decreased from CY14 and is slightly below the Small-Rural MHP rate but well above the Statewide metric.
    - The MHP's CY15 Foster Care (FC) PR went down significantly and is under 20%, which is well below the Small-Rural MHP and Statewide metrics.
    - The MHP's Hispanic PR went up significantly from previous years, and in CY15 nearly equals Small-Rural MHPs, and well exceeds the statewide rate.
    - The MHP's number of traditional Medi-Cal (MC) eligibles decreased from 4,373 (CY14) to 4,305 (CY15). The number of beneficiaries served also decreased, from 334 (CY14) to 319 (CY15). This correlates to a PR drop from 7.64% (CY14) to 7.41% (CY15), still well above the statewide overall PR of 4.82%.
    - In CY15, the MHP served 79 ACA beneficiaries out of 4,305 eligibles for a PR of 5.57% for this sub-group (see Table C-1 in Appendix C).
- Timeliness of Services
    - The MHP's 7- and 30-day follow-up rates subsequent to hospital discharge decreased significantly in CY15, and were well below statewide rates. However, the prior several years had reflected much better than statewide averages for the same metric. Due to the small number of annual MHP hospitalizations (CY15, N = 7), continued tracking of this element will be useful.
- Quality of Care
    - The MHP had no high cost beneficiaries (HCBs) in CY15, and has experienced very low rates for this metric of consumers and costs in the last two years.
    - Overall, CY15 FC and Hispanic average approved claims per beneficiary (ACB) decreased after increasing in the prior two years. The CY15 Overall ACB were somewhat below the Small-Rural MHP, and well below the statewide averages. CY15 Foster Care ACB well exceeded the Small-Rural MHP and Statewide averages. Hispanic ACB were well below the Statewide average but exceeded the Small-Rural MHP average.
    - The MHP's 7- and 30-day rehospitalization rates greatly increased in CY15 and were well above the statewide rates. However, the MHP had much lower rates compared to Statewide for the prior several years. Due to the small number of annual MHP hospitalizations (CY15, N = 7), significance may not be attributable.
    - The MHP's CY15 diagnosing patterns and percentage of approved claims per diagnostic category remain similar to CY14. The MHP continues to identify far fewer Disruptive Disorders and "Other" diagnoses, and also reflects lower total approved claims than statewide averages. The MHP continues to identify far

more adjustment and anxiety diagnoses and expends more resources on these conditions. Bi-polar and depressive disorders are identified at a slightly higher frequency than Statewide, and total claims are also slightly higher as well.

- Consumer Outcomes
    - No consumer outcomes were identified in this process.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." 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 2015.

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 one/two MHP submitted PIPs as shown below.

Table 3—PIPs Submitted

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Improving Consumer Retention Rate
Non-Clinical PIP	1	Improving Call Logging Workflow for Crisis Communication and Follow up

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

Table 4—PIP Validation Review

Step	PIP Section	Validation Item		Item Rating* Clinical PIP	Item Rating* Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	M
		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	M
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	PM

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

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	UTD
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	NM
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	PM
		6.5	Prospective data analysis plan including contingencies	NR	NM
		6.6	Qualified data collection personnel	NR	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NM
		8.2	PIP results and findings presented clearly and accurately	NR	PM
		8.3	Threats to comparability, internal and external validity	NR	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	PM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	PM
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	PM

Table 4—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
		9.3	Improvement in performance linked to the PIP	NR	PM
		9.4	Statistical evidence of true improvement	NR	M
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NM

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine; NR = Not Rated (Concept Only or None Submitted)*

Table 5 gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 5—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	NR	11
Number Partially Met	NR	8
Number Not Met	NR	5
Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling)	NR	25
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	NR %	60%

CLINICAL PIP—IMPROVING CONSUMER RETENTION RATE

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

- "Will an effective screening process reduce the number of mild to moderate and reduce the dropout rate to 25%?"
- Date PIP began: January, 2016
- Status of PIP:

  ☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☒ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

The stated focus of this clinical performance improvement activity is improving consumer retention rates in the early engagement phase. However, the MHP has concerns about the number of applicants coming through the assessment process that are mild-to-moderate and tend to drop-out from treatment. Also, the MHP voiced concern that when mild-to-moderate clients enter the assessment process, they may consume clinician time that might otherwise be used to serve those more seriously ill.

The MHP states that during the standard intake and assessment time, mild-to-moderate individuals are discovered, or drop-out. It is not clear why a treatment plan is developed for individuals that are assessed as mild-to-moderate, if not eligible or appropriate for services. Since the MHP has produced very limited data on the drop-out individuals, it is difficult to understand the volume of such individuals or the reasons that they drop out. The table provided by the MHP includes some limited data on missed services but not on absolute drop-outs. The MHP also did not produce a table of diagnosis or medical necessity scores of those who drop out.

Supporting data on service drop-out rates with non-psychiatry clinicians of 33% (Q1, FY14-15) is cited and compared to a 2009 National Center for Biotechnology Information (NCBI) study reflecting 18.9% early termination for the same type of provider. The MHP proposed a more modest goal of 25% drop-out, in consideration of the possible individual dynamics of the Medi-Cal population.

The MHP then states that its "Orientation Group" intervention was started in January of 2015. There was no submission of this PIP in the last EQR review cycle, and there has been no reporting out the data following January 2015, which is customarily expected monthly but at minimum quarterly. Furthermore, a multi-year PIP must have new interventions for each review cycle, which is not the case here.

There appears to have been no other analysis by the MHP to identify and study other characteristics of this population, which should have included: additional quarterly data-runs for the treatment abandonment subsequent to the FY14-15 baseline; identification of the diagnosis distribution for those who leave treatment early, needed to establish if the MHP's hypothesis about individuals who abandon treatment is valid; the medical necessity scores of those who leave treatment early; and results of efforts to survey those who abandon services and identify the consumers' reasons, to the extent possible. Many of these aspects are presented by the MHP as conclusions of fact, absent supporting data.

The MHP does not explain why it has targeted the initial screening process, and what had been determined to be lacking about that process in its exploration of this issue. Furthermore, it is not clear what resulted in the selection of an "orientation group" as the intervention to solve the screening/assessment problem, which may actually be comprised of a number of issues. It would seem that to determine if an individual is mild-to-moderate, an assessment by a clinician must still first be completed.

The "orientation group" might be better configured as a treatment intervention offered to the mild-to-moderate, following an assessment. This would provide the individual with some limited services, and also limit the impact these consumers have on available clinical time. In other words, it would fit more precisely after diagnosis and medical necessity are established to refer non-serious mentally ill and lower acuity/risk (low medical necessity) to an ongoing crisis group, or to alternate resources to the extent that such are available in Inyo County

The MHP presents the "orientation group" as the intake process all adult consumers will receive. It is not clear how an orientation group would impact drop-out rates. The amended PIP includes a bypass process when in the orientation group an individual seems to have a serious mental disorder or severe impairments or symptoms, with severe diagnosis and/or high medical necessity. However, if the orientation group always precedes the assessment process, it's not clear how or when this can be determined.

Inyo County MHP is not alone among its peers is trying to better understand and a structure the intake and assessment process, so as to optimize clinical staff hours and better serve core consumers. A number of other MHPs have been looking at this issue as well, which is possibly associated with the increases in Medi-Cal eligibles that has occurred following the ACA expansion.

From a technical point of view, this PIP effort is about a process of care, and while the use of the Milestones of Recovery Scales (MORS) is part of the activity, the focus of the activity is to reduce the amount of clinical resources that lower need, non-SMI and the treatment uncommitted utilize. This PIP does not involve the application of an intervention directly linked with improving the outcomes for seriously mentally ill adults, nor in improving satisfaction, as required for a Clinical PIP.

In a secondary aspect to this line of inquiry, the MHP stated that other diagnoses that did not meet SMI criteria could have high medical necessity. Apparently, the MHP utilizes a medical necessity review process that can output scores. In this area, the MHP would have presented a more complete picture had the range of medical necessity scoring been described, the "high medical necessity" scores been delineated, and the percent of non-SMI diagnosed high need consumers been identified. The lower need population could then be identified, representing those consumers without SMI and without high medical necessity. The magnitude of the problem could then be presented. The same inferences were made with those who abandon treatment after one to three appointments. No data was presented on these individuals, not diagnosis, nor medical necessity scores.

Problematically, the MHP does not describe what other possible interventions were considered, in addition to the Orientation Group. Furthermore, the MHP did not present supportive literature or other comparable MHP experiences for the use of an orientation group, information that would have potentially validated the selection of this intervention.

Onsite discussion with key clinical staff involved in this PIP indicated currently there was uncertainty as to the effectiveness and even practicality of using this strategy. It was learned that often the number of individuals initially seeking treatment at one time are too low to form a group, and in other instances some have too high acuity to be appropriate for an orientation group. In other cases, individuals often do not feel comfortable with attending a group and discussing personal issues in front of strangers.

While the application of a treatment group to individuals who meet specific criteria may be useful and appropriate, the current construct of requiring participation in an "Orientation Group" for three to four sessions appears to have limited clinical utility, and could comprise a barrier to care. As mentioned, a group might be an appropriate and effective way of providing limited services to those not experiencing high-levels of illness, acuity, or impairment. Certainly, an orientation group of three to four weeks in advance of any assessment could also be experienced as a barrier to timely clinical services.

As configured, this is not a PIP. Were the MHP to consider a clinical intervention, such as some sort of ongoing treatment group for the mild-to-moderate and those with lower medical necessity, there could be potential for a Clinical PIP.

Lastly, the timing of this PIP, and that it is founded on FY14-15 data, followed by the application of an intervention at a time when it had not been configured or presented as a PIP are problematic issues. Lacking subsequent data and changes to the intervention strategy makes it not possible to be considered an active PIP.

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

The technical assistance provided to the MHP by CalEQRO consisted of onsite discussion about the need to follow the PIP Outline format rigorously, the conceptual challenges of this PIP. The MHP submitted the revised PIP within a week of the review, using the correct format, but still not meeting the requirements.

NON-CLINICAL PIP—IMPROVING CALL LOGGING WORKFLOW FOR CRISIS COMMUNICATION AND FOLLOW UP

The MHP presented its study question for the Non-Clinical PIP as follows:

- "Will identifying and implementing an improved system for follow up for the Call Logging result in completed logs allow us to determine that have or have not met the goal established by the QIC for Urgent and Emergent calls?"
- Date PIP began: July, 2016
- Status of PIP:

  ☐ Active and ongoing

☒ Completed

☐ Inactive, developed in a prior year *(Not Rated)*

☐ Concept only, not yet active *(Not Rated)*

☐ Submission determined not to be a PIP *(Not Rated)*

☐ No PIP submitted *(Not Rated)*

This Non-Clinical Call Logging PIP was started by the MHP on 7/1/16. The MHP noted that the call log for urgent and emergent calls was not being completed consistently. Various elements of the date, time, and notes were substandard, with concerns arising that critical follow-up might not occur due to this lack of consistent information. It is worth noting that this focus demonstrates the MHP's QIC active role in the review of data and addressing issues identified by that data, an aspect it has received encouragement to do in recent reviews.

The MHP has set a completion standard for this element in the QI Work Plan of 80%; with data reflecting (presumably this is FY16-17, but it is not stated) of Q1: 18%; Q2: 37%. The MHP concluded that it did not meet its QI Standard. There were concerns this lack of information could result in lack of critical follow-up actions taken by clinical staff, but no data on this risk was presented.

There are a number of issues that are relevant to this topic as a PIP. First, a Non-Clinical PIP must address a process of care, those having a direct impact upon the consumer. The activities identified by the MHP in this current PIP are internal documentation challenges for this MHP in documentation of activities and maintaining compliance with a QI standard and state requirements, and are challenging to directly align, as stated, with a process of care. As related to impacting care, the MHP presented no data on the number of events in which a critical potential or actual lack of follow-up occurred, or incident reports from non-response to urgent/emergent calls, nor on the number of call events that had been previously followed-up afterwards.

The MHP did not provide any sort of extensive data reporting with numbers by quarter or month. But it did provide an overall summary of the improvement in call log documentation. That narrative seems to reflect that this sort of call log review will become a part of more frequent QI monitoring. The MHP might consider adding to that tracking the number/percentage of follow-up calls made by the MHP through the use of this logged information.

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 preliminary discussion of the PIP and the nonstandard format it was presented in, option offered to the MHP to convert to the PIP Outline format and resubmit within one week.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The MHP's intake process and proposed Clinical PIP that would insert a three-session orientation group process before assessment, plan development, and treatment, have the potential for placing a barrier to treatment. The intention of this PIP seemed blended: Reduce the number of service applicants that come through and become a regular consumer; and, reduce early abandonment of treatment. These two issues are somewhat at odds with each other without separation of the population by diagnosis and medical necessity.
- Timeliness of Services
    - The MHP's Clinical PIP, when updated, documents a bypass process that can directly move into treatment those with apparent high medical necessity and/or severe diagnoses, but also has the potential for delaying the assessment by three to weeks for those who do not meet bypass criteria.
- Quality of Care
    - The MHP's PIPs reflect an increasing focus on the review of data within the QIC and the use of those findings in development of PIP topics, which is positive.
    - The MHP's selection of PIP topics would benefit from a broader examination of data over time, to ensure that the data triggering a PIP is part of a consistent pattern.
    - The MHP's PIP process in which solutions, strategies and interventions are identified would benefit for a broader more inclusive, transparent and well-documented approach, which considers a variety of alternatives before selection of the primary intervention.
- Consumer Outcomes
    - None identified.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management 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.

Access to Care

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

Table 6—Access to Care

Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	Foster Care penetration rates are rather low (SW vs MHP CY15) and were in the prior data, although the total N is small. The MHP has documented efforts to engage and partner with Indian Health Services, and engage the ethno-cultural groups that comprise its eligibles. There has been some service expansion, and improvement is physical resources such as the Wellness Center that now includes TAY.
1B	Manages and adapts its capacity to meet beneficiary service needs	FC	Programming that serves seriously ill individuals is significantly MHSA driven, including FSPs and Progress House, the latter providing respite care and structured Board and Care beds. There is no mobile response capability; consumers self-present to the MHP or law enforcement takes them to the emergency department. The MHP is contemplating adopting broader use of telemedicine, in that securing prescribers will be easier if the candidates could work remotely. The MHP has no local acute care resources, and that which is provided requires transport to Reno, Nevada, and other distant areas in California, including San Bernardino. Crisis stabilization services that are received by MHP consumers are incidental and occur when they receive treatment by another MHP.
1C	Integration and/or collaboration with community based	FC	Collaboration activities include: Toiyabe Indian Health, Northern Inyo Rural Health, Elder Outreach, Bilingual therapist, Death Valley coverage via Skype psychiatry services, and Skype clinical supervision. Contract with

Table 6—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
	services to improve access		Pahrump Mental Health services augments remote services. Specific activities involve MHP nurse navigation with the Rural Health Clinic, and crisis services provided at the local Bishop Emergency Department. The Bishop health clinic also receive MHP crisis response.

**FC =Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

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. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	The MHP identifies a 7-day standard, and reports averaging 4 days for adults, and 3 days for children and youth. The standard the MHP utilizes is based on the face-to-face eligibility screening that occurs, and does not track back to time of initial phone call. That said, the MHP directs individuals who have a mental health need to immediately self-present. There are no indications that any delays in services occur. Staff and consumers equally report quick access and that assessment is completed and therapy begins in two weeks at latest. The MHP identifies challenges in implementing Access Call Log functionality in the CCBH system.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP's standard for psychiatry access is 30 days. The average for adults is 8 days, and zero days for children and youth. The anchor point is established as the time when the Director has evaluated the referral and authorized psychiatry services. The second data point is the time of first scheduled psychiatry appointment. This is not the typical construct utilized by most MHPs, which track either the consumer request or assessing clinician's recommendation for psychiatric evaluation as the starting time for tracking.

Table 7—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
			As with the initial assessment, those starting MHP services within the past year had nothing but positive comments about the quality and timeliness of psychiatry services.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	The MHP has a process in place that intends to track this element. However, front office staff turnover and challenges with entry of after-hours calls into the log have resulted in absence of a quarter of data and other quarters considered unreliable. The data for this metric was not presented in the Timeliness Self-Assessment tool, but was presented in the QIC meeting minutes.
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP standard for post-hospital follow-up is 2 days. There was one hospitalization meeting the follow-up requirement, with one day to the appointment. The MHP does not track individuals who have current Inyo eligibility but reside outside of the county, and does not make an effort to coordinate (when they are informed of it during the stay) aftercare, nor work to determine if transfer of eligibility to another locale would be indicated. This is an area the MHP might wish to explore for change, in that aftercare would be much easier if a beneficiary who resides in another county had eligibility in that county.
2E	Tracks and trends data on rehospitalizations	FC	For CY15 data, the MHP experienced zero rehospitalizations. The MHP tracks psychiatric inpatient hospitalizations on a paper log, that record received TARs.
2F	Tracks and trends no-shows	PC	The MHP is tracking no-shows for psychiatry services, but does not discriminate as to type. The no-shows of clinical staff are not currently tracked.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

Quality of Care

As shown in Table 8, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, 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			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	FC	The MHP recently lost to retirement the long-term MFT staffer who performed a blend of QI and clinical work. The MHP is making efforts to shift and train individuals who are in analyst type positions to augmenting QI activities and is looking at other options to fill the QI clinical oversight role. As of this review, the MHP had completed an analysis of the FY15-16 QI Work Plan, and developed a FY16-17 plan. While the MHP is able to output reports from the Cerner system with the assistance of Kings View, the switchover is fairly recent, and there is not a strong history of the MHP utilizing available data on an ongoing basis when evaluating services. The MHP cannot currently track or report out co-occurring conditions, which would likely require change of assessment protocol and retraining of staff on the assessment process, followed by expansion of CCBH / Kings View reports. The MHP continues to work to improve their Performance Improvement Projects.
3B	Data are used to inform management and guide decisions	FC	The MHP possesses data from the CCBH / Kings View system. Much of the data reporting is fairly recent, and the MHP's abilities in this area are growing as it becomes more conversant with the technical details and terminology of the new system. The January 2017 QIC Minutes include MHP overall PR, and PRs by age, gender, and race/ethnicity. The MHP also generated monthly staff productivity for FY15-16, including direct and MHSA services. The MHP has lost 4 data analytic staff during the last year, with 2 positions remaining vacant. The MHP's current PIPs are examples of areas in which consideration of system data related to the problem area would have assisted in the choice of interventions and tracked indicators. The MHP staff seem eager to learn and grow in this area.
3C	Evidence of effective communication from MHP administration	FC	Communication was identified as an area of strength according to the feedback of MHP line staff. Supervisors share that perception. The MHP has nearly 100% directly operated programs. Consumers felt they receive information from the MHP and know about real and potential changes. Family members and community groups were not represented in this review. The MHP is still working to have a public website that can be used to inform the community of available resources.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	FC	The most recent formal input session noted for this review was in March of 2016. The MHP has a clear process to meet with stakeholders including the Tribal health, local hospitals and other community agencies, in which input on services is sought.
3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	Currently, the MHP is working with Probation and the Social Services division on the Continuing Care Reform issues to improve Foster Care beneficiary services. The MHP partners with Pahrump Counseling to provide additional capacity in the Death Valley/Shoshone area. There are relationships between the MHP and the Northern Inyo Hospital and associated outpatient clinics. Strong collaborative communication exists between the MHP and the Toiyabe Indian Health Clinic, with sites in Bishop and Lone Pine.
3F	Evidence of a systematic clinical Continuum of Care	NC	The MHP does not utilize instruments to monitor level of care or level of acuity systematically. The MHP recently started obtaining regular reports from the CCBH/Kings View system. The MHP will need to adopt level of care/level of service tools and integrated review and use of this information with the annual update process for there to be a structured level of care system in place.
3G	Evidence of individualized, client-driven treatment and recovery	FC	The MHP has received WRAP trainings. A key staff member is out on leave who was key to working with consumers on WRAP plans. The MHP utilizes the Wellness Center as part of the process. Consumer education regarding mental health conditions is a key element of treatment. The MHP is contemplating adoption of better consumer measures, particularly individual session feedback. There is concern about consumer abandonment of treatment, which is also reflected in the EQRO CY15 retention data which shows the MHP lower than the Statewide number of services above five.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP utilizes a consumer employee in a supervisory role at the Wellness Center. Individuals with lived experience report that their input is requested individually by the director. These individuals also report support for applying to vacant positions, when they are ready. Peer Specialists work in a number of roles, including the Progress House, and helping consumers move between the regional health center and the MHP.

Table 8—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	The Wellness Center operates with an MHP staff and consumer employee. The program is open to anyone in the community. The Wellness Center staff also perform informal community outreach and engagement. The Wellness Center is often the first place an individual new to the community may receive services and have initial contact. Input from various sources during this review indicated that Wellness Center referrals come from a variety of sources, including clinicians, psychiatry, and other means. Whether there is a systematic approach to informing all new consumers about this resource was not clear from the review input. The Consumer Focus Group included individuals who could have benefitted but were unaware. If there is not a regular process to inform all incoming adult consumers of the Wellness Center, the MHP should develop one. Consumer concerns exist about the less that 8-5 hours of the Wellness Center, and would like to see more hours. While there is some provision for TAY to receive wellness services, the MHP could perform an assessment of need, surveying existing TAY consumers, law enforcement and probation staff to see if sufficient need exist to develop dedicated space for TAY and more regular hours.
3J	Measures clinical and/or functional outcomes of consumers served	NC	The MHP's utilization of outcome instruments is currently limited to consumers served by the MHSA "Friendly Visitor" older adult outreach program, and with infants and children ages zero to seven. Outside of those populations, and the MHSA FSP consumers, there is not a routine use of outcome instruments by the MHP. There continues to be contemplation of which instruments would offer the best feedback, with the Milestones Of Recovery Scale (MORS) rising as a likely candidate for implementation. In some review sessions, there were discussions of possible use of a session rating tool that could help track engagement and reduce early abandonment of treatment.
3K	Utilizes information from Consumer Satisfaction Surveys	PC	The MHP analyzed Performance Outcome Quality Improvement/Consumer Perception Survey result for Fall 2016. Data is broken out by age. There was no comparison of current with prior findings.

**FC = Fully Compliant; PC = Partially Compliant; NC = Non-Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - Access to acute care requires individual negotiation with hospitals ranging from Bakersfield, to the Reno, Nevada, area, and including as far as San Bernardino. The MHP has no contracts with these hospitals but uses an informal call-list. Formal crisis stabilization services are received by MHP beneficiaries only if they happen to be in another county. The MHP has created limited, informal, diversion/respite care beds at the Progress House.
    - The MHP continues to have high Medi-Cal penetration rates for most Medi-Cal demographic groups.
    - The MHP does not identify or track co-occurring substance use disorder (SUD) rates.
    - The MHP cites increasing difficulty in hiring licensed mental health clinicians who can supervise other unlicensed staff to provide Medi-Cal billable services.
- Timeliness of Services
    - The MHP's 7-day initial access standard is based upon the time from a face-to-face screening to the offered assessment. It does not include the time from the initial contact. That said, the MHP's protocol is to request that callers walk in immediately when they call, but there is no documentation of this process in timeliness tracking.
    - The MHP currently tracks time to routine appointments and psychiatry no-shows in CCBH, and hopes to add timeliness to first psychiatric appointment to the EHR.
    - Psychiatry timeliness is counted from the MH Director's review and approval of the recommendation for medications to the time of the psychiatry appointment. The standard is 30 days; however, the average access time is eight days for adults and zero days for children and youth.
- Quality of Care
    - In the last year, the MHP has turned to QIC reviewed data to identify potential PIP topics, a positive development.
    - Procedurally, the MHP does not identify additional diagnoses in the assessment process, and is unaware how this would be entered into the Cerner Community Behavioral Health EHR. This approach prevents the MHP from identifying the extent to which other diagnoses, such as substance use disorders, are present.
    - The MHP has two vacant data analyst positions out of five staff budgeted. This may delay implementation of the new EHR and QI/QA efforts.
    - The MHP would like to join a Kings View Users Group.

- Consumer Outcomes
    - There are consumer-employee positions that are part-time and without benefits.
    - The MHP does not routinely administer consumer outcome tools, and none are currently included in the EHR.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus groups 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 was a culturally diverse of 10-12 adult consumers and family members, representing high and low service utilizers, and to the extent possible emphasizing those initially accessing care within the last 12 months. This focus group was conducted at the MHP's office in Bishop, California.

Number of participants – 7

For the 3 participants *who entered services within the past year*, they described their experience as the following:

- Initial access took no more than one week for all participants. Time to psychotherapy ranged from 1.5-3 weeks. Psychiatry access took no more than two weeks.
- The majority of these consumers rated initial service quality as "excellent."
- Information about services came from a local primary care provider, a direct call to the MHP about services, and from contacting a former therapist.
- Universally, all initial access consumers felt there were no obstacles to services.

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

- Frequency of psychotherapy services varies from weekly to monthly. Approximately half of the participants see improvement. No issues were identified with adequate frequency.
- Regarding group treatment modalities, only those who have received services for more than one year have experience with groups. This included family treatment, couples therapy; other modalities include PCIT and alcohol and other drug interventions.
- None of the focus group participants receive case management services.

- Support group services received are characterized as AA, NA, and WRAP.
- None of the participants have required urgent services, but are aware of 411 and 911 resources.
- In the event that additional services or sessions are required, the experience of these participants is that it takes "a long time," with other comments including: you have to learn to cope, find meds to help, and find a better day.
- Both long-term and short-term consumers feel they have a say in their treatment planning. A very small number had been involved in developing a WRAP plan.
- The significant changes within the last year were not described in detail by these focus group participants. However, the changes are seen as positive, including more attention, accessibility, and personal contact.
- Nearly half of the group participants use the Wellness Center. An individual with decades of treatment was unaware of the Center. The Wellness Center was identified as helpful with promoting independence by those who use it.
- Information about mental health services and changes is available through word of mouth, clinic postings, radio public service announcements, and the paper. A small component has received information about MHP changes. Approximately one-third have accessed the MHP website and reviewed that information.
- The experience of being asked for input was varied, with only one individual who could recall being asked for feedback on services. None of these participants had been previously asked to attend a focus group or participate in any organized planning session conducted by the MHP. Only one individual could recall completing a written survey before.

Recommendations for improving care included the following:

- The suggestions about improvements to care were limited to the need for additional employees, and no improvements in the quality or type of services were identified. Related to medications, consumers offered that one doctor dispenses the medications but there are more consumers than can easily be handled. (The MHP does have a number of RNs on staff, and it is not clear if they are able to assist with the medication issue.)
- Recommendations that were not associated directly with mental health care included: require less work hours per week to enable greater time with family; lower prices; more jobs; more help for the homeless, such as a shelter; new and larger buildings.

Interpreter used for focus group 1: ☒ No ☐ Yes

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Focus group participants expressed a mixture of feelings about the adequacy of service frequency. There were many positives about the care received, but it was clear that seeking additional services outside of the regular schedule was very difficult process.
    - A clear and consistent comment by these consumers was a desire for more clinical staff to provide greater treatment access.
- Timeliness of Services
    - Initial access was reported by these participants as very quick. It took no more than one week to obtain the assessment, and between one and three weeks for therapy to begin.
    - Psychiatry service access takes no more than two weeks for all of these participants.
- Quality of Care
    - Participants were positive about the quality of care and the clinical staff.
- Consumer Outcomes
    - There is an awareness among consumers for employment opportunities within the MHP system.
    - Feedback about work seemed to indicate preference for limited hours and greater free-time.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 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 is dedicated to support information technology operations: (includes hardware, network, software license, IT staff)

  1%

- Consumers have on-line access to their health records either through a Personal Health Record (PHR) feature provided within EHR or a consumer portal or a third-party PHR:

  ☐ Yes ☐ In Testing/Pilot Phase ☒ No

- MHP currently provides services to consumers using a telepsychiatry application:

  ☐ Yes ☐ In Testing/Pilot Phase ☒ No

  - If yes, the number of remote sites currently operational:

    0

- MHP self-reported technology staff changes since the previous CalEQRO review (FTE): Technology staff report to Health and Human Services Agency. Additional support is provided by Kings View as their ASP contract.

Table 10 – Summary of Technology Staff Changes			
Number of IS Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
1	0	0	0

- MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE): Data analytical staff are Health and Human Services Agency employees who support both mental health and substance use divisions.

Table 11 – Summary of Data Analytical Staff Changes			
Number of Data Analytical Staff	Number of New Hires	Number of Staff Retired, Transferred, Terminated	Current Number of Unfilled Positions
5	0	4	3

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

- The MHP has 2 vacant data analyst positions out of 5 staff budgeted which may impact implementation of the new EHR and QI/QA efforts.
- The MHP would like to join a Kings View Users Group.

CURRENT OPERATIONS

- The MHP went live with CCBH with Kings View as Application Service Provider (ASP) on July 1, 2016. The projected final go-live date is Fall of 2017.
- The MHP has thus far implemented Practice Management (i.e. billing). The MHP hopes to go live with the Progress Note soon, and will then focus on implementing the CCBH Assessment and Treatment Plan. Priorities after this are consumer signature and e-Prescribing.
- The MHP's full-time psychiatrist continues to use the Echo Doctor's First product for e-prescribing.
- The MHP has only one Staff User Group (Clinical Users).

- The MHP still generates the "Timeliness of Service Entry" Report to determine that progress notes are valid for claiming. Fiscal and QI/QA staff manually check for current Assessments and Treatment Plans.
- Kings View as ASP now conducts the 837/835 claims transaction reconciliations.

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 (CCBH)	MH	Kings View	9 months	Kings View
Doctor's First	e-prescribing	DrFirst	6 years	The Echo Group

PLANS FOR INFORMATION SYSTEMS CHANGE

- New system remains in implementation phase. They went live with CCBH on July 1, 2016 and project full implementation during the Fall of 2017.

ELECTRONIC HEALTH RECORD STATUS

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

Table 13—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts				X	
Assessments				X	
Document imaging/storage	CCBH	X			
Electronic signature—consumer				X	
Laboratory results (eLab)				X	
Level of Care/Level of Service	CCBH		X		
Outcomes				X	
Prescriptions (eRx)	CCBH		X		
Progress notes				X	
Treatment plans				X	
Summary Totals for EHR Functionality		1	2	7	

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

- Only Practice Management (i.e., billing) is operational to date.
- The MHP still needs to implement progress notes, the Assessment, Treatment Plan, consumer signatures and CCBH Sure-Script for e-prescribing.
- The MHP's psychiatrist still uses Doctor's First supported by ECHO for e-prescribing.
- The MHP has not yet selected any system of care-wide consumer outcomes tools nor implemented any in the EHR.
- Consumer's Chart of Record for county-operated programs (self-reported by MHP):

  ☐ Paper ☐ Electronic ☒ Combination

MAJOR CHANGES SINCE LAST YEAR

- The MHP implemented the CCBH EHR effective July 1, 2016.
- ISCA Tables B.14 and F.1, and the site review confirmed that there are currently at least 2 vacant data analyst positions at this critical time in implementing a new EHR.

PRIORITIES FOR THE COMING YEAR

- Go live with the remaining CCBH modules for progress notes, Assessments, the Treatment Plan, consumer signature, and Sure-Script e-prescribing.
- Collaborate with Kings View to expand reports capability. Set up QA/QI and/or Fiscal staff systems to review reports on a regular basis.
- Fully train all user staff on the EHR.

OTHER SIGNIFICANT ISSUES

- The MHP plans to implement reporting capability in CCBH. They stated that if possible, they would like to include Access log functionality to create more robust QI reports and data templates. To create nuanced reporting capability the MHP would like to participate in a Kings View User Group.

MEDI-CAL CLAIMS PROCESSING

- Normal cycle for submitting current fiscal year Medi-Cal claim files:

☒ Monthly ☐ More than 1x month ☐ Weekly ☐ More than 1x weekly

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

☒ Yes ☐ No

If yes, product or application:

Web-based application supported by Kings View.

- Method used to submit Medicare Part B claims:

  ☒ Clearinghouse ☐ Electronic ☐ Paper

Table 14—Summary of CY15 Processed SDMC Claims—Inyo							
Number Submitted	Gross Dollars Billed	Dollars Denied	Percent Denied	Number Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
4,761	$1,007,052	$32,099	3.19%	145	$974,953	$4,715	$970,238

Note: Includes services provided during CY15 with the most recent DHCS processing date of May 19,2016

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - Fill vacant data analyst positions, to implement the remaining CCBH modules and ensure all users are fluent in use of the EHR.
  - Implement EHR capacity and develop protocols to screen and enter diagnoses of co-occurring substance use disorders (SUDS) in mental health consumers.
- Timeliness of Services
  - Develop a protocol and standardized processes for Front Office staff to enter Urgent/Emergent requests for services in the Access Call Log. Develop a reliable process to obtain and enter Urgent/Emergent requests made to after-hours clinicians and other staff.
  - Work with Kings View to determine if there are any economical ways to add initial contacts/requests to CCBH so that more staff (e.g., after hours) can perform Access functions.
- Quality of Care
  - No issues identified.
- Consumer Outcomes
  - No issues identified.

SITE REVIEW PROCESS BARRIERS

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

- There were no site review process barriers identified.

CONCLUSIONS

During the FY16-17 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 MHP maintains relatively high penetration rates well above the statewide rates for most Medi-Cal race/ethnicity demographic groups.
  - Five additional authorized positions have been added in this last year.
  - Inyo County has added two positions to assist in meeting the requirements of CCR.
  - The Wellness Center is now operating services for TAY.
- Opportunities:
  - The CY15 Foster Care penetration rate decreased and was under 20%.
  - The MHP maintains relatively high penetration rates well above the statewide rates for most Medi-Cal demographic groups.
  - Recruitment of licensed clinicians and psychiatrists is challenging for this remote, frontier area MHP which might benefit from the broader use of technology supported services such as telemedicine and teletherapy.

Timeliness of Services

- Strengths:
  - The MHP utilizes a very brief 7-day standard for initial access, averaging four days for adults and days for children and youth. The caveat to this positive data is that the MHP uses a time from screening to the appointment. The MHP also reports that the initial request and the screening often occur on the same day.
  - The MHP's initial psychiatry appointment standard has a 30-day target, with data reflecting eight days for adults and zero days for children and youth. Again, the caveat to this data is a non-standard approach to this tracking, which has the time start following review and approval of a request by the Director.

  - The Katie A. assessment can be completed within one week of identification; IHBS can be provided within several days of request.

- Opportunities:
  - The MHP's approach to tracking timeliness does not adhere to typical industry standards for methodology.
  - Katie A. assessments can take up to three weeks when the family is Spanish-language preferred.
  - The MHP currently does not have reliable manual processes to track time for urgent/emergent services or follow-up services after hospital discharge.

Quality of Care

- Strengths:
  - The MHP's QI Work Plan and QIC Minutes are starting to reflect data from CCBH reports, which is assisting in the tracking QI goal performance.
  - The MHP's QI process and identification of PIP topics is linked to data on emerging issues in QI performance areas.
  - MHP leadership is broadening the participant base in the direct QI process, including a more diverse number of analysts and others.
- Opportunities:
  - The completion of the transition to the CCBH EHR and clinical documentation elements, as well as full understanding of the report constructs and language will improve the MHP's ability to continue its data-focused approach to quality.
  - The MHP lacks a mechanism to track acute hospital discharges for beneficiaries who are presently residing in another county, and does not track or participate in after-care planning for those individuals.

Consumer Outcomes

- Strengths:
  - Expansion of the numbers and roles of lived experience consumer-employees has occurred and appears to be a continuing trend.
  - The quality of space and availability of services is expanding at the Wellness Center, offering individuals a bridge and support between treatment and some type of meaningful community activity, including part-time employment.
- Opportunities:
  - The MHP has been on the cusp of selecting and universal use of outcome instruments for a number of years, and will have been data for care planning when instruments are in wide use and integrated with the EHR.

RECOMMENDATIONS

- 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.
- 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.
- 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.
- Join the Kings View User Group to take advantage of collaborative activities and information sharing this forum would provide.
- Explore and identify the issues around lower foster care penetration rates.
- Continue efforts to identify and begin implement within the EHR outcome and level of care instruments that are used with all children and all adults.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

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
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 Employee Group Interview
Consumer Family Member Focus Group
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
Wellness Center Site Visit

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, MPA, RN
Richard Hildebrand, IS Reviewer
Janyce Leathers, Consumer/Family Member

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

Sites of MHP Review

MHP SITES

162 J Grove Street
Bishop, CA 93514

CONTRACT PROVIDER SITES

Bishop Wellness Center
586 Central St.
Bishop, CA 93514

Participants Representing the MHP

Name	Position	Agency
Name	Position	Agency
Beall, Miquela	Admin Analyst	HHS
Blackwell, Pam	Program Chief (Child and Family)	HHS-Behavioral Health
Cataldo, Ralph	Admin Secretary II	HHS-Behavioral Health
Zwier, Gail	HHS Deputy Director-Behavioral Health	HHS-Behavioral Health
Romero, Brock	CF	HHS-Behavioral Health
Bowman, Robert	Therapist	HHS-Behavioral Health
Rent Janelle	LPCC in process	HHS-Behavioral Health
Dixon, Cindy	BH RN	HHS-Behavioral Health

Name	Position	Agency
Spoonhunter, Topah	Admin Analyst	HHS
Justine Kokx	Administrative Analyst,	HAS
Anthony Rader	Social Worker Supervisor	DSS/HSA

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

Approved Claims Summaries are separately provided to the MHP in a HIPAA-compliant manner.

Two additional tables are provided below on Medi-Cal ACA Expansion beneficiaries and Medi-Cal beneficiaries served by cost bands. The actual counts are suppressed for cells containing n ≤11.

Table C1 shows the penetration rate and approved claims per beneficiary for the CY15 Medi-Cal ACA Expansion Penetration Rate and Approved Claims per Beneficiary.

Table C1—CY15 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary
Inyo

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,045,306	131,350	4.31%	$533,318,886	$4,060
Small-Rural	26,103	1,992	7.63%	$5,569,311	$2,796
Inyo	1,419	79	5.57%	$204,624	$2,590

Table C2 shows 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.

Table C2—CY15 Distribution of Beneficiaries by ACB Range
Inyo

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
$0K - $20K	316	99.06%	94.46%	$981,903	$3,107	$3,553	93.51%	61.20%
>$20K - $30K	3	0.94%	2.67%	$68,098	$22,699	$24,306	6.49%	11.85%
>$30K	0	0.00%	2.86%	$0	$0	$51,635	0.00%	26.96%

ATTACHMENT D—PIP VALIDATION TOOL

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 CLINICAL PIP

GENERAL INFORMATION

MHP: Inyo

PIP Title: Improving Consumer Retention Rate

Start Date (MM/DD/YY): 7/1/2014

Completion Date (MM/DD/YY): 6/30/2014

Projected Study Period (0of Months):

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY): April 11, 2017

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

☐ No Clinical PIP was submitted

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

The MHP identifies the issues that generated this PIP as: "Too many people being added to the MHP caseload that are only coming three or fewer sessions before dropping out." This was supported by the MHP's finding for Q1 FY14-15, that a 33% drop-out rate for services with non-psychiatry clinicians. The MHP also cited a NCBI clinician drop-out rate of 18.9%. The MHP sought to reduce the drop-out rate to 25% or less, based on the belief that the MHP's caseload has differing dynamics than that in the referenced literature.

The MHP further explains that the current intake process admits consumers to services based on request, followed by an assessment, medical necessity is determined, and a treatment plan is developed. The time to discovery of the mild-to-moderate consumer is 2 to 3 clinician hours. The MHP believes an improved intake screening process could identify these mild-to-moderate consumers prior to the intensive

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 original Clinical PIP submission described the team; however, the updated version that uses the PIP Outline format does not. The MHP advises that it will correct that deficiency. There is no reference to consumer participation in this PIP. However, Director did state that consumers participate in QIC and are thereby included.
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 responded to data on the number/percentage of consumers that abandon treatment within three sessions. There was no data on the distribution of diagnoses and medical necessity scores/levels for those who abandon treatment, even though the MHP is suggesting that these are the individuals who drop out. The MHP believes that these individual either lack serious mental illness diagnoses and/or lack high levels of medical necessity. While it is perfectly appropriate to utilize some historic data (in this case Q1 FY14-15) to establish a possible problem, the MHP did not utilize any data from CY15-16 to demonstrate the continuation of this issue. While this is an important topic, it would have been useful and informative to have this type of information.

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	While the PIP cites the percentage of early treatment drop-outs, and in general terms speaks about lower medical necessity of these individuals, it is not clear at all what flaws exist with the current assessment process and what would lead them to develop the idea of an orientation group. There may actually be nothing wrong with the MHP's intake/assessment process, but it could be that the proper action following that process is not occurring. Based on the narrative provided, it could be that there is a failure to take correct action when an individual is identified as lower medical necessity or lacking an SMI diagnosis.
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 new admissions. It is not clear if this is limited to adults or includes children and youth, as written. The PIP data table has the comment that children and youth are excluded. It is not clear if that related to this one table or to the PIP in general. The section calls for the description of the study population, and the MHP describes this as the Q1 FY14-15 data table – which is not the study population, it is a reference population to identify if there is a problem. The study population is comprised of all adults requesting services during the course / timeframe of this PIP.
	Totals	**1** Met **1** Partially Met **0** Not Met **2** 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 an effective screening process reduce the number of mild to moderate clients reduce the dropout rate to 25%or less?	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP needs to look at this study question and review it for clarity. Would another MHP be able to pick this PIP up and initiate an identical effort? That needs to be answered. What is not clear nor stated anywhere are the aspects about the existent screening process that have been determined to be weak or inadequate. With a bit of specificity, what is this lack and what is the MHP going to do to address it. It is completely unclear the association between an improved screening and the resultant decrease in drop-outs. The MHP is presuming that those who drop-out would not be part of the served population with improved screening. The MHP did not furnish significant data that identified the probable or known diagnoses of those who drop out, nor did it roll-up and present the medical necessity scores of those who drop out. The MHP was successful in identifying a target percentage (25%) goal for the drop-out statistic.
	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	All new admissions. The PIP section for identification of the study population seems to indicate that they are the new admissions in Q1 FY14-15. The included table states that children are not included in this Q1 FY14-15 data table. It is not clear if this is an attempt to describe the study population as excluding children and youth, or only in this table are children and youth excluded. Furthermore, the MHP is actually using the Q1 FY14-15 data to establish a problem with new admission drop-outs. If this was the entire study population, there would be no PIP. It appears the MHP means to say that the study population and included MC enrollees are all new ongoing admissions of adults. The time-frame, from when, is not clear.

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: All new requests for service.	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP presented the data from Q1 FY14-15 that related to drop-outs and establishing this issue. Onsite discussion included MHP thoughts about this PIP starting the application of an orientation group in 1/2/2015, but there has been no data on the number of new intakes since 1/2/2015, nor of the number participating in the orientation group, nor the number who meet the criteria of Mild-to Moderate.
	Totals	**0** Met **0** Partially Met **1** Not Met **1** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* Drop-out rate of new admissions	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP identified a single metric of drop-out rate within three services. The MHP had theorized that drop-outs were most likely to occur with mild-to-moderate individuals, thus tracking the percentage/numbers of those who are diagnosed as mild-to-moderate would have been informative. It would have been also helpful to track the number of new intakes that went through the orientation group, and the percentage of all admissions these numbers would comprise.

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	Reflects engagement. But that is also making an assumption. Perhaps tracking and follow-up attempts to collect and track reasons individuals drop out of treatment would also be informative.
Totals	**0** 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	
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	Drop-out rate within three sessions.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: Text if checked	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	EHR
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	Reportedly, the MHP began this PIP based on FY14-15 data run of new admission drop-outs, and started an orientation group in 1/2015. There has been no data collected and reported, with quarterly reports expected. Furthermore, this PIP was not evident in the prior EQRO review periods.
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	No data has been reported since the baseline data in FY 14/15.
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	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Gail Zwier, PH.D.-Inyo County HHS Deputy Director: Behavioral Health QIC Committee- Inyo County Miquela Beall- Inyo County HHS Administrative Analyst Gina McKinzey- Inyo County HHS Administrative Analyst Inyo County HHS Management Analyst Inyo County Behavioral Health: QIC Coordinator and Psychotherapist Inyo County HHS Mental Health Nurses Merry Brown- Inyo County HHS SUD Program Manager Christina Palomo- Inyo County HHS Specialist, Wellness Center	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**0** Met **0** Partially Met **0** 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:* *Orientation Group- Before a prospective client is admitted into services they must attend 3 "group sessions". These sessions explain to the potential clients the process of treatment and a brief assessment will be done. Those that are not severely mentally ill will receive information on where they can seek treatment for mild to moderate mental illness. However, clients that are in crisis will be moved directly into services.*	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	The MHP presents a multitude of hypotheses about why these individuals would drop out but has presented no data on the characteristics of these new admissions that drop out, nor of the presumably flawed assessment process.
Totals		**0** Met **0** Partially Met **1 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	No definitive plan was presented.
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 **0** 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 **5** Not Met **0** 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: This activity has its basis in data from 2014 and with an intervention of an orientation group starting on January 2015. The basis investigatory process appears inadequate for conclusions that an orientation group would be of help to the problem. There was a lack of understanding of the study population. And no further data runs have been performed. Furthermore, if this PIP was started before the FY15-16 EQRO review cycle, no data was produced and no PIP was submitted at that time.

Recommendations:

If the MHP considers treatment abandonment, as specifically related to mild-to-moderate consumers, remains a problem. It should fully study the new intakes, obtain data on the number of M2Ms that are in that group, and develop appropriate interventions. It will need to start over and run data to see if treatment abandonment continues to be a problem.

Check one: N/A

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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY16-17 NON- CLINICAL PIP

GENERAL INFORMATION

MHP: Inyo

PIP Title: Improving Call Logging Workflow for Crisis Communication and Follow up

Start Date (MM/DD/YY): 7/1/16

Completion Date (MM/DD/YY): 6/30/17

Projected Study Period (#of Months): 12

Completed: Yes ☐ No ☒

Date(s) of On-Site Review (MM/DD/YY):

Name of Reviewer:

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

Rated

☐ Active and ongoing (baseline established and interventions started)

☒ Completed since the prior External Quality Review (EQR)

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

☐ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP reviewed QI data and discovered that the call logging practices was failing to meet the goal of 80% specified in the QI Work Plan for completion of date, time, and notes. This could negatively impact those callers who required an immediate follow-up. Without specifying the FY, the MHP stated data of Q1: 18%, Q2: 37%. The included population was all adult urgent and emergent callers, excluding youth.

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	Consumer participation assured through the involvement of QIC.
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	Review of after-hours emergent/urgent call response by on-call clinician.
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	Those who required follow-up will not receive same if the call is not logged into the system for the in-coming workers to respond to.
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: Adults only* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All after-hours adult callers.
Totals		**4** Met **0** 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 a change in the call logging record process improve the completeness of the Call-Logging Database to at least a75% completion rate?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While completion of the call logging is essential to any needed follow-up with after-hours callers, the act of recording these calls are not in itself creating any clinical impact. Were the MHP to also include in the study question an element about improving or increasing the % of after-hours calls that receive a follow-up contact, there would be a clear link to clinical care.
	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: Adults after hours	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Adults calling after hours	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	It is not clear if the MHP can match on-call clinician claimed work hours with call events, then track those to the completion of a call-log entry. However, it is likely that is the case otherwise the MHP would have no idea that calls were going under-reported. Furthermore, it is not clear why children/youth are exempted, because they too can have an after-hours event.
	Totals	**0** Met **0** Partially Met **0** Not Met **1** UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Call Logging completion rate using previous system of the clinician inputting the information on their own. • Call Logging completion rate using the new system of front office support staff initiating follow-up with the clinicians	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The first indicator of call logging using previous system is the baseline data, and serves no purpose as a separate indicator. That data should be involved in the evaluation of the call logging completion rate data of the new system. The MHP would have made this activity more consumer-focused were it to also track the number of after-hours adult calls that had historically (by quarter) received subsequent follow-up, and then use this as an element to track with the new system. In other words, does the new recording system result in more follow-up calls to consumers who have called. A time element could have also been added, such as: "within three days of after-hours contact."

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 MHP's selected indicator tracks only the completion of the log process, and is disconnected from any element that directly involves the consumers. The MHP could have elected to also track the number/percentage of callers who required or received follow-up contact before the new system and after – which could reflect improvements in care. The baseline data for the previous system could have been reviewed for a quarter period to establish the extent to which follow-ups had occurred.
Totals		**0** Met **0** Partially Met **1** 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	No sampling.
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	Completed call logs: date, time, contact description.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Call log – after-hours	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: Text if checked	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	There was a narrative summary including percentages but no raw data of the success of this PIP since the activities were initiated. No data tables were provided. The results were very positive, accomplishing the PIP goals. It would appear this PIP is completed, as written.
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	

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Gail Zwier, PH.D.-Inyo County HHS Deputy Director: Behavioral Health QIC Committee- Inyo County Miquela Beall- Inyo County HHS Administrative Analyst Gina McKinzey- Inyo County HHS Administrative Analyst Inyo County HHS Management Analyst Inyo County Behavioral Health: QIC Coordinator and Psychotherapist Inyo County HHS Mental Health Nurses Merry Brown- Inyo County HHS SUD Program Manager Christina Palomo- Inyo County HHS Specialist, Wellness Center	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**4** Met **1** 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:* *Utilizing front office staff to connect with the clinician and complete the log*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
Totals		**1** Met **0** 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	There was no specific data analysis plan spelled out in the PIP. But a narrative analysis was in fact provided.

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	The PIP narrative explained the findings and results from monitoring after the application of the intervention.

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: Summary information Indicate the statistical analysis used: percentage_ Indicate the statistical significance level or confidence level if available/known: ___NA____% ___NA__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:* None described *Conclusions regarding the success of the interpretation:* There were improvements, as the MHP had anticipated, which appear from the high-level data (% only) to be true. *Recommendations for follow-up:* Consider tracking F/U calls % subsequent to after-hours calls	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	MHP did not identify additional activities in this area, which could include tracking subsequent follow-up calls, and/or adding children and youth to this activity.
	Totals	**0** Met **2** Partially Met **2** Not Met **0** 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	The MHP mentioned quarterly data but did not represent this in data tables. It is therefore difficult to confirm its conclusions. Provided were high-level percentage summaries of the process.

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	The improvement of available information from on-call, after-hours clinician contact improved from the baseline to within the area of desired improvement. No stat tests conducted; none were really required.
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	The improvement in the process record is apparent, whether or not this has impacted clinical services or consumers directly is not clear. As previously mentioned, the relevance to consumers would be greater should the MHP have decided to track the conversion of after-hours calls to follow-up calls, before and after the intervention. There could be an overall improvement in consumer care/follow-up, but this was not tracked.
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	The simple increase in the percentage completion rates from high 30% to the 75-80% range now occurring is a clear improvement.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Whether the MHP terminates this PIP at this point or continues, as originally planned, through June, there is a mechanism and plan for continued monitoring and more frequent QI reporting going forward.
	Totals	**1** Met **3** Partially Met **1** Not Met **0** 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	The MHP presented findings, not raw data.

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

Conclusions:

The MHP's PIP activity related to improving documentation of after-hours contacts has improved the process. Whether or not that has resulted in any change in consumer care is not clear. The MHP would be advised to consider, going forward, ensuring that all PIPs have a direct link to consumer care, evidenced by a relevant indicator. It would also be advised to consider tracking in QIC the conversion rate of after-hours calls to follow-up contacts, as a mechanism of ensuring that the recording practice translates into, when appropriate, follow-up care.

Recommendations:

See above.

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