FY16-17

**Medi-Cal Specialty Mental Health**

External Quality Review

MHP Final Report

***Ventura***

***Conducted on***

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# Ventura Mental Health Plan Summary findings

* Beneficiaries served in CY15—7,302
* MHP Threshold Language(s)—Spanish
* MHP Size—Large
* MHP Region—Southern
* MHP Location—Ventura
* MHP County Seat—Ventura

**Introduction**

Ventura County Behavioral Health (VCBH) is a Large MHP. Noteworthy is 58% (CY15) of its eligibles are Hispanic. Efforts have been made to improve Hispanic penetration rates, but they remain lower than statewide and other Large MHP rates. In recent years, the VCBH has undergone a leadership changeover. As the MHP seeks to study and improve service delivery issues, it has also adopted the structured analytic tools embodied in Lean Six Sigma principles.

**Access**

The MHP has created significant enhancements to its services in recent years, developing a wide spectrum of programming including Mental Health Rehabilitation Centers, Crisis Stabilization Units, Crisis Residential Programs, and other services such as Assisted Outpatient Treatment. The MHP has continued to improve access capacity for the Hispanic population, including the addition of a clinic specifically targeting this population, telemedicine in Spanish, greater numbers of bilingual/bicultural hired staff, and a Spanish language treatment plan. Service expansion has occurred in many other service areas within the MHP.

**Timeliness**

Over time, the MHP has developed a fairly complex crisis, access and assessment process. It has undertaken an extensive analysis of its initial access process from first contact to first psychiatric appointment. The analysis and system change effort is incomplete at this time. The MHP’s routine timeliness efforts are variable; in some areas, standards have yet to be set; and in others, some important data elements are not tracked.

**Quality**

During the last several years, the MHP has made efforts to change how it structures its Quality Improvement (QI) Work Plan and executes quality improvement efforts. It is striving to utilize the Lean Six Sigma principles in its improvement efforts. The MHP has also trained staff in Cognitive Behavioral Therapy to provide a uniform intervention to those requiring psychotherapy.

**Outcomes**

The MHP utilizes a locally developed outcome collection system, Ventura County Outcome System (VCOS), which incorporates aspects of numerous other instruments. The process of performing an item-level analysis is nearly complete. The MHP utilizes numerous other instruments in its endeavor to track the progress of its consumers.

# 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 Ventura 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]](#footnote-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)

(2) Validating Performance Improvement Projects[[2]](#footnote-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]](#footnote-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](http://www.caleqro.com).

# 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: Complete the caseload and capacity analysis, and based on the findings from analysis, develop an ongoing monitoring process that tracks level of care/level of service, and assures inactive cases are resolved and either determined to require continued treatment or closed. This involves a combined automated reporting functions, coupled with a standardized review protocol which would be informed by the use of standardized outcome and/or level of care instruments.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* The MHP acknowledged that it had been unable to fully engage with this recommendation due to the lack of resources to perform necessary analyses. As detailed in the body of this report, currently the MHP appears to be understaffed in basic clinical data analytics to complete routine analyses such as this one in a timely manner.
* The MHP is able to run routine caseload reports which indicate higher than desirable case numbers. Absence of contact within 90 days is one of a number of reports that are also run. Clinical leadership has instructions to redistribute caseload as indicated, and also to initiate follow-up when cases are discovered that have not received timely attention.
* An area in which progress has been made is the recent requirement that all cases coming up for the annual update receive clinician review of level of service needs and are considered for adjustments, including consideration of lower levels of care. Another aspect of this process is the creation of a field within the Avatar EHR to capture the review of the plan with the consumer or guardian and that discussion about alternate options have occurred, such as a lower level. This process will be enhanced when there exists a mechanism to utilize level of care instruments to inform this process.
* Recommendation #2: While finalizing its formal evaluation of the efficacy of the VCOS outcomes system and the frequency of application of the measures, the MHP should expedite the integration and use of more broadly utilized tools like the CANS/ANSA or MORS.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* Evaluation of the VCOS system is not completed as of this review; however, an item-level analysis has begun, including internal consistency and reliability of select Basis-24 and Hopefulness instruments administered to adult consumers. Thus far, the MHP is satisfied with the analysis results of the reviewed indictors.
* The MHP is implementing use of instrument data in the treatment and discharge planning process which occurs at a minimum of annually. Training in the use of the trauma-informed CANS measure and MORS have also occurred to further the MHPs expertise in the use of outcomes.
* Recommendation #3: Related to the MHP’s level of care/discharge project, the MHP should conduct an evaluation of its high cost beneficiary (HCB) population to better understand where resources are currently being allocated and which cohorts may be experiencing treatment bias. Once characterized, the over-consuming populations should be targeted for enhanced evaluation to strategize clinical treatments that may improve wellness.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* The MHP performed an evaluation of the high-cost (>$30k) beneficiaries (HCBs). VCBH identified 37 adult system HCB consumers, and examined the service history of these individuals. These individuals often have service histories that include utilizing one of the MHP’s intensive residence resources, including Casa de Esperanza or the Hillmont MHRC. Utilization of these services typically is an indicator of severe functional impairment.
* As part of its response to this recommendation, the MHP identified the Pacific Clinics peer support specialist contract, which recently included the assignment to link with individuals discharged from the acute inpatient unit and ensure follow-up.
* As part of this current review, it should be noted that the total number of HCB individuals increased from 202 in CY13, to 203 in CY14, and then decreased to 193 in CY15. The percentage of beneficiaries represented by HCBs has also slightly decreased in CY15 (2.65%), lower than the statewide measure (2.86%), and down from the CY14 level (2.72%). The percent of all claims that are comprised of HCBs is also down in CY15 (24.06%), below the statewide number (26.96%), and less than the CY14 (24.81%) rate. These are early indicators and may be reflective of actions to optimize services to the most severely ill consumers. The MHP’s response did not address HCB children.
* Recommendation #4: Assign resources to complete Medicare Part B recertification. Submit test claims to Medicare fiscal intermediary to ensure successful setup. Resume Medicare claim submissions as soon as practical.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* The MHP has been making incremental progress toward this goal. Operational barriers, such as having to recertify the signing authority at the Health Services Agency (HSA) level created significant delay.
* The billing staff indicated that most of the barriers to fully implementing this recommendation have been overcome and expect to be fully compliant in the near future.
* Recommendation #5: In concert with the current improvement project to reduce denials due to documentation errors, investigate the reasons for initial SD/MC (6%) claim denials. Examine Policy and Procedures instructions and documentation to Avatar billing and claiming protocols to ensure that both are compatible and support the business practices of the MHP.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* While the MHP’s billing staff continue to investigate and remediate the factors behind its higher than normal denial rate, they continue to experience new barriers.
* During the review, the MHP shared a reason code analysis that detailed MHP efforts to understand and fix barriers to billing.
* At this time, staff acknowledge that there appear to be ongoing challenges to remediating all of the MHP’s barriers, such as the State’s birthdate/gender edits, but feel they are on a path to a sound and responsible solution.
* Recommendation #6: Engage in a stakeholder process with contract provider agencies who have operational EHR systems. Examine what other MHPs who use Avatar have implemented for data interoperability solutions. Research electronic data interchange (EDI) standards for the exchange of healthcare data between systems.

[ ]  Fully addressed [x]  Partially addressed [ ]  Not addressed

* The MHP engaged in an in-depth, agency-centric process that examined the topic of system interoperability. This lead the agency to craft a tactical plan that will deal with many of the issues surrounding practical data exchange.
* Stakeholder feedback was inconsistent about the extent to which the MHP substantially engaged with its contract provider community to craft immediate and practical solutions.
* The MHP did not provide information on when its plans would be implemented. Nor did the MHP did not provide for interim solutions such as broad read/only access to the EHR for its provider community that specifically called out this feature as a critical interim step for improved consumer care.

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

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

* Access to Care
* The MHP has initiated telepsychiatry services, currently utilized for providing services to those who are Spanish language-preferred countywide.
* The DMC-ODS waiver application was reviewed by both the State and CMS, and is now approved.
* The MHP was granted SAMSHA funds to support a full-service partnership for Assisted Outpatient Services (AOT) programming.
* In concert with Telecare Corporation, the MHP completed and opened Horizon View, a 16-bed, locked Mental Health Rehabilitation Center (MHRC) at the Camarillo Airport complex. Individuals who were previously placed in Sylmar IMD have been transferred back into the County.
* The MHP has developed a specialized treatment track for the 0-5 population, including a universal assessment for all beneficiaries referred by HSA-CFS, the only county in the state to do so.
* A Priority Access to Services and Supports (PASS) pilot program for parents and children detained by HAS-CFS for expedited services in those cases indicating a behavioral intervention need.
* Timeliness of Services
* Efforts to study the entire spectrum of timeliness measures, and collaborative problem-solving in which changes to improve the process are being identified, will likely show a positive effect upon the consumer experience.
* Quality of Care
* The MHP’s management team has experienced a complete turnover in personnel, changes that have been experienced positively by all who were interviewed in the course of this review.
* All clinical staff have received training by the Academy of Cognitive Behavioral Therapy, with the intent of utilizing this Evidence-Based Practice (EBP) with fidelity to model.
* The Latino/Hispanic disparity is being addressed through a number of strategies, including the use of four bilingual outreach staff who seek to engage children and families.
* The MHP continues to target smoking cessation as a key health intervention with its consumers, including those who are being served at Horizon View, the newly opened locked Mental Health Rehabilitation Center (MHRC). They are demonstrating that, while difficult, it is possible to have an impact with those who are severely mentally ill and smoke.
* The MHP's previous challenges with the individual recruitment and retention of psychiatrists and NPs have been assumed by the recently formed Sterling Psychiatric Services. As an entity, Sterling contracts with Ventura Behavioral Health, and assumes responsibility for maintaining adequate coverage, recruiting for turnover, and managing quality of services. Part of this responsibility entails assumption of responsibility to develop and operate a Clinical PIP, and perform quality reviews of prescriber personnel. In the past year, this has included a “360” type of review in which colleagues and consumer feedback was sought and delivered to practitioners; those with identified issues were counseled by the Sterling leadership.
* The MHP has brought all crisis services in-house, adding response to children and youth in crisis to the existing 24/7 team. It should be noted that Ventura was one of California’s early pioneers of mobile crisis services providing 24/7 crisis coverage dating back to the 1970s.
* The MHP established joint governance with the Human Services Agency, Probation, and Public Health in order to implement Continuum of Care Reform.
* Consumer Outcomes
* The MHP stations Pacific Clinics Peer Support Specialists at the County Inpatient Psychiatric Unit. Whereas case manager follow-up with existing open consumers to the MHP, the Pacific Clinic staff engage and follow-up with those who are NOT open to the MHP at the point of acute admission.
* The MHP reports a decrease in the hospitalization of children, with the Crisis Stabilization program diverting 71% of children in crisis.
* To improve outcomes of DUI interventions, the MHP is testing the inclusion of CBT techniques.

# 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.



## 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 Ventura MHP:

[ ]  Uses the same method as used by the EQRO.

[x]  Uses a different method: Numerator = the unduplicated clients with approved claims within the period measured (Source: Avatar). Denominator = regularly released Medi-Cal eligibility file from the state (ITWS Monthly Medi-Cal Eligibility File (MEDS)).

[ ]  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 Large MHPs.





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





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



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.

|  |
| --- |
| 9% Youth, 26% Adult, 18% All |

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





## Performance Measures Findings—Impact and Implications

* Access to Care
* While the MHP’s number of Medi-Cal eligibles rose from 167,224 (CY14) to 176,111(CY15), beneficiaries served dropped from 7,506 to 7,302 during this period.  This correlates to a penetration rate (PR) drop from 4.49% (CY14) to 4.15% (CY15). The MHP’s CY15 PR remains less than both the Large county (4.52%) and statewide (4.82%) averages.
* The MHP’s total Affordable Care Act (ACA) eligibles for CY15 was 54,632, and the beneficiaries served was 2,203, for a penetration rate of 4.03% for this sub-group (see Table C1 in Appendix C).
* The MHP’s FC penetration rate remains flat for a fourth year and is in line with both the State and Large MHP cohorts.
* The MHP’s penetration rate for Hispanics is below both the Large MHP and the State averages for this metric. It should be noted that this reflects low performance as the MHP’s largest group of beneficiaries is Hispanic (~57.6% of the total beneficiary pool; see Table 1 above.).
* Timeliness of Services
* This year the MHP’s follow-up rates for both 7- and 30-days after hospital discharge are substantially higher than State experience.
* Quality of Care
* The MHP’s High Cost Beneficiaries (HCB) rate was lower than the statewide average and has gradually declined since CY13. The MHP is expending less of its total Short-Doyle/Medi-Cal (SD/MC) revenue on its HCB consumers and is now almost 3 percentage points below State experience.
* The MHP’s Average Approved Claim per Beneficiary Served (AACBS) continues to trend slightly upward from CY13 and is now well above peer MHP and statewide performance.
* The MHP’s FC AACBS continues to trend downward from CY13 and is now below both the Large MHP and Statewide experience.
* The MHP’s Hispanic AACBS is up from CY13-14 but and is now above both Large MHP and Statewide performance.
* The MHP continues to experience higher rates of diagnosis for both Psychosis and Bipolar diagnostic groupings when compared with the statewide numbers.
* While Disruptive diagnoses are assigned at rates slightly higher than statewide experience the MHP continues to return fewer revenue dollars than is the norm Statewide.
* Consumer Outcomes
* The rehospitalization rates for the MHP at the 7- & 30-day post-discharge periods are similar to the corresponding statewide averages.

# 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.

## ventura 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 | Integrating Smoking Cessation into Behavioral Health Services |
| Non-Clinical PIP | 1 | Spanish Treatment Plan |

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]](#footnote-4)

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

*\*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 | 0 | 0 |
| Number Partially Met | 0 | 0 |
| Number Not Met | 0 | 0 |
| Number Applicable (AP) (Maximum = **28** with Sampling; **25** without Sampling) | 0 | 0 |
| Overall PIP Rating ((#Met\*2)+(#Partially Met))/(AP\*2) | NR% | NR% |

## Clinical PIP—Smoking Cessation

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

* “Will integration of smoking cessation services within VCBH decrease the proportion of consumers who describe themselves as active tobacco users.”
* Date PIP began: June, 2016
* Status of PIP:

 [ ]  Active and ongoing

 [ ]  Completed

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

 [x]  Concept only, not yet active *(Not Rated)*

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

 [ ]  No PIP submitted *(Not Rated)*

The MHP targeted smoking cessation within its adult services population for the current Clinical PIP, which has an inception date of June 2016. This topic was identified based on a survey sample of consumers, consisting of 95 individuals drawn across all adult clinic sites and a comprehensive literature review. The tobacco use survey found the following: 46% were active smokers; 72% who smoked had an interest in quitting; and 95% of these smokers had attempted quitting before. The literature focused on the loss of lifespan and diseases associated with smoking tobacco. In addition, material was reviewed that provided assistance in tailoring interventions for individuals with mental illness.

While the direct impact of smoking on psychiatric conditions is inconsistent, some studies have indicated that nicotine may aggravate anxiety and other symptoms related to mental illness. Smoking related physical illness is the single greatest health risk of the severely mentally ill, and cessation is a reasonable health improvement strategy for this MHP. The MHP is a unit of the larger Health Services Agency, within which health care integration, including Whole Person Care, is a clear priority expressed by the Director during this review.

The smoking cessation PIP includes screening of the entire adult population for smoking, and then, for those reporting tobacco use, offering a structured intervention “Call It Quits,” followed by subsequent monitoring of tobacco cessation over time. The intent is to continue monitoring for tobacco usage in assessments and within individual service events. However, a challenge for this PIP is the current lack of a reliable health record-based data tracking of tobacco usage. The MHP is in the process of developing a unique field or documentation standard that would permit universal, continuous tracking of tobacco usage, but as of this EQRO review, there was no system data or target population baseline smoking data available.

As of this review, the MHP had not implemented any of the described interventions. The PIP does show the promise of improving the health of the MHPs consumers as related to tobacco use and tobacco-related illnesses. At this time, however, absent baseline data and active interventions, this PIP is considered “Concept Only,” and is rated in the validation tool for the purpose of providing feedback to the MHP. These ratings will not appear in Table 4, in the body of this current EQRO report.

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 discussion of the PIP, the need to add to the study question the anticipated success rate goal of this activity, and discussion of the status rating of this PIP.

## Non-Clinical PIP—Spanish Treatment PLan

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

* “Do clients who receive a treatment plan in Spanish receive equitable levels of service when compared to non-Spanish consumers?”
* Date PIP began: January, 2015
* Status of PIP:

 [ ]  Active and ongoing

 [ ]  Completed

 [x]  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 Spanish Language Non-Clinical PIP evolved from MHP efforts to improve services for the Hispanic and Spanish-preferred individuals served, who comprise significant portion of the overall beneficiaries and particularly in the Oxnard and Santa Paula areas where 70% of Hispanic/Latinos reside. The MHP initiated this PIP in January 2015.

Historically, the MHP has had valid concerns about penetration rates and service access for Spanish-speaking individuals, particularly regarding those whose preferred language was Spanish.

To establish the PIP topic as a local issue, the MHP initially referenced a 2013 local survey that indicated 71% of Spanish-preferred consumers preferred a treatment plan in Spanish. The MHP noted that 80% also reported not receiving a Spanish language treatment plan. Additionally, the MHP reviewed literature on this topic, and found support to consider it a problem worthy of addressing with a PIP.

In seeking to identify data that might substantiate if a Spanish language treatment plan was effected, the MHP examined the units of service consumed by Spanish speakers versus others. The MHP reported there was a differential, but does not seem to have tracked and reported the units consumed by non-Spanish speakers throughout the course of the PIP. The reporting out should occur quarterly and not be limited solely to Spanish speakers, and reflect not simply units, but average unit consumption and also provide comparative data for non-Spanish speakers.

The selection of service utilization as the tracked metric to determine effectiveness of this intervention is questionable. Service utilization can be one variable that may reflect engagement and/or cultural relevance of services at a global level. However, the MHP has also experienced changes in its workforce, with greater numbers of bilingual clinicians working for the MHP now than at the PIP inception, and this was not controlled for in this PIP, aside from some brief occasional narrative comments. Other indicators could be stronger predictors of successful changes, such as comparisons of VCOS (the local outcome system) scores for those with versus without a Spanish language treatment plan.

Even in the presence of significant increases in utilization, the connection between the Spanish language treatment plan and utilization seems a bit nuanced, and does not take into consideration the other variables at play. Likely, more relevant indicators could be tracked with a targeted consumer survey containing specific questions related to the potential impacts of a Spanish treatment plan.

In the MHP’s initial submission of this PIP, the non-Hispanic data was provided for comparison; but this comparative data is not part of any quarterly updates provided during the course of the PIP. It should be noted that much of the narrative and process of this PIP is more akin to a PDSA (Plan Do Study Act) than a PIP.

It is important to note that PIPs must identify new interventions for each EQRO review cycle to be considered active. This PIP did not identify any new interventions since March 2015. Therefore, it must be considered an inactive PIP, even though data collection and quarterly reporting did continue through January 2017, with plans to summarize all data in June 2017. This PIP is scored for reference purposes only, and the below scores are not reflected in Table 4 of this report.

The MHP engaged in extensive work on the development and implementation of this project, including technical development.

The PIP was scored with the Validation Tool, but this information is not entered into Table 4 of this report. For this current review cycle, this PIP was considered completed, and a new Non-Clinical PIP topic is required.

## Performance Improvement Project Findings—Impact and Implications

* Access to Care
* The MHP’s Clinical PIP targeting smoking cessation improves access to services that impact physical health within an environment that has not historically provided this type of care.
* The MHP believes its Spanish language Non-Clinical PIP has improved service access and utilization to mental health services, and improved engagement.
* Timeliness of Services
* No timeliness issues identified by these PIPs.
* Quality of Care
* The provision of a treatment plan in one’s preferred language provides a higher quality of care to relevant consumers, by furnishing them with information related to the reasons and focus of their services in a manner that they can fully comprehend.
* Consumer Outcomes
* Linguistically appropriate treatment plans have the strong possibility of improving outcomes for these consumers, through improvement of participation in and understanding of treatment plan goals.
* Support for smoking cessation is linked to improved longevity and reduction of smoking related health issues, including hypertension and vascular disease, COPD and malignancies.

# 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 | PC | For this review, the MHP submitted a three=year Latino Equity, Strategic Plan spanning 201602019, spearheaded by the Office of Health Equity and Training. The plan is focused on Latino/Hispanic equity, and does not include LGBTQ nor African American issues. One month following the review, the MHP submitted a version of the Cultural Competence Plan that was in the update process. This update draft included efforts to reach a number of underserved populations including GLBTQ and African-Americans.The MHP’s changes in program deployment, including the South Oxnard Clinic expansion several years ago, telemedicine efforts initially focused on Spanish speaking services, and increased hires of bilingual/bicultural staff demonstrate the MHP’s efforts to improve services to this majority, minority population of eligibles. Despite these efforts, the MHP’s Hispanic penetration rates continue to be lower than would be expected. Hopefully, the efforts targeting improvements in services in this area will have a penetration rate impact in CY16 data. |
| 1B | Manages and adapts its capacity to meet beneficiary service needs | FC | The MHP has made significant changes to the range of services delivered. In the intensive services area, Crisis Residential Treatment was established; in the last few months, a second Mental Health Rehabilitation Center (MHRC) was created, a locked facility capable of serving those typically requiring out of county placements. A Laura’s Law Assisted Outpatient Treatment (AOT) program was launched as well. The MHP attempted to open a Crisis Stabilization Unit for adults, but the licensing requirements prohibited it. The MHP has opened a Crisis Stabilization Unit for children instead. In the place of Adult Crisis Stabilization unit, an Outpatient Psychiatric Observation Service (OPOS) has been created at the Ventura County Medical Center complex.The MHP reports that 67% of all services are office-based, with the balance field or phone delivered. With the MHP’s focus on severely ill adults and severely disturbed and at-risk children, perhaps continued evaluation of the location in which services are delivered merits study. The MHP made changes in the authorization of services for contract programs, now requiring direct referral by MHP representatives. While this change is a logical move with the utilization of high-level, structured 24-hour resources, the full utilization of capacity is important in retaining resources long-term. Telemedicine has improved services to Spanish speakers without interpreters. Crisis services have been enhanced by the merging of Children’s with Adult crisis response. Adult crisis residential has long existed in the MHP, provided under contract by Anka.  |
| 1C | Integration and/or collaboration with community based services to improve access | FC | The MHP collaborates with faith-based programs, and Child Welfare on the provision of Katie A. services, and is preparing for the Continuing Care Reform process. As a unit of the Health Service Agency, the MHP has a close connection with Public Health and AOD services.The MHP extensively collaborates with organizational providers such as Telecare, Anka, and others for full service partnerships and high intensity residential programs, as well as supported housing, such as The Casas, in Camarillo.Outside of Children and Family services, the collaborations utilized by the MHP tend towards increasing capacity and not initial access. |

*\*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 utilizes a 28-day standard for initial access to first offered assessment, and reports FY15-16 data of 12 days for Adults, and 14 days for Children’s Services. While the actual data results are timely, the standard is longer than typically seen in peer MHPs.  |
| 2B | Tracks and trends access data from initial contact to first psychiatric appointment | NC | The MHP has not established a standard or goal for the length of time from first request to first offered psychiatry appointment. The MHP does, however, does track two categories of initial psychiatry service access – expedited and routine. Expedited relates to higher acuity presentations and those coming from high intensity services such as inpatient or jail.The MHP’s average for expedited is 16 days for Adults, and 25 days for Children’s Services. The routine psychiatry access average is 38 days for Adults, and 67 days for Children’s.Tracking and improvement focus throughout the entire initial assessment and treatment process is evident in the run-charts of the MHP that track all service access for adults and children/youth. The MHP has a team that is focused on developing improvements, some of which relate to reducing the numbers of requests for service that are not followed-through for the assessment appointment. This may see changes in the interview process as well as other aspects. It is clearly too early in this process to determine what the full scope of changes are that will be tested in this process. However, the MHP certainly deserves acknowledgement for its efforts to approach timeliness in such a comprehensive manner. |
| 2C | Tracks and trends access data for timely appointments for urgent conditions | FC | The MHP established a three-day standard for urgent service access. The MHP’s average for FY15-16 reflects two days for Adult Services, and one day for Children’s Services. |
| 2D | Tracks and trends timely access to follow up appointments after hospitalization | PC | The MHP utilizes the 7-day HEDIS standard for post-hospital follow-up. The MHP reports FY15-16 data averages of 19 days for Adult Services, with a 4-day median. There is no data for Children’s Services.The MHP reports that it is not informed of children’s hospitalizations, nor are its crisis services routinely involved if the event occurs at an ED. The lack of information about hospitalization and subsequent follow-up that occurs with children is an important aspect of care which the MHP should endeavor to remedy. |
| 2E | Tracks and trends data on rehospitalizations | PC | As previously identified, the MHP cannot track rehospitalization of children, because there do not exist processes for the MHP to be involved in all such events. Within Adult Services, the MHP reported FY15-16 data of 1251 adult admissions, and 202 readmissions within 30 days, for a 16% readmission rate. |
| 2F | Tracks and trends no-shows | PC | The MHP has not established no-show standards for psychiatry/prescribers or licensed clinical staff.However, for FY15-16 the MHP reported actual psychiatry no-show rates of 9% for adults and 14% for children. Non-psychiatry clinicians experienced no-show rates of 15% for adults, and 11% for children.These no-show rates appear to be rather low when compared with peer MHPs, and might benefit from the creation of a standard or goal. |

*\*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 | NC | It is noteworthy that the MHP has engaged in an in-depth study of timeliness for adults and children that includes first contact, first offered appointment, actual assessment, first appointment at assigned clinic, and first appointment with assigned clinic psychiatrist. Analysis of each segment data is also part of the process. The use of the analytic tools incorporated in the Lean Six Sigma approach appear evident in this analysis, and show promise of providing the MHP with the information needed to make and monitor changes in access.As of this current EQRO review, February 22-24, 2017, the MHP did not have a current QI Work Plan for FY16-17, which should be in place shortly after the start of the new fiscal year. It is noted that the EQRO process provides latitude for the summary of the prior year and development of the current fiscal year plan -- customarily no more than two months after the start of the new fiscal year. The MHP did perform an evaluation of the FY15-16 QI Work Plan results, furnishing analysis of a number of measures, and proposing on-going actions for others. This analysis included summaries of the following areas: 0-5 Workgroup; Post-Hospitalization Workgroup; Full Service Partnership; Discharge Planning & Level of Care; Cognitive Behavioral Therapy; Compliance & Utilization Review, and Regulation Processes; Safe Prescribing; Equitable Access Latinos; Spanish Language Plan; and Foster Youth Psychotropic Medication Monitoring.The MHP’s emphasis on a structured evaluation and improvement process is reflected in the training and certification of four of its staff as Lean Six Sigma Green Belts. The MHP advised that it is planning program evaluation before program development occurs so that it is equipped to monitor when rollout occurs. The MHP utilizes its locally developed Ventura County Outcome Systems (VCOS), which is comprised of key elements of a number of instruments. The MHP is in the process of incorporating a clinician review of all cases coming up on the annual update period. Imbedded in this process is the use of VCOS outcome data. This procedure has not yet impacted the full served population, but is well under development.While the MHP has been involved in significant and time-consuming projects during this last year, there are quality areas which emerged during the course of this review that would likely benefit from close review. One area is the variability with which the MHP’s extensive crisis response is involved with crisis events within the county. It would appear that the MHP does not consistently have involvement with individuals who present in crisis to emergency rooms, and this may result in unnecessary hospitalizations when other alternatives might suffice. A similar issue results in the MHP being unaware of children’s hospitalizations, including Medi-Cal eligibles, and does not track these events nor rehospitalization of children and youth. Also, the combination of centralized functions of the STAR triage and assessment program and its interface with ongoing treatment teams may benefit from further study and optimization. Because of system design, STAR can become a staging area where consumers are temporarily – which can span days or weeks at times – served until resources develop at the regional clinic. When this occurs, the treatment of the consumer can be segmented and serial in nature, which is not the optimum care model. |
| 3B | Data are used to inform management and guide decisions  | FC | As mentioned in 3A, above, the MHP is engaged in the use of data throughout its operations. Work groups have been established as part of the QI process, each which focus on key data elements. Examples of the use of data include an extensive reporting out on “Katie A.,” Pathways to Wellbeing services, tracking initial contact, key events, and rescreen events, and other analysis.The study of the VCOS system, and tracking the intake/access process in a granular fashion, with plans to develop interventions to improve that process is very detailed and data driven. |
| 3C | Evidence of effective communication from MHP administration  | FC | The MHP has many different vehicles for communication with staff, contractors, and other stakeholders. The new leadership team is comprised of individuals from various setting, some with extensive local experience and others who have come to the department from other counties, bringing with them diverse experiences. The Director received compliments from staff for her personal presence at clinics and manner of presentation, which indicated to staff that she was open to feedback and wanted their input. In addition to specific team meetings that occur weekly, there are quarterly All-Staff division meetings. Leadership members in the new team are characterized as empathetic and knowledgeable.A few consumer participants reported accessing the website information – but this was not typical. Information flyers are posted at County offices and the Wellness Center. Information sharing with consumers was experienced strongest from participants drawn from the Ventura and Oxnard areas. |
| 3D | Evidence of stakeholder input and involvement in system planning and implementation  | FC | Line and other employees experience the current administration and leadership team to welcome input. Greater LGBTQ and other cultural/ethnic areas need more emphasis was also mentioned. There is awareness by many for the strong efforts of the department to improve access for Latinos. Consumers receive information and provide input through MHSA meetings, QIC, RISE, Client Advisory Council, and group supervision. Focus group participants from the Santa Clara Valley and East County did not experience much opportunity to provide input. |
| 3E | Evidence of strong collaborative partnerships with other agencies and community based services | FC | The MHP operates as a unified Behavioral Health organization, inclusive of Alcohol and Drug Services. Cognitive Behavioral Treatment is being piloted in used with AOD services.The MHP works with faith-based resources, such as the Guadalupe Church, Project Esperanza, and St. Paul’s Baptist Church.Improving access to care includes co-location with primary care. These co-locations include the Health Care Agency clinics in Fillmore, Oxnard, Santa Paula, Simi Valley, Thousand Oaks, and Ventura. In addition, there is co-location with Clinicas del Camino Real.The department is ramping up for participation in a large Whole Person Care implementation that is underway. |
| 3F | Evidence of a systematic clinical Continuum of Care | FC | The MHP has initiated an annual review process for all open cases that involves continues the process of reviewing the continuum of care. Some of the challenges that exist for step-down services is the lack of psychiatry services possessed by Beacon, the mild-to-moderate provide. An aspect of EHR enhancement includes a section for documenting that level of care and possible changes in services were discussed with consumers.The MHP is monitoring prescribing and medication related events, and the quality of psychiatry services has been reviewed by the recently established Sterling group psychiatry service. The quality review included input from peers and colleagues, and specific feedback was provided to the practitioners.  |
| 3G | Evidence of individualized, client-driven treatment and recovery | FC | Wellness and Recovery Action Plan (WRAP) training is provided to all of the consumer-employees, and consumers at the Wellness Center.While the MHP is clearly placing greater emphasis on the monitoring of consumer needs and provision of necessary levels of care, the system has yet to demonstrate this process working effectively as of yet. Hopefully, during the coming year, more results will come from the annual review process, consideration of outcome data and related efforts to assist those who are appropriate to move to lower levels of service. Consumers provide input and guidance on goal setting within the treatment plan, an aspect that was verified by consumer-family focus groups. |
| 3H | Evidence of consumer and family member employment in key roles throughout the system | FC | Consumer-employees are hired largely by contract providers, significantly Pacific Clinics and others who have such roles within their scope of work. Uniformly, the work of these individuals is appreciated and valued by other MHP and contractor staff. Parent partners are also hired to work within the Children and Family system.Opportunities for advancement relies upon the contracting organization provider. Some programs have advancement opportunities, and others do not. Session participants identified a Mental Health Associate County position that can be applied for when vacancies develop.The consumer-employees are involved in expanding roles, including working in concert with the RISE program and engaging hospitalized individuals in follow-up care, along with working to support outpatient clinic consumers in making appointments. |
| 3I | Consumer run and/or consumer driven programs exist to enhance wellness and recovery | FC | The MHP operates two Peer Support Specialist operated programs, one at the CenterPoint Mall in Oxnard, with a satellite in Ventura. The Wellness Center program is based on the nationwide movement to integrate Peer Staff into mental health services demonstrating the importance of self-help and peer programs as a part of mental wellness. Self-help is a valuable part of recovery from mental health and/or drug and alcohol recovery. People who have experienced both sides of the mental health system (“been there, done that”) provide hope, education and direct support among their peers. They can share goals, conquer fears, and celebrate successes. The TAY Tunnel is another Wellness Center/program, but is specifically designed for TAY. There is also a small satellite center called the Club House. |
| 3J | Measures clinical and/or functional outcomes of consumers served | FC | The MHP has established a local outcome tracking system, called Ventura County Outcome System (VCOS), comprised of elements of various established measures. During this last year, an item analysis was initiated, and from the information presented at this review, the MHP expressed confidence that findings are valid and they are capturing useful information. Staff have awareness for the coming process that includes review of outcome data when performing the annual reassessment and plan update. |
| 3K | Utilizes information from Consumer Satisfaction Surveys | FC | The MHP performs an analysis of the Consumer Perception Survey data, and does an analysis of Ventura County Outcome System satisfaction data that is published in the annual behavioral health data summary report as part of the quality indicators. There are plans to conduct focus groups with Spanish- and English-speaking consumers to assess satisfaction with services. The most recent data presented was from the November 2015 Consumer Perception Survey (CPS), and for the key element of language, 84% reported receiving services in their preferred language. |

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

## Key Components Findings—Impact and Implications

* Access to Care
* The submitted material regarding access presented a comprehensive Hispanic analysis of needs, capacity and actions to improve care for this population.
* Cultural competence efforts that address the needs of cultural, ethnic or linguistic issues of other cultures, such as GLBTQ, African-American population, were not available at the time of the review.
* The MHP has made continued, clear efforts to address the spectrum of service needs for its served population. Of particular note, have been the efforts to serve higher acuity individuals, through Crisis Stabilization Units, Crisis Residential programs, and Mental Health Rehabilitation Centers, of which the MHP now has two.
* Access and capacity is also being addressed by the MHP’s efforts to design a case review process that occurs regularly, and has clinician oversight to ensure that the proper level of care is being provided. This may result in optimal usage of capacity in time.
* Timeliness of Services
* The MHP continues to utilize a dated 28-day initial access standard; however, it is able to report actual averages which are 50% or less than the standard.
* The MHP continues to lack a specific psychiatry access timeliness standard. However, it does track and report psychiatry timeliness by two levels of need, expedited and routine.
* The MHP currently has a comprehensive analysis of the entire spectrum of access experience in process, from first contact through kept psychiatry appointment, and all steps in between. This study is resulting in the MHP considering all aspects of the access process, starting from the questions asked at the initial call. The MHP anticipates that this process will result in improvements in kept initial appointments, and decreased lost staff hours for no-shows.
* The MHP’s urgent service standard of three days, is longer than many of its peers.
* The MHP does not track hospitalizations nor readmission rates for children.
* Quality of Care
* The MHP has adopted Lean Six Sigma (LSS) practices and trained four of its staff to the Green Belt level.
* The MHP is applying these LSS practices to its study of timeliness and other activities within the MHP.
* As of this review, the MHP has not produced a QI Work Plan for FY16-17.
* The MHP was not able to submit currently active Clinical and Non-Clinical PIPs for this review cycle.
* Consumer Outcomes
* The MHP’s use of Peer Support Specialists has been increasing, and includes working with individuals who initially access care through an acute psychiatric admission.
* The Ventura County Outcomes System (VCOS) continues to be reviewed to assess if it is providing the type of information that is needed to effectively evaluate consumer progress.
* The Wellness Centers demonstrate strong consumer leadership and are significantly staffed by individuals with lived experience.
* During the review, the positive experience of Parent Partners was noted by a broad spectrum of participants.

# CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted three 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 three 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 initial focus group was to be comprised of 10-12 Spanish speaking parents/caregivers of children and youth in treatment, the majority of who initially accessed services within the last year. The focus group was conducted at the South Oxnard Clinic, 2500 South “C” Street, Oxnard, California.

Number of participants – 7

There was only one participant *who entered services within the past year*, and to preserve confidentiality, the responses are integrated with those of other focus group participants.

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

* Overall, the participants learned about the existence of mental health services from schools (teacher or school psychologist), pediatrician, or Interface, a Ventura County children’s and family service program.
* For a limited set of participants, lack of health care insurance was a potential barrier to access; this was resolved through the Ventura County Health Care Agency’s Access Coverage Enrollment (ACE) program, which provides services to those without health insurance.
* Regarding adequacy of services, all participants reported their child or children receive weekly sessions. Approximately half would like more frequent services. As to additional treatment modalities, over half have been offered group treatment. For some, work and family responsibilities get in the way of being about to take advantage of group/family therapy. A very small minority of participants reported not having been offered group treatment.
* None of the focus group participants reported receiving case management services. There were no comments made about unmet linkage needs.
* Psychiatry services were generally identified as occurring every one to two months. If prescriptions are changed, there is a follow-up phone session to identify medication response or side effect issues, and then a face to face in one or two months. In another case, the psychiatrist is seen every six weeks routinely, but more frequent visits can occur if needed.
* Outside of regular ongoing appointments, approximately half feel they can obtain additional support when needed. A small portion of participants felt additional services could only be obtained in an emergency.
* In the event of a crisis, these participants call either the front desk or the clinician. Callback varies; for some it is immediate, and for others it can take as much as three days.
* Continuity of care is viewed as a challenge for these caregivers. In one instance, there has been three clinician changes in the course of the last year. The effect is confusion for the children in treatment. The caregivers believe they should be notified in advance when these changes occur.
* After-hours emergencies are handled in various ways, report focus group participants. Some use techniques learned from the clinician. Everyone seemed aware that they should call 211 or 911 and request a CIT trained officer, or go to the hospital.
* The changes that occurred during the last year for these participants were generally positive, and specifically related to the help provided by the psychiatrist, and the TBS services received for their children. An exception was reported, with the loss of a clinician for months, and a TBS referral that has not been responded to for over a month.
* Where it applies to change of provider, a small segment did not know how they would go about making a change and another had done so successfully.
* Participants do identify transportation as an issue for them. Generally, the MHP is reported as not providing direct transportation for consumers and family members. Bus passes may be provided, but the MHP infrequently directly assists with transportation. Participants see this as a change in the last year.
* Regarding cultural and linguistic needs, some participants reporting receiving a Spanish interpreter for psychiatry services but have a Spanish-speaking clinician; others report both bilingual psychiatry and therapy are provided.
* Information about mental illness, the department, and other services comes chiefly from the treating clinician. Parents United is seen as an information resource for the 20% who have that contact. None of these participants use the MHP’s website.

Recommendations for improving care included the following:

* Faster responses to phone requests for assistance at clinics would be helpful.
* Youth transportation, to support field trip activities.
* Provision of more information about services in Spanish within the clinics.
* More notices and information via text and email to parents and caregivers.
* More field trips and activities within the community, and programs such as the YMCA. These activities could possibly be supported by a family advocate or case manager.

Interpreter used for focus group 1: [ ]  No [x]  Yes Language(s): Spanish

## Consumer/Family Member Focus Group 2

The second focus group of this review requested 10-12 culturally diverse adult consumers, the majority of whom initially accessed services within the last 12-15 months. This session was conducted at the Ventura Adult Clinic, located at 4258 Telegraph Road, Ventura, California.

Number of participants – 14

None of these focus group participants entered services within the past year, therefore initial access was not discussed.

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

* 71% of participants reported seeing a clinician for therapy on a regular basis; of those seeing a therapist, 40% have weekly contact, 20% monthly, and 30% every two months.
* The conversation about therapy included:

 “I actually had to ask to see someone (for therapy). One year ago, I was seeing a clinician who left and I was without a clinician for six months. I had to have a crisis to get reassigned.”

“I had my clinician leave. I had a crisis and regressed…We lost lots of groups, too, so things were difficult. I got a new doctor, too.”

“…The transition from Recovery Innovations to the new clinics did not go smoothly. There has been a large reduction in groups. (This individual was unaware of the Wellness Center.)”

* Of these consumers, 71% receive psychiatry services. The frequency of services varied widely across this group, but all were satisfied with the frequency; yet most would like to be seen more frequently.
* The group modalities experienced by these participants include: WRAP, COD, Anxiety, LET group, ART, Seeking Safety, LGBTQ, and Medication. Those served in the Santa Clara Valley report there are no support groups to attend.
* Only 14% of these focus group participants were aware of the Wellness Center. A very small component used web-based information provided by the MHP.
* A case manager provides support to 79% of these consumers; one was not sure if s/he had a case manager.
* Understanding how to proceed when one needs additional care varies greatly among these participants. Some understand the range of options, and cite: 211, 911, clinic front desk, clinician, STAR team, and others just go to the clinic. One person reported having a loved one attempt suicide recently, and did not know who to call. One individual reported going to the Simi clinic about a suicidal daughter and was informed that she was not eligible for services until she had been sober for one year.
* Wait time for crisis services varied according to circumstances and portal of access. Crisis team services occur reportedly within two hours. The Officer of the Day will try to help if one calls the clinic directly. Others reported that a call to the STAR team resulted in an immediate response.
* Reports regarding response of law enforcement typically included experiences with ambulances and hospitals. When comments were limited strictly to law enforcement contact, being ignored by the police was reported. Requests for help that resulted in ambulance response for an “anxiety attack,” resulted in the individual feeling treated dismissively.
* Experience with the Hillmont adult inpatient unit was generally not described in positive terms. Some felt lack of respect, some believed denial of food and medications had occurred, with the experience characterized as “like punishment.”
* Generally, the experiences with acute care and the process of hospitalization were not described in positive terms. Feedback varied from participants, citing receiving feedback that they are not “sick enough,” and complaints about poor inpatient procedures that have resulted in untoward events.
* All focus group participants experienced involvement in the development of their plan of care and identifying treatment goals. Nearly 50% have been provided with WRAP training. They participated in the updating of their treatment goals at least annually. They believe their goals can be changed on their request.
* Perceived changes in the MHP over the last year included: Addition of an LGBTQ group in Oxnard, and a psychiatry shortage, with one consumer changing doctors three times in one year; 29% of all participants experienced a change of psychiatrist. Clinician turnover occurred for 43% of focus group members.
* The Turning Point Wellness Center provided a well-liked dual diagnosis group, and also goes out to apartment buildings of some participants to provide groups. Overall, participants felt that more marketing of the wellness center needs to occur.
* These participants have a different view of transportation. These individuals report options such as a Roadrunner shuttle, dial-a-ride, and in Camarillo, there is “CAT.” One participant receives only a one-way pass home from appointments. However, it can take six hours of travel time to make a one-hour appointment.
* Some participants reported the support of recovery coaches and employment support.
* Information about changes within the county come from Board Meetings, mental health workers, peers, and clinicians. None were aware of any newsletters.
* Feedback to the MHP is obtained via surveys, various committee meetings, NAMI, Peer-to-Peer training, and the NAMI Walk. Communication about services is variable, with some consumers uninformed about therapists’ vacations. This results in the consumers coming in for appointments only to learn the clinician is away.

Recommendations for improving care included the following:

* Provide monthly bus passes, not individual trip passes.
* Improve communication about services, and clinician vacations/schedule changes.
* Peer navigators.
* Post lists of available groups in prominent locations.
* Improve psychiatrist timeliness – late as much as an hour.
* Increase stigma reduction work.

Interpreter used for focus group 1: [x]  No [ ]  Yes

## Consumer/Family Member Focus Group 3

The third focus group requested was 10-12 ethnically diverse caregivers of children and youth in treatment, the majority initially accessing services within the last 12-15 months. This session was conducted at the Santa Paula Children’s Clinic, 725 East Main Street, Santa Paula, California.

Number of participants – 5

For the 4 participants *who entered services within the past year*, they described their experience as the following:

* Initial access took between two weeks to six months, with an average of two months. From assessment to first clinical appointment took a similar period of time.
* The overall experience with initial access was considered smooth and positive.

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

* Information about services came from the school system, or from a social worker.
* The only initial access barrier noted was related to social services, but the participants also noted that mental health representatives were strong advocates.
* Experience with group or family therapy was variable, with most receiving informal family work.
* Psychiatry services are utilized by only one participant in this focus group.
* Provision of case management services varies widely among these participants. For some, this is by mainly by telephone; for others it may be meeting with foster family agency staff weekly; others have a family meeting weekly with a therapist.
* Other support groups are available, with three utilizing NAMI groups, and others a Foster Parent’s Association.
* These parents and caregivers report no difficulty obtaining additional services between routine appointments. Some are able to email the case manager or clinician, others are aware of vacation times and backup resources. All have a number to call.
* When a crisis occurs, these participants know to call the “new” children’s crisis team. They respond to calls right away, and have been very helpful with 5150 hospitalizations.
* The experience with law enforcement is variable in quality and helpfulness. Some officers seem trained and helpful, while others were not perceived as helpful. Among participants, they have encountered law enforcement response at least thirty times.
* As to the success of the services, several reported their children successfully completing treatment and have moved on to college; another has completed an industrial certificate. Others have received assistance so that their children have learned independent living skills and can drive.
* Information about services and events occurring in mental health are discovered on the website, in a “yellow book” published by the schools. Other participants learn about services “by accident,” with some flyers noted occasionally. Some learned of services through the IEP, but felt these resources were only offered when continual caregiver insistence occurred.
* With regard to providing input into services, most feel their experiences have been positive, and they frequently receive requests to participate in surveys. A minority have not received any surveys.

Recommendations for improving care included the following:

* There is a need for locked youth facilities for high need youth. Otherwise children and youth fail into the foster care system. Casa Pacifica was identified as such a resource that is not as available any longer.
* Approaching VCBH directly is seen as the most effective strategy for services, in that the school-based IEP process is experienced as gate-keeping, producing barriers, and is not helpful.
* Provide more parent groups, and training for parents to help their children.
* Ensure that law enforcement officers receive yearly CIT training.

Interpreter used for focus group 3: [x]  No [ ]  Yes

## Consumer/Family Member Focus Group Findings—Implications

* Access to Care
* A common theme was the inability to stay with a therapist or psychiatrist, with some experiencing many changes of providers over relatively brief periods of time.
* Some consumers report losing a clinician, and then being unable to be reassigned until a crisis event occurred. Some consumers also reported changes that resulted in the loss of group therapy.
* One theme that emerged related to access was that of transportation. Consumers would like to receive a monthly bus pass, instead of being required to get a separate unique one with each appointment.
* More supportive parent groups were recommended by participants.
* Some parents/caregivers believe that there exists a need for longer term locked facilities for some children/youth who may be too challenging to keep at home. The supports are not adequate.
* Timeliness of Services
* Only five participants, across three focus groups, initiated services in the past year. Of these, the time to initial access varied widely, from two weeks to six months, the latter an outlier with complicating circumstances.
* There was no reporting out of timeliness of access to initial psychiatry appointments from these participants.
* Some timeliness related issues did emerge: Referrals between programs, wherein the receiving program may determine the consumer does not qualify, can complicate and greatly extend time to treatment.
* Quality of Care
* Consumers would appreciate process that informs them in advance when clinicians are out on vacation or an appointment is cancelled. If a psychiatrist has been reassigned or has left the MHP, also inform the consumer in advance of the appointment. To this end, the use of email and text messaging was thought to be a useful way for the MHP to communicate with consumers.
* Participants experienced psychiatrists as often running late for appointments, by as much as an hour.
* Consumers are not certain that all law enforcement officers receive yearly CIT training, which they believe that should occur.
* Post more information about additional groups and services for parents/caregivers.
* Consumer Outcomes
* Consumers recommend greater use of system navigators, to help locating and advocating with resources.

#

# 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 | 62.81% |
| Contract providers | 37.09% |
| Network providers | 0.10% |
| Total | 100% |

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

|  |
| --- |
| 5% |

* 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 [x]  No

|  |
| --- |
| MHP plans to begin Netsmart Client Portal (myHealthPointe) implementation in late 2017. |

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

 [x]  Yes [ ]  In Testing/Pilot Phase [ ]  No

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

|  |
| --- |
| 6 |

* Direct services through telepsychiatry practitioners are available in the following languages (does not include the use of additional translators): English and Spanish.
* Stakeholders providing input during this review expressed enthusiasm for the successes achieved to date. The MHP is looking to further recruit telepsychiatrists to expand its specialty needs particularly in the area of linguistic competence.
* MHP self-reported technology staff changes since the previous CalEQRO review (FTE):

|  |
| --- |
| 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 |
| 3 | 0 | 0 | 0 |

* MHP self-reported data analytical staff changes since the previous CalEQRO review (FTE):

|  |
| --- |
| 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 |
| 4 | 0 | 0 | 1 |

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

* The MHP is in an expansion phase with its telepsychiatry project. Psychiatrists connected with the project appear enthused and are actively investigating recruitment possibilities for new telepsychiatrists nationwide.
* The MHP notes that current data analytical staff are primarily focused on Fiscal analysis and the expansion to CQI has not occurred systemically.
* A number of the MHP’s efforts during the past year, such as a comprehensive capacity analysis, were hampered by the lack of sufficient data analytics staff.

## Current Operations

* The MHP continues to have a minimal IS staff presence to support ongoing operations and training needs and begin implementation of the MHP’s new analytics tool.
* The MHP continues to use and enhance its EHR, Avatar. This suite of tools continues to support about 619 internal users and provides practice management access to about 45 organizational provider administrative staff to facilitate billing.
* The IS staff are currently exploring additional resources such as Avatar Consoles and Scriptlink to enhance the utility and ease of use of the toolset during practical clinical workflow.

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 |
| myAvatar/CalPM | Practice Management | Netsmart | 7 | Netsmart Hosted |
| myAvatar/CWS | Clinical Record | Netsmart | 3 | Netsmart Hosted |
| myAvatar/OrderConnect | eRx | Netsmart | 3 | Netsmart Hosted |
| myAvatar/Data Warehouse | Data Warehouse | Netsmart | 1.75 | Netsmart Hosted |
| Kofax Insight | Data Analytics | Kofax/Western Integrated Systems | 1.5 | VCBH IT |

## Plans for Information Systems Change

* The MHP has no plans to replace its current EHR, the Avatar Suite of tools hosted in ASP mode by Netsmart Technologies.
* The MHP is currently exploring the addition of Avatar interoperability toolsets such as ConnectCare to begin the steps to full Health Information Exchange (HIE) with its service partners.

## 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 |  | x |  |  |  |
| Electronic signature—consumer |  | x |  |  |  |
| Laboratory results (eLab) |  |  | x |  |  |
| Level of Care/Level of Service |  |  |  | x |  |
| Outcomes |  | x |  |  |  |
| Prescriptions (eRx) |  | x |  |  |  |
| Progress notes |  | x |  |  |  |
| Treatment plans |  | x |  |  |  |
| Summary Totals for EHR Functionality | 7 | 1 | 2 | 0 |

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

* The MHP has recently implemented the Perceptive document imaging product and is in the process of fine tuning its implementation and protocols. It expects this to be an intermediate methodology for documentation storage between organizational providers and the MHP.
* While the MHP has some outcome tools embedded in Avatar, it has yet to craft workflows that capture outcomes tool data as a part of the normal clinical protocol in a system wide manner.
* The MHP continues to amass a wealth of eRx data that is not being used for medication monitoring surveillance or national quality measure analysis.
* The MHP is partially through the implementation process that will embed eLabs in the medical workflow and remove the current standalone database. This process should facilitate the MHP’s transition to fuller utilization of telepsychiatry for specialty clinical care.
* Consumer’s Chart of Record for county-operated programs (self-reported by MHP):

[ ]  Paper [x]  Electronic [ ]  Combination

## Major Changes Since Last Year

* Implementation of Data Analytic Package
* CalWORKs Staff Engagement Tracking Implementation
* Netsmart Avatar Multi-Year Contract Negotiation
* Program Consolidation Implementation
* Analysis of Interoperability Service Options

## Priorities for the Coming Year

* Implement Document Scanning Module
* Development of Interoperability Services Plan
* Implementation of Scheduling Module
* Implementation of Lab Orders & Results
* Implementation of Client Portal Module

## Other Significant Issues

* The MHP’s IS staff have clearly accepted the charge to implement practical Health Information Exchange (HIE). Staff provided a whitepaper detailing the scope of an initial set of interoperability projects for the MHP which was very practical and manageable. It is unclear if the MHP currently has enough staffing to reasonably manage this constellation of intertwined projects in a reasonable timeframe given the existing projects already in the queue. The Executive team may also be overly cautious in its pacing of new project rollout. Properly staged, this set of projects could spread out impacts to a variety of components that make up the system of care without unduly stressing it as a whole.
* While the MHP is crafting its HIE project the system of care still needs to reasonably function. Interim functionality such as service uploads for larger service providers and read-only access for a larger group of end users might be a logical stepping stone to true interoperability. Both steps are technologically well understood and would not pose a large technical burden on the MHP.
* The MHP began the initial exploration of its new data analytics tool, Kofax Insight, this year and provided a practical demonstration of the potential of this innovation. The demonstration showed a basic service flow analysis which is foundational to many potential practical tools that could be used at multiple levels within the system of care. It is unclear, however, if the MHP has enough data analytics staff to provide a rich set of these dashboards in a reasonable timeframe. Data analytics staffing, once trained, could potentially be of benefit to the MHP, the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver initiative and eventually the Healthcare agency at large.
* The MHP began the functional analysis of its Ventura County Outcomes System (VCOS) to ensure functionality. Initial analyses appear to support the accuracy and efficacy of the individual measures. The MHP has not, however, taken the step to begin the regular and systemic use of this data set for secondary purposes such as program effectiveness. This is due, in large part, to the lack of sufficient data analytics staff. Current use of this data for right-sizing service is limited to manual examination of the measures on a case by case basis by clinical oversight rather than broadly identified trend reports.
* The MHP does not yet seem to have investigated changes in workflow to ease the burden of EHR adoption. Projects like Collaborative Documentation have nationally been shown to increase consumer engagement and integrate electronic documentation more fully into the therapeutic process to enhance outcomes.

## medi-cal Claims processing

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

|  |  |  |  |
| --- | --- | --- | --- |
|[ ]  Monthly |[ ]  More than 1x month |[ ]  Weekly |[x]  More than 1x weekly |

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

|  |  |
| --- | --- |
|[x]  Yes |[ ]  No |

If yes, product or application:

|  |
| --- |
| ADRS, Automated Data Retrieval System in combination with excel reports. |

* Method used to submit Medicare Part B claims:

[x]  Clearinghouse [ ]  Electronic [ ]  Paper



* The MHP continues to experience higher than average denials of its SD/MC claims. Staff shared analyses with the EQR team that demonstrated their understanding of the issues and the changing nature of these issues over the course of the past year. IS management may wish to allocate resources sooner to its already planned Scriptlink implementation to strengthen business rule edits. Management may also wish to explore commercial claims reconciliation products to support the Billing team’s hard work.

## Information Systems Review Findings—Implications

* Access to Care
* The MHP continues to struggle with having a unified clinical record for its entire system of care. Service providers, except in some targeted cases like the new CSU, do not have regular bi-directional access to the MHP’s EHR for up to date clinical information.
* The MHP’s capacity analysis was only partially accomplished due to the lack of sufficient data analytics staff to perform the necessary investigations into program capacity and current performance.
* Timeliness of Services
* The MHP is becoming familiar with the potential benefits of telepsychiatry. Rational steps to expand its use are being embraced by medical staff who see the advantage of specialty service provision such as linguistically competent psychiatry.
* The MHP continues to lag in the production and use of regular and consistent timeliness analyses. This may be, in part, due to the lack of sufficient clinical data analytics staff. The MHP also continues to lack reasonable timeliness standards across all the dimensions it examines.
* Quality of Care
* The MHP is in the process of implementing its new data analytics software to produce regular real-time dashboards. The current dashboards are appropriately focused on establishing a window into the system of care’s service flows. Attention will need to be given to producing as much longitudinal perspective as possible before predictive analysis begins.
* The MHP continues to experience a changing set of challenges in its Billing function which reduces available revenue to program. It may be time for the MHP to explore additional contemporary tools to bolster its Billing team.
* Consumer Outcomes
* The MHP continues to lack the means to perform regular and consistent evaluation of its Ventura County Outcomes System (VCOS) data. Secondary analysis of this data is currently hampered by the lack of adequate Clinical Data Analytics staffing.

# Site Review Process Barriers

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

* In spite of CalEQRO requesting that recruitment of consumer/family members for focus groups emphasize those who started services within the prior year, few participants were new to services. As well, the overall number of participants fell short of targets. This limits the extent to which consumers’ perspectives can be derived from the review.
* For the second consecutive year, the MHP did not supply the current Cultural Competence Plan with other requested submissions before the review.

#

# 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 has continued its efforts to improve services for the Latino/Hispanic and non-English speaking populations with its emphasis upon the hiring of bilingual/bicultural staff, community outreach, siting of clinics, a Spanish language treatment plan, and telemedicine.
* The MHP has merged children’s crisis response with the directly operated adult crisis services, brought aboard a supervisor who had relevant children’s crisis experience, and is receiving positive responses from family members for this change.
* The MHP’s telepsychiatry implementation has made it more likely that Spanish speaking consumers direct receive services in their preferred language at two geographically separate clinics that predominantly serve Spanish speakers.
* Opportunities:
* The material provided for this review was limited in scope with regard to cultural competency, having a sole focus upon Hispanic/Latino populations, and omitted the efforts to engage and serve African American, LGBTQ, and other special populations. A comprehensive Cultural Competence Plan was not submitted in advance of the review as requested.
* The MHP continues without having a unified clinical record among its entire system of care. Efforts to provide bi-directional interoperability or at the least ubiquitous read only access and service uploads should be expedited to facilitate access and care coordination.
* The MHP should facilitate hiring enough clinical data analytics staff to perform necessary investigations into caseload and capacity analysis efforts.
* The use of telepsychiatry to meet the linguistic needs of Spanish speakers is the first element of telepsychiatry implementation. The MHP can also use it to redistribute resources in the presence of vacancies, illness and vacation. Greater use of this technologic medium can result in quicker initial access and continuity of care.
* While diversion of youth and family consumers is reportedly at 71% level of crisis events, the MHP would be well-advised to undertake the tracking of youth and family consumers admitted to acute psychiatric inpatient units and the aftercare received following discharge.

### Timeliness of Services

* Strengths:
* The MHP’s efforts to study the entire initial access process, from first contact, to first psychiatry service, has the potential of furnishing developments that improve overall timeliness as well as optimize utilization of available clinical hours.
* Opportunities:
* The MHP continues to lag in the production and use of regular and consistent timeliness analyses. This may be, in part, due to the lack of sufficient clinical data analytics staff. The MHP also continues to lack reasonable timeliness standards across all the dimensions it examines.
* The MHP’s access process has numerous elements, such as Access/STAR, RISE, and regional clinics that can segment and complicate the experience of consumers due to the linkages and handoff process that must occur. This area deserves more study and consideration of streamlined processes.

### Quality of Care

* Strengths:
* The MHP is currently focusing attention on its new data analytics software to produce regular, real-time dashboards. The current dashboards are appropriately focusing on service flow analysis to provide an accurate picture of the system of care.
* The MHP is taking definitive steps to provide a new vantage point on service delivery, utilizing new approaches to address ongoing service delivery problem areas. These innovations have yet to produce tangible results, but show potential for impacting care.
* Opportunities:
* Neither of the PIPs submitted could be considered active. The Smoking Cessation Clinical PIP shows promise but did not have active consumer interventions. The Spanish Language Treatment Plan Non-Clinical PIP, a multi-year effort, lacked new interventions for this last year.
* The MHP continues to experience a changing set of challenges in its Billing function which reduces available revenue to program. It may be time for the MHP to explore additional contemporary tools to bolster its Billing team.
* The MHP should consider examining discharge flows through the system of care to ensure that consumers are appropriately graduating to lower levels of care where appropriate.

### Consumer Outcomes

* Strengths:
* The MHP continues to selectively utilize the GAD-7 and PHQ-9, Basis-24 and Hopefulness, along with MHSA required instruments to determine outcomes.
* The MHP created training for staff to utilize VCOS information in the treatment planning process.
* The MHP’s internal sub-item analysis of VCOS items has thus far validated their selection to the MHP.
* Opportunities:
* The MHP continues to lack the means to perform regular and consistent evaluation of its Ventura County Outcomes System (VCOS) data. Secondary analysis of this data is currently hampered by the lack of adequate clinical data analytics staffing.
* The MHP should consider implementing a pilot program to test the principles and efficacy of Collaborative Documentation workflows within the system of care to provide for enhanced consumer engagement and outcomes.

## Recommendations

* It is essential that the MHP develop a process that ensures there are two active PIPs, one Clinical and one Non-Clinical PIP.
* The MHP needs to develop a tracking system for children and youth who receive an acute psychiatric admission and the related follow-up activities subsequent to discharge.
* The MHP needs to develop a formal Quality Improvement (QI) Work Plan for the FY16-17 period; and, subsequently evaluate results of and develop a QI Work Plan within two months of the start of the next fiscal year.
* The MHP needs to study and evaluate the impact that the segmented system process involving Access, STAR, RISE and subsequent clinic services have upon consumer access timeliness through the use of data and focus groups.
* The MHP should continue working on an integrated caseload and capacity analysis that monitors both active and inactive cases and provides predictive information to the executive team for program formation. With sufficient staffing, this project could become a real-time dashboard in the MHP’s Kofax Analytics tool.
* The MHP should move forward with its interoperability project in an expeditious manner to alleviate many of the barriers to integrated care management that currently exist between directly operated and contract provider services.

# 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 - Ventura MHP |
| Opening Session – Changes in the past year; current initiatives; and status of previous year’s recommendations  |
| Use of Data to Support Program Operations  |
| Disparities and Performance Measures/ Timeliness Performance Measures |
| Quality Improvement and Outcomes |
| Performance Improvement Projects |
| Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Consumer Employee Group Interview – Line staff |
| Consumer Family Member Focus Group(s): Spanish speaker Parents/Caregivers; Adult Consumer Focus Group; Parent/Caregiver Focus Group |
| Prescriber Session: Psychiatry, NP, Med Management, Telemedicine and Quality |
| Contract Provider Group Interview –Quality Management & Administration and Operations |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) |
| ISCA/Billing/Fiscal |
| EHR Deployment  |
| Wellness Center Site Visit |
| Contract Provider Site Visit  |
| Site Visit to Innovative Clinical Programs: Seneca Children’s Crisis Stabilization Unit; Anka Adult Crisis Residential Program; Telecare Camarillo Locked Mental Health Rehabilitation Center (MHRC) |
| Crisis, RISE, STAR, Inpatient liaison staff session |

Attachment B—Review Participants

CalEQRO Reviewers

Rob Walton, RN, MPA, Quality Reviewer

Ewurama Shaw-Taylor, Ph.D., Quality Reviewer

Duane Henderson, Information Systems Review

Marilyn Hillerman, 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

Ventura County Behavioral Health

1911 Williams Drive

Oxnard, California, 93036

Ventura County Behavioral Health

South Oxnard Clinic, 2500 South “C” Street, Oxnard CA 93003

Ventura County Behavioral Health

Ventura Adult Clinic, 4258 Telegraph Road, Ventura, CA 93003

Ventura County Behavioral Health Children’s Clinic

725 East Main Street, Santa Paula, CA 93060

CONTRACT PROVIDER SITES

Seneca Children’s Crisis Stabilization Unit

2130 North Ventura Blvd., Oxnard, CA 93036

Turning Point Foundation Wellness Center

2697 Saviors Road, Oxnard, CA 93003

Anka Adult Crisis Residential Program

3291 Loma Vista Road, Ventura CA 93003

Telecare Corporation Horizon View MHRC

333 Skyway Drive, Camarillo CA 93010

Participants Representing the MHP

| **Name** | **Position** | **Agency** |
| --- | --- | --- |
|  |
| Abarca, Emilio  | Program Administrator II | VCBH-Quality Improvement |
| Aguila, Gabriela | Clinic Administrator | VCBH |
| Ashur, Ophra  | Clinic Administrator | VCBH |
| Avila, Ruby | BH Clinician | VCBH |
| Baker-Wilkinson, Tyler | Assistant Director- Ventura Crisis Stabilization Unit |  Seneca |
| Barrientos, Sandra | Senior Psychologist | VCBH |
| Barrios, Carlos | Psychiatrist | VCBH |
| Barron, Clara | Program Administrator | VCBH |
| Berendt, Larry  | Administrator- Casa De Esperanza | Telecare Corporation |
| Boscarelli, Robin | Clinic Administrator | VCBH |
| Bradley, Victoria  | Clinic Administrator | VCBH |
| Burau, Mary | Clinic Administrator | VCBH |
| Burns, Shana | Administrator- Vista/VOICE/Assist | Telecare Corporation |
| Castro, Chris | BH Clinician | VCBH |
| Crandall, Elaine  | Director | VCBH |
| Crikelair, Brianna  | Clinic Administrator III | VCBH-Ventura Adults |
| Cross, Carla  | BH Manager | VCBH |
| Cummings, Crystal | Clinical Program Director |  Kids and Families Together |
| Damerjian, Vania | BH Clinician | VCBH |
| Donovan, Liesa  | Fiscal Manager | VCBH |
| Dougherty, Jennifer | Behavioral Health Manager | VCBH |
| Duenas, Alicia | Administrative Assistant III | VCBH |
| Eastburn, Crystal | Contractor | Telecare Corporation |
| Egan, Narci | Assistant Chief Financial Officer | VCBH |
| Elhard, Erick | Clinic Administrator | VCBH- Crisis Team |
| Ellis, Carly | Behavioral Health Clinician | VCBH |
| Farhat, Linda  | Program Manager | PathPoint |
| Fekete, Doreen | Program Administrator | VCBH |
| Flores, Raudel | Behavioral Health Clinician | VCBH  |
| Fox, Cheryl  | Behavioral Health Manager | VCBH |
| Friedlander, Faith | Clinical Vice-President | Kids and Families Together |
| Garmin, Kari | QI Administrative Specialist |  VC- HSA |
| Gil, Johnson  | Agency Director | HCA |
| Glantz, Julie  | Behavioral Health Manager | VCBH- STAR/RISE/CRISIS |
| Godtel, Beau | TBS/IHBS Program Manager | Casa Pacifica  |
| Gonzalez, Patricia | Research Psychologist | VCBH |
| Gooden, Toni | Behavioral Health Clinician | VCBH |
| Gross, Bob  | Clinic Administrator | VCBH |
| Hartman, Josh | Administrator- Horizon View MHRC |  Telecare Corporation |
| Hernandez, Maria A  | Manager Policy and Procedures | VCBH |
| Johnson, Heather L | Clinic Administrator | VCBH-CalWorks |
| Johnson, Sevet  | Behavioral Health Manager | VCBH |
| Johnson, Heather | Community Services Coordinator |  VCBH |
| Khan, Traci  | Clinic Administrator | VCBH-Adults |
| Kindschi, Dahlia | Program Manager |  Aspiranet Behavioral Health  |
| Kravets, Cynthia | Behavioral Health Clinician | VCBH |
| Kwock, Lennie  | Clinic Administrator | VCBH |
| Leafman, Meredyth  | Behavioral Health Manager | VCBH |
| Lee, Jason | Behavioral Health Clinician | VCBH |
| Lepore, Joshua | Assistant Director Transitional Youth Services | Casa Pacifica  |
| Litel, Lori | Executive Director | United Parents  |
| Lopez, Gabriela  | Clinic Administrator | Ventura Youth & Family |
| Maki, Aliya | TBS/IHBS Manager | Aspiranet Behavioral Health |
| Manzo, Salvador  | Behavioral Health Manager | VCBH |
| Marquez, Grissel | Behavioral Health Clinician | VCBH |
| Martinez, Yvonne | Behavioral Health Clinician | VCBH |
| Matisek, Kalie  | Program Manager | Turning Point Foundation |
| McCloud, Rebecca  | Clinic Administrator III | VCBH |
| McDonald, Tina | Clinic Administrator | VCBH |
| Miles, Martie | District Director | Aspiranet Behavioral Health |
| Miranda, Cristina  | Youth Policy Advocate and Special Projects Liaison |  Casa Pacifica |
| Nagle, Laura | Clinic Administrator | VCBH |
| Olivas, Dina | Behavioral Health Manager | VCBH |
| Peterson, Brittany | Behavioral Health Clinician | VCBH |
| Powers, Larry  | OSC-IV | HCA |
| Pringle, Pete  | Youth Division Chief | VCBH |
| Putt, Jennifer  | Clinic Administrator | VCBH-STAR |
| Ranawaka, Nadeera | Financial Analyst | VCBH-Fiscal |
| Riddle, Angela  | Behavioral Health Manager | VCBH |
| Roberts, Julie | Clinic Administrator | VCBH |
| Rojas, Michelle E.  | Program Administrator | VCBH |
| Roman, Dave | Information Systems Manager | VCBH-Admin |
| Sahota, Kiran  | MHSA Manager | VCBH |
| Sallee, Andrea  | Regional Director | Anka |
| Sanchez, Sara | Clinic Administrator - Transitions | VCBH |
| Schipper, John  | Adult Division Chief | VCBH |
| Schreiner, Peter | Clinic Administrator | VCBH |
| Seal, Maryza  | Behavioral Health Manager | VCBH-Contracts |
| Shimell, Dan | Center Director- Hillmont House MHRC | Anka Corporation |
| Skaggs, Felicia | Clinic Administrator | VCBH |
| Springer, Nancy | Behavioral Health Clinician | VCBH |
| Taylor, Brian  | Medical Director | VCBH |
| Taylor, Lauren | Behavioral Health Clinician | VCBH |
| Thurber, Deborah  | Medical Director | VCBH |
| Torres, Monica  | Clinic Administrator | VCBH-CWS |
| Torres, Cynthia | Clinical Director | New Dawn Counseling and Consulting, Inc. |
| Tovar, Luis  | Ethnic Services Manager | VCBH Admin |
| Tran, Anh  | Administrative Assistant | VCBH |
| Ummer, Faizal  | Program Administrator | VCBH |
| Vessels, Joelle | Director Youth and Mental Health Services | Interface |
| White, Michael | Clinic Administrator | VCBH |
| Yanez, Terri | Division Manager | VCBH |
| Yazujian, Rachel  | Clinic Administrator: Simi-Y&F | VCBH |
| Yoshida, Patti | QM Manager- Pharmacist | VCBH |
| Zanolini, Shanna  | Senior Psychologist | VCBH |
| Zarate, Patrick  | Chief Executive Officer | HCA-VCBH |
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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 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.



Attachment D—PIP Validation Tool

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

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| **GENERAL INFORMATION** |
| **MHP**: Ventura County Behavioral Health (VCBH)  |
| **PIP Title**: Integrating Smoking Cessation Programs Into a Behavioral Health System |
| **Start Date** (MM/DD/YY): June 2016**Completion Date** (MM/DD/YY): N/A**Projected Study Period** (0of Months): N/A**Completed**: Yes [ ]  No [ ] **Date(s) of On-Site Review** (MM/DD/YY): 3/22-24/17**Name of Reviewer**: Rob Walton, RN, MPA | **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.** |
| [x]  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 Ventura County Behavioral Health (VCBH) MHP selected smoking cessation due to the literature on smoking, premature loss of life associated with smoking consequences, and data from a pilot survey which confirmed their initial concerns, with documented efforts dating back to June 2016. The Medical Director of Adult and ADP Services, Brian Taylor, MD, was identified as project leader of this effort. The focus upon physical health issues by MHPs continues to emerge as a trend when one looks at health integration and efforts of mental health service delivery to attend to health matters such as hypertension and other physical health issues – of which smoking has a negative impact upon the health and longevity of MHP consumers. In fact, smoking related illness is the number one cause of death in people with mental illness or addiction. The initial validation survey of consumers involved 95 individuals interviewed at all adult clinic sites. The results indicated that 46% were smokers, and 72% of the smokers expressed an interest in quitting; 94% indicated prior cessation attempts that had failed. Following local confirmation that there existed a problem with smoking and tobacco use among its served population, the MHP also considered other literature some of which was specific to treatment interventions and application of smoking cessation to the mentally ill and addicted populations.The MHP identified indicators for tracking the results of this PIP, spanning from data from screening of consumers, referral to the “Call It Quits” program, the use of pharmacotherapy support, and tracking over time the data on those who remain fee of tobacco; the MHP also is tracking the data on the staff trained in Basic Tobacco Intervention Skills, a certification program. The MHP identified four interventions, as well, the majority of which are training and tracking changes, particularly relevant are those that support the tracking process. As of this review, February 22-24, 2017, the MHP was unable to report baseline data for any of its indicators and had not yet implemented any of the described interventions. The PIP does show the promise of improving the health of the MHPs consumers as related to tobacco use and tobacco-related illnesses. At this time, however, absent baseline data and active interventions, this PIP is considered “Concept Only,” and is rated in this validation tool for the purpose of providing feedback to the MHP. |

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| **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? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Random sample of MHP adult consumers surveyed to determine if they use tobacco and would have interest in smoking cessation assistance. The MHP also surveyed MHP consumers who have reported current or previous tobacco use. The MHP also involved clinics staff and Ventura County Public Health subject matter experts. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP reviewed morbidity data related to mental illness and smoking, as well as considered the survey and self-report data obtained. From the sample survey, 46% self-identified as smokers; 73% expressed a desire to stop smoking. In contrast with the MHP’s findings, in 2014, only 9.4% of Californian’s consumed tobacco products, mainly smoking. The sample survey seems to confirm the existence of smoking as a health threat for its served adult population. |
| ***Select the category for each PIP:****Clinical:* [x]  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.* | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP is using a standardized practice, has considered information about the special needs of mentally ill and addicted individuals in smoking cessation approaches, and is incorporating pharmacotherapy to support success of this PIP. |
| 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:* [x]  Age Range [ ]  Race/Ethnicity [ ]  Gender [ ]  Language [ ]  Other  | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP will screen all adult consumers and include all adult tobacco users in the PIP population. That said, the MHP currently has no reliable method of determining tobacco use status. If discussed, tobacco use is identified by a narrative free-text comment in an assessment or progress note.  |
|  | **Totals** | **4** Met **0** Partially Met **0** Not Met **0** UTD |

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| **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 integration of smoking cessation services within VCBH decrease the proportion of consumers who describe themselves as active tobacco users. | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The study question should better represent “how” the integration of smoking cessation into services is going to occur, at least the big picture, enough to understand what will be occurring. The SQ does not state any goal for improvement, which is a requirement of the SQ. |
|  | **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:* [x]  Age Range [ ]  Race/Ethnicity [ ]  Gender [ ]  Language [x]  Other: Adult tobacco users | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The basis of this PIP rests upon the sampling survey and epidemiologic data cited in the foundation of this work. The MHP does not currently possess comprehensive data on tobacco users among its consumers in any trackable manner. |
| 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 [x]  Other: Survey of all adults and subsequent EHR tracking element for tobacco usage – to be established. | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine |  |
|  | **Totals** | **2** Met **0** Partially Met **0** Not Met **0** UTD |
| **STEP 4: Review Selected Study Indicators**  |
| 4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* * VCBH adult consumers are screened regarding tobacco use status
* % of tobacco users referred to Call It Quits program
* % of tobacco users completing the Call It Quits program
* % of tobacco users receiving smoking cessation pharmacotherapy
* % of tobacco users who remain quit for 90 days after completing a Call It Quits program
* % of tobacco users who remain quit for 6 mos. after completing a Call It Quits program
* % of tobacco users who remain quit for 12 mos. after completing a Call It Quits program
* % staff trained in the Basic Tobacco Intervention Skills Certification Program *(The 5 A's)*
 | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | It should be noted that as of this current review the MHP did not possess baseline data for its consumers’ consumption of tobacco products. The instruments to capture this data were not in place, and sampling was required to establish a threshold for the department. |

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| 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.  [x]  Health Status [ ]  Functional Status  [ ]  Member Satisfaction [ ]  Provider SatisfactionAre long-term outcomes clearly stated? [ ]  Yes [x]  No Are long-term outcomes implied? [x]  Yes [ ]  No  | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The direct evidence of changes in physical health status, such as blood pressure, COPD incidence, and cancer are not tracked elements of this PIP; however, it is well accepted that there exists a link between tobacco use and health – thus changes in physical health status are clearly covered by inference. |
|  | **Totals** | **2** Met **0** Partially Met **0** Not Met **0** UTD |
| **STEP 5: Review Sampling Methods**  |
| 5.1 Did the sampling technique consider and specify the:a) True (or estimated) frequency of occurrence of the event?b) Confidence interval to be used?c) Margin of error that will be acceptable? | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  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[x]  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[x]  Not Applicable[ ]  Unable to Determine |  |
|  | **Totals** | **0** Met **0** Partially Met **3** Not Applicable **0** UTD |

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| **STEP 6: Review Data Collection Procedures**  |
| 6.1 Did the study design clearly specify the data to be collected? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine |  |
| 6.2 Did the study design clearly specify the sources of data?*Sources of data:*  [ ]  Member [ ]  Claims [ ]  Provider [ ]  Other: Text if checked | [x]  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[x]  Not Met[ ]  Unable to Determine | The frequency and other aspects of monitoring were not described. |
| 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  [x]  Other: Progress notes and other instruments, sign-in sheets, etc. | [ ]  Met[ ]  Partially Met[x]  Not Met[ ]  Unable to Determine | As of this review the no system data is available yet. |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?  | [ ]  Met[ ]  Partially Met[x]  Not Met[ ]  Unable to Determine | The data analysis plan was incomplete at the time of this review. |

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| 6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Brian Taylor, MD, Adult and ADP Medical DirectorName: TextTitle: TextRole: Text*Other team members:*Names: Text | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The PIP describes the project leader by name but no other team members are individually identified. There are descriptions of categories and titles of participants but the PIP does not identify others by name, which is required. |
|  | **Totals** | **2** Met **1** Partially Met **3** 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:* * *Staff training*
* *Add information in electronic health record on consumer tobacco use status*
* *Provide training on pharmacologic treatments for smoking cessation*
* *Offer Call It Quits groups at all VCBH clinic sites*
 | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The improvement strategies identified are mostly infrastructure and training activities, indirect actions that relate to the ability to consistently identify smokers within the Ventura County Behavioral Health (VCBH) system and provide the needed services. It should be noted that as of the date of this review, none of the interventions were in indicated as active. In addition, aside from pharmacologic support for smoking cessation, the MHP has not identified any other possible modification of standard smoking cessation that may be implemented with this unique population in order to improve outcomes. |
|  | **Totals** | **0** Met **1** Partially Met **0** Not Met **0** NA  **0** UTD  |
| **STEP 8: Review Data Analysis and Interpretation of Study Results**  |
| 8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is “Not Met” if there is no indication of a data analysis plan (see Step 6.5)*  | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  Not Applicable[ ]  Unable to Determine |  |
| 8.2 Were the PIP results and findings presented accurately and clearly?Are tables and figures labeled? [ ]  Yes [ ]  No Are they labeled clearly and accurately? [ ]  Yes [ ]  No  | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  Not Applicable[ ]  Unable to Determine |  |

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| 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[x]  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[x]  Not Applicable[ ]  Unable to Determine |  |
|  | **Totals** | **0** Met **0** Partially Met **0** Not Met **4** NA  **0** UTD  |
| **STEP 9: Assess Whether Improvement is “Real” Improvement** |
| 9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?**Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?* | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  Not Applicable[ ]  Unable to Determine |  |

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| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?Was there: [ ]  Improvement [ ]  DeteriorationStatistical significance: [ ]  Yes [ ]  NoClinical significance: [ ]  Yes [ ]  No | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  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[x]  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[x]  Not Applicable[ ]  Unable to Determine |  |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  Not Applicable[ ]  Unable to Determine |  |
|  | **Totals** | **0** Met **0** Partially Met **0** Not Met **5** NA  **0** UTD  |

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| **ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)** |
| **Component/Standard**  | **Score** | **Comments** |
| Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement? |  [ ]  Yes [ ]  No | N/A |
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| **ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS** |
| *Conclusions:*N/A |
| *Recommendations:*N/A |
| Check one: N/A [ ]  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 |

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

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| **GENERAL INFORMATION** |
| **MHP**: Ventura County Behavioral Health  |
| **PIP Title**: Spanish Treatment Plan |
| **Start Date** (MM/DD/YY): January 1, 2015**Completion Date** (MM/DD/YY): June 30, 2017**Projected Study Period** (0of Months): 29**Completed**: Yes [x]  No [ ] **Date(s) of On-Site Review** (MM/DD/YY): February 22-24, 2017**Name of Reviewer**: Rob Walton, RN, MPA | **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)[x]  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 Spanish language treatment plan was an effort by the Ventura County Behavioral Health MHP to improve services to Spanish speakers/Hispanics, with emphasis upon the two areas which have the greatest number of relevant individuals – Santa Paula and Oxnard. The MHP has long been concerned about the accessibility of services to the Hispanic population. Literature and a 2013 local survey both supported the importance of a linguistically appropriate treatment plan for Spanish speaking consumers. The MHP also performed local data analysis on the service utilization of Spanish language preferred individuals in comparison to the English-speaking population. Data indicated a significantly lower utilization by Spanish preferred individuals. The MHP embarked upon this project, and discovered there were quite a few challenges that, while anticipated, loomed larger than originally thought. Aspects included establishing a Spanish treatment plan within Avatar; in addition, the challenge of staff who were literate in written Spanish was another issue. These complexities took time, but were eventually resolved. It is important to note that for each review cycle new interventions must be identified for PIPs that span multiple review cycles to be considered “active.” This PIP did not identify any new interventions since March 2015. Therefore, it must be considered an inactive PIP, even though data collection and quarterly reporting did continue through January 2017, with plans to summarize all data in June 2017. This PIP is scored for reference purposes only, and the below scores are not reflected in the report body itself.The MHP was also advised that this PIP is considered completed, and a new Non-Clinical PIP topic is required.  |

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| **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? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Part of the initiative for this PIP was the MHP’s recognition that Spanish speakers and Hispanic individuals are underserved relatively to the portion of the eligibles that they represent. In addition, the MHP referenced a local 2013 survey of Spanish-speaking consumers that indicated 71% of these individuals would prefer to have a treatment plan in Spanish, but 80% had not received one in their preferred language. While it seems reasonable to project that this issue remains stable, a more recent survey could also prove beneficial. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP examined adult and youth and family service data for FY11-12 and FY12-13, which indicated that actual service disparities existed for both adult and children. The MHP also reviewed the percentages of individuals receiving services directly in their preferred language versus with language assistance services. Other aspects of this issue were considered, including the distribution of staff who were bilingual. In summary, the MHP felt that there could be a connection between receiving a service plan in one’s preferred language (Spanish) and access and retention with services. Thus, the notion of a Spanish language treatment plan emerged. |
| ***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:* [x]  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[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | As discussed during the prior and current review with MHP staff, the MHP seems to have a broader goal of improving access, retention, and service equity with Spanish preferred individuals and the overall Hispanic population. The development of the Spanish language treatment plan, while fraught with both known and unknown challenges (EHR, staff resource issues, etc.), seems to comprise a narrow aspect of this improvement. However, this PIP does address an aspect of barriers to Spanish speaking consumers, an increasingly large group in several of the MHP’s geographic regions. |
| 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 [x]  Race/Ethnicity [ ]  Gender [ ]  Language [x]  Other Spanish language preferred individuals | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | No individuals were excluded from this process. However, the MHP’s Hispanic, Spanish-speaking populations are most significant in the Oxnard (N=667) and Santa Paula (N=257) clinics. |
|  | **Totals** | **3** Met **1** Partially Met **0** Not Met **0** UTD |

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| **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:*Do clients who receive a treatment plan in Spanish receive equitable levels of service when compared to non-Spanish consumers? | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP states what the intervention/improvement strategy is and describes a general goal; however, the goal needs to specify the amount of improvement anticipated by the change. As discussed with MHP staff, providing a treatment plan in one’s preferred language (Spanish) could impact a number of service related elements in addition to service levels, such as retention or satisfaction.However, the MHP has opted to focus upon service equity. |
|  | **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 [x]  Language [ ]  Other | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Spanish speakers.  |
| 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:*  [x]  Utilization data [ ]  Referral [x]  Self-identification [x]  Other: Avatar and M/C claiming data | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP utilized its Avatar demographic information, Language Assistance Services utilization, Medi-Cal beneficiary data reports to identify consumers involved in this PIP. |
|  | **Totals** | **2** Met **0** Partially Met **0** Not Met **0** UTD |
| **STEP 4: Review Selected Study Indicators**  |
| 4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* **Units of Service (UOS):** Do identified consumers receive the same number of UOS as do non-project consumers in the five-project identified domains:* Assessment
* Case Management
* Plan Development
* Medication Support
* Rehabilitation

**Treatment/client Plans,** number ofT/CP’s created in target language of Spanish.**Language Identity,** record the number of consumers who identify Spanish as a primary language and/or language of preference. | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Discussion from the prior review suggested that the MHP considered comparisons of outcomes from VCOS of those with and those without Spanish language treatment plans. Comparison of no-shows could also occur, as well as frequency of treatment abandonment without goal achievement. |

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| 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 SatisfactionAre long-term outcomes clearly stated? [ ]  Yes [x]  No Are long-term outcomes implied? [x]  Yes [ ]  No  | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The units of service reflect utilization of care, and are desired to increase. The increase in utilization is thought to relate to having a Spanish language treatment plan, thereby improving the understanding of and participation in care.  |
|  | **Totals** | **2** Met **0** Partially Met **0** Not Met **0** UTD |
| **STEP 5: Review Sampling Methods**  |
| 5.1 Did the sampling technique consider and specify the:a) True (or estimated) frequency of occurrence of the event?b) Confidence interval to be used?c) Margin of error that will be acceptable? | [ ]  Met[ ]  Partially Met[ ]  Not Met[x]  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[x]  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[x]  Not Applicable[ ]  Unable to Determine |  |
|  | **Totals** | **0** Met **0** Partially Met **3 Not** Applicable **0** UTD |

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| **STEP 6: Review Data Collection Procedures**  |
| 6.1 Did the study design clearly specify the data to be collected? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Units of service. Initially all modalities were to be tracked but on follow-up it was determined to not track assessments. Likely this relates to the circumstance that assessments services may yet to have a treatment plan. |
| 6.2 Did the study design clearly specify the sources of data?*Sources of data:*  [x]  Member [x]  Claims [ ]  Provider [ ]  Other: Text if checked | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Avatar claims for all modalities of services.  |
| 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? | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Treatment plan report and units of service reports – standard parts of Avatar.The MHP eliminated tracking of assessment data, in that can occur before the development of a treatment plan. |
| 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  [x]  Other: service utilization, 0 of Spanish TX plans | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The MHP did provide quarterly summaries of the data results for the PIP as part of its workgroup presentations. The most recent data was reported in January 2017. |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?  | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Unable to Determine | The PIP narrative suggested monthly reporting and review at targeted clinics. Actual reporting appears to be quarterly.  |

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| 6.6 Were qualified staff and personnel used to collect the data? *Project leader: Office of Health Equity & Training**Quality Assurance Manager, Quality Improvement Liaison, Clinic Administrators from the department’s Adult and Youth & Family divisions, licensed clinicians from the Adult mental health division, alcohol and drug programs division staff, language assistance services contract vendor, Office of Health Equity and Training, Spanish speaking consumer and ethnic services manager*. | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine |  |
|  | **Totals** | **5** Met **1** 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:* * Implement training to staff to record primary language of consumer in AVATAR system.
* Training of staff to generate Spanish Treatment Plans and use of language resource tools of AVATAR system.
* Implementation of Spanish Treatment Plan across MHP.
* Generate of Units of Service (UOS) Reports
* Clinic Administrators in two project regions to generate Treatment Plans Report and Language Use Reports\ Provide consumers with Treatment Plans in Spanish.
 | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Unable to Determine | Discussion with the MHP revealed there have been other barriers to implementation which included written proficiency in Spanish language for bilingual staff. Apparently, this issue has been overcome.It must be noted that the most recent interventions were dated March through June of 2015. There were no new interventions developed for the FY16-17 review period.  |
|  | **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[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | The MHP opted to utilize standalone tables that were not integrated with the PIP itself.  |
| 8.2 Were the PIP results and findings presented accurately and clearly?Are tables and figures labeled? [x]  Yes [ ]  No Are they labeled clearly and accurately? [ ]  Yes [x]  No  | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | The Excel tables for units of service were labeled clearly; the table elements for treatment plans and Spanish language need were not equally clear. |

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| 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: quarterlyIndicate the statistical analysis used: simple percentageIndicate the statistical significance level or confidence level if available/known: \_\_\_\_\_\_\_% None - Unable to determine | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | There was some variance in change, with two of the five service types not experiencing an increase in services, as was anticipated by the Spanish treatment plan.It is important to note that simple service utilization may not be the sole or best indicator of success for the linguistically appropriate treatment plan. Retention, VCOS outcomes, satisfaction, completion of treatment goals are other potential indicators of success of a more involved consumer/caregiver.  |
| 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:*Some service categories did not improve, an example being assessment – which seems logical.*Conclusions regarding the success of the interpretation:*The MHP sees success in this PIP.*Recommendations for follow-up:*Consideration of comparing outcome results, retention, etc. | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | See 8.3.Simple service parity may be an oversimplification of this linguistic issue. Outcome comparisons, no-shows, completion of treatment, and initial retention may be more strongly related to a linguistically appropriate treatment plan. |
|  | **Totals** | **1** Met **3** 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?* | [x]  Met[ ]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | The data process was simple aggregation of total services utilized by Spanish speaking consumers/caregivers, thus exact comparison was not required. The MHP was actually seeking to identify trends of increased utilization. |

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| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?Was there: [x]  Improvement [ ]  DeteriorationStatistical significance: [ ]  Yes [x]  NoClinical significance: [ ]  Yes [x]  No | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | Improvement for 3 of 5 variables in the service utilization areas. |
| 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 [x]  Small [ ]  Fair [ ]  High  | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | Service utilization did increase, whether that is a factor of increased numbers of Spanish speaking/bilingual staff or the Spanish language treatment plan is not possible to determine. |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement? [ ]  Weak [ ]  Moderate [ ]  Strong | [ ]  Met[ ]  Partially Met[x]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | No statistical tests were utilized in this PIP. |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | [ ]  Met[x]  Partially Met[ ]  Not Met[ ]  Not Applicable[ ]  Unable to Determine | Three of five variables were increased/improved, relevance to the intervention is difficult to assess. |
|  | **Totals** | **1** Met **3** Partially Met **1 Not** Met **0** NA  **0** UTD  |

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| **ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)** |
| **Component/Standard**  | **Score** | **Comments** |
| Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement? |  [ ]  Yes [x]  No | Some of the elements were possible to calculate, others were not, particularly those in the external Excel tables. |
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| **ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS** |
| *Conclusions:*It is not clear what the connection is between a Spanish language treatment plan for Spanish speakers has on service utilization. Logically, and supported by literature, is the relationship between improved understanding of services and increased participation. However other measures might more directly relate to this PIP. |
| *Recommendations:*Likely satisfaction with a linguistically relevant treatment plan would have a greater direct connection to a Spanish treatment plan. Service utilization may be impacted, but more likely this is more effected by greater access to Spanish speaking clinicians and other mental health workers.  |
| 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 [x]  Confidence in PIP results cannot be determined at this time |

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. [↑](#footnote-ref-1)
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. [↑](#footnote-ref-2)
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. [↑](#footnote-ref-3)
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. [↑](#footnote-ref-4)