Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SOLANO MHP FINA REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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INTRODUCTION

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

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also takes into account the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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 fiscal year (FY) 2019-20 findings of an EQR of the Solano MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Medium

MHP Region — Bay Area

MHP Location — Fairfield

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 4,693

MHP Threshold Language(s) — Spanish

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

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

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

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

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site focus group was conducted as part of CalEQRO's desk review of <MHP Name> this year.

Consequently, the scope of validation for EQR activities and resulting recommendations were limited.

PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: Clinical PIP: Rewrite PIP study question to be measurable. Remove indicators that will not be tracked according to interventions. Interventions need to tie to indicators. Define when the baseline data was taken.

Status: Partially Met

- The study question was revised to be measurable: "Can we increase the number and type of field-based, person-centered, recovery-oriented services to full service partnership (FSP) clients in order to improve client engagement in the FSP outcomes such that at discharge at least 75 percent have achieved their goals (among other outcomes)?"
- None of the interventions were linked with a tracked indicator.
- This PIP has ended, and the MHP is working on development of a replacement.

Recommendation 2: Non-clinical PIP: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. Rewrite proposed PIP study question to be measurable. Clarify how

each indicator measures or is a proxy for engagement. Refine the interventions into measurable activities that affect the indicators, and are interventions directed at the probable cause of the issue of dropping out of and not engaging in services. Execute the interventions and analyze data not less than quarterly to ensure this PIP is active and ongoing.

Status: Partially Met

- The study question was revised to be measurable: “Will the addition of personal engagement & proactive follow up calls for adults in Vallejo lead to an increase (sic) rate of service requests to assessment by at least 25 percent in order to better engage clients, especially those from underserved communities?”
- Indicators were not modified to reflect measures of or proxy for engagement.
- Interventions were modified to more clearly state an association with engagement activities.
- This PIP has been terminated, and further work on this topic is not indicated.

Recommendation 3: Consult with EQRO early and often during the continuation of both PIPs.

Status: Partially Met

- Both PIPs have concluded, and the MHP has been encouraged to seek technical assistance (TA) as concepts emerge.

Access Recommendations

Recommendation 4: Establish and implement mobile crisis services in Solano County in the three major population centers, starting with one city for a stepwise and successful implementation.

Status: Partially Met

- The MHP released an request for proposal (RFP) seeking mobile crisis services in July 2019. There were no responses from potential contract agencies.
- Identification of an appropriate willing provider is essential to establishing a mobile crisis service level.
- The MHP plans to repost the RFP.

Recommendation 5: Follow up mobile crisis implementation with collaboration with law enforcement agencies (LEA) to create Crisis Intervention Teams (CIT) that include the MHP and a law enforcement representative at a minimum.

Status: Partially Met

- 292 peace officers have participated in the 8-hour Introduction to CIT training.
- In collaboration with Fairfield Police Department and National Alliance on Mental Illness (NAMI) Solano, the MHP is developing a 40-hour weeklong CIT curriculum based on the Memphis model, to be released in 2020.
- Mobile crisis implementation has not yet occurred.

Recommendation 6: Develop and implement outreach to increase recruitment and retention of Spanish-speaking clinicians.

Status: Partially Met

- MHSA funds are being utilized to support an annual intern program, which includes 1st and 2nd year masters and PsyD/PhD individuals as well as post-doctoral interns. This approach is intended to attract bilingual/bicultural candidates and meet the needs of the non-English preferred populations.
- Contractors reported that 18 percent of staff are bilingual in Spanish.
- The MHP has included the goal of increased bilingual staffing in the Cultural Responsiveness Plan (CRP) and is working to establish incentives to improve recruitment and retention of bilingual, Spanish-speaking staff.

Timeliness Recommendations

Recommendation 7: Begin collecting and reporting no-show data for psychiatrists and other clinicians, for directly operated clinics and contracted providers. If psychiatrists and clinicians at directly operated clinics are not using the Avatar Scheduling tool, using Scheduling would be the first step in addressing this recommendation.

Status: Partially Met

- The MHP created report 170X which reflects systemwide data for directly operated programs, including no-show and cancelled appointment data in aggregate. For a variety of reasons, out-stationed staff and FSP programs deliver services without use of the scheduler. No-show information is most comprehensive and accurate for psychiatry and clinicians who are clinic-based.
- Contract agencies usually operate with their own unique EHRs, and that no-show data is not included.

Recommendation 8: Complete testing and implement in-production use of the referral form that facilitates reporting time from request for child psychiatry services to the first psychiatric appointment. This would be one step towards addressing the consistent longer timeliness measures for children and children in foster care.

Status: Met

- The Avatar form “Referral for MH and Psychiatric Services” and associated training were rolled out in June 2019. The Psychiatric Referral tab was implemented in late August 2019.

Quality Recommendations

Recommendation 9: Complete the LOC tool selection process, procure the tool, and initiate implementation.

Status: Met

- The MHP has chosen Reaching Recovery (RR) as their LOC tool. The Netsmart contract was increased in July 2019 to include this tool in the EHR.
- Next steps are to hold a kickoff call with Netsmart to open modules and begin pilot phase of testing.

Beneficiary Outcomes Recommendations

Recommendation 10: Investigate the feasibility of adding a TAY wellness and recovery center in addition to the wellness centers in Solano County.

Status: Partially Met

- Solano County Behavioral Health (SCBH), in partnership with the Solano County Office of Education, is implementing school-site wellness centers for both K-12 and adult education participating sites.
- Five pilot centers opened early in the 2019-2020 school year and include an alternative education site that will serve the TAY population. In addition, the adult ed site will also serve TAY and three elementary schools in Dixon.
- The MHP would be advised to identify the number and location of those TAY who are not reached by school-based wellness centers and determine if the population size and geographic distribution would merit development of a non-school-based wellness center.

Foster Care Recommendations

Recommendation 11: Create capability to track all foster care (FC) children separately from other children data. Use this data to assess and correct timeliness to services for foster care beneficiaries.

Status: Met

- The FC tracking form is now being simplified and streamlined and was recently rolled out as a Children’s Mental Health System project. This tracking added all open Child Welfare (CW) cases that are also open to MH. The data point will be added to the Avatar 333 report, Timeliness from Psychiatric Referral to Offered

Psychiatric Appointment and the Avatar 339 report Youth Medications Children's Polypharmacy.

Information Systems Recommendations

Recommendation 12: To improve IT capacity throughout the MHP, increase information systems human resources by filling the following roles: Manager; Clinical Informaticist; Financial/Claiming Systems Chief; System Administrator; Data Manager; Report and Dashboard Developer; Script link and Forms Developer; Integration Manager; Integration Technician; and Help Desk Technician. Prioritize Clinical Informaticist to optimize the system for clinicians, followed by Data Manager to prepare for supervision over other additions of personnel and technology as it is obtained.

Status: Met

- The MHP requested 2.0 FTE in the FY 19-20 budget process. The request for positions was not approved.
- This recommendation rated as met due the MHP's efforts to add positions, which were ultimately unsuccessful. The MHP's IT organizational structure has is assigned to the super-agency level. The requested changes are not currently feasible.

Recommendation 13: Complete the implementation of the X.12 270/271 electronic eligibility transaction.

Status: Met

- Avatar was configured for 270/271 transactions and enabled in the Avatar LIVE environment. In September/October 2019 the Billing Manager was testing and confirming that the process worked as expected.

Recommendation 14: As soon as it becomes available, begin using the county's implementation of Service Now to document calls to the Help Desk and the resolution of those calls. Reporting already available in Service Now should provide far more useful information than is currently available about the volume, type, and resolution of trouble calls.

Status: Met

- ServiceNow went live in August 2019 for Change Management. The Service Request and Incident Management components had not been rolled out as of October 2019. ServiceNow will provide information on Help Desk calls and their resolution as the County centralizes help desk activities.

Recommendation 15: Provide enough laptop computers for clinicians performing collaborative documentation and documentation in the field.

Status: Met

- All clinical staff who are primarily field-based have a laptop assigned to them. This was achieved through a combination of reassignment of existing equipment and purchase of additional laptop computers.

Structure and Operations Recommendations

Recommendation 16: When the MHP is successful in gaining approval to expand its IT organization, have the IT organization report to the Director and participate in the Executive Committee.

Status: Met

- The Department of Information Technology, which includes the Avatar IT support team, reports directly to the County Chief Information Officer. County Administration is not open to reporting relationships across departments and favors a centralized IT function.

- While the requested organizational change has not occurred, the MHP has provided evidence of the inclusion of IT through a monthly meeting between the manager for the Avatar IS Support team and HSS executive staff.

Carry-over and Follow-up Recommendations from FY 2017-18

Recommendation 17: Develop a plan to grow data analysis capability. Explore the possibility of further increasing IT staffing. (*This recommendation is also a carry-over from FY 2016-17*.)

Status: Met

- The MHP requested 2.0 FTE in the FY 2019-20 budget process. The request for positions was not approved.

- The MHP engaged in a good-faith effort to meet this recommendation, which is not currently achievable.

Recommendation 18: Complete the implementation of the Accredited Standards Committee X12 270/271 electronic eligibility transactions. Staff turnover and some long-standing vacancies were barriers in addressing this recommendation. A new billing manager has been hired since the last EQRO which makes staff to address this issue more robust.

Status: Met

- Avatar was configured for 270/271 transactions and enabled in the Avatar LIVE environment. In September/October 2019 the Billing Manager was testing and confirming that the process was working as expected.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 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 (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

Table 1. Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Solano MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	25,020	20.8%	1,477	31.5%
Latino/Hispanic	37,289	31.1%	843	18.0%
African-American	22,701	18.9%	1,041	22.2%
Asian/Pacific Islander	14,701	12.2%	276	5.9%
Native American	627	0.5%	53	1.1%
Other	19,754	16.4%	1,003	21.4%
Total	**120,091**	**100%**	**4,693**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

During CY 2018, the MHP experienced claims submission delays that resulted in a significant number of claim transactions not being included in the analysis below for CY 2018 results.

Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

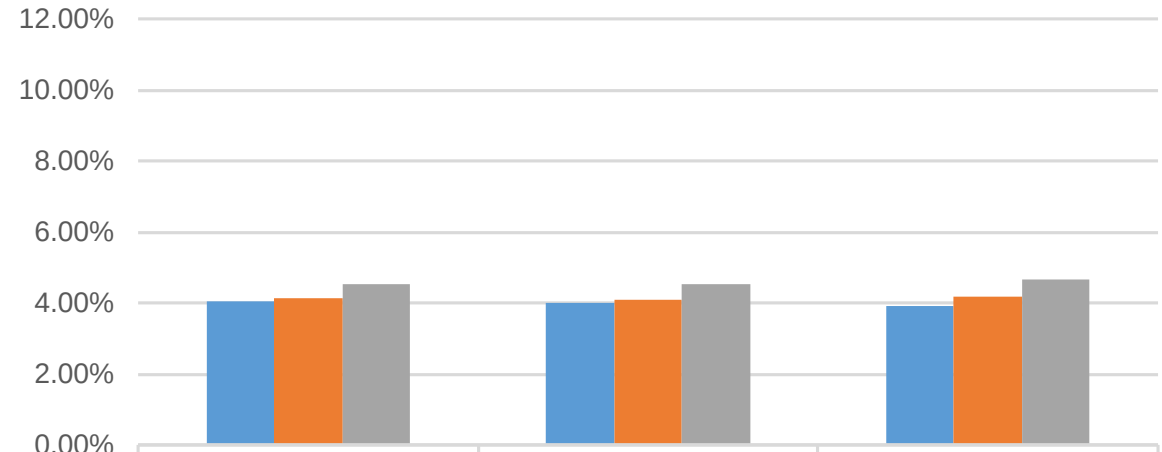
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Solano MHP uses the same method used by CalEQRO. Note: The denominator for Solano penetration rate calculations includes all Solano Medi-Cal beneficiaries, of which more than 20,000 beneficiaries are carved out to Kaiser Medi-Cal for their specialty MH care. This factor negatively

impacts the EQRO penetration rates for this MHP. Kaiser data is not available to the MHP nor EQRO.

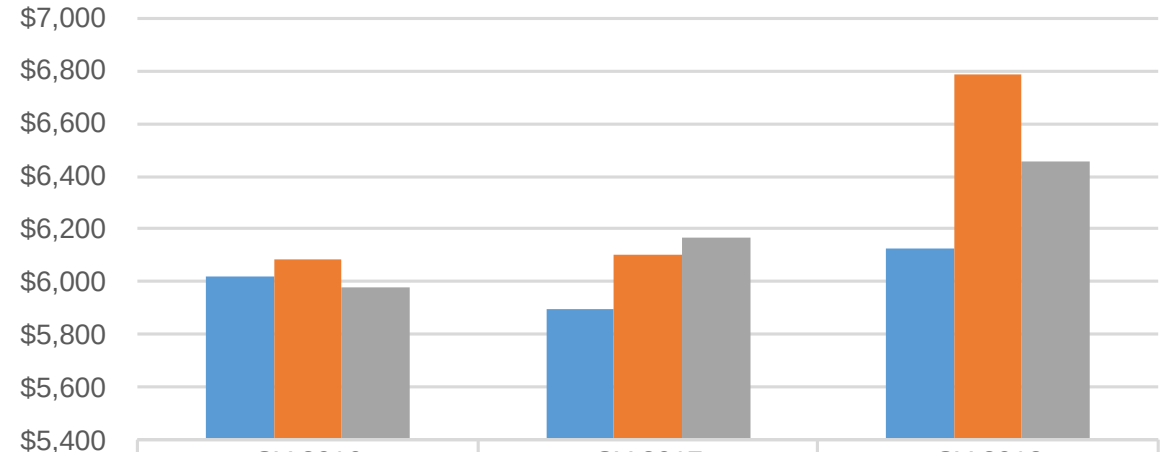
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1A. Overall Penetration Rates
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	4.05%	3.99%	3.91%
Medium	4.12%	4.10%	4.16%
State	4.53%	4.52%	4.66%

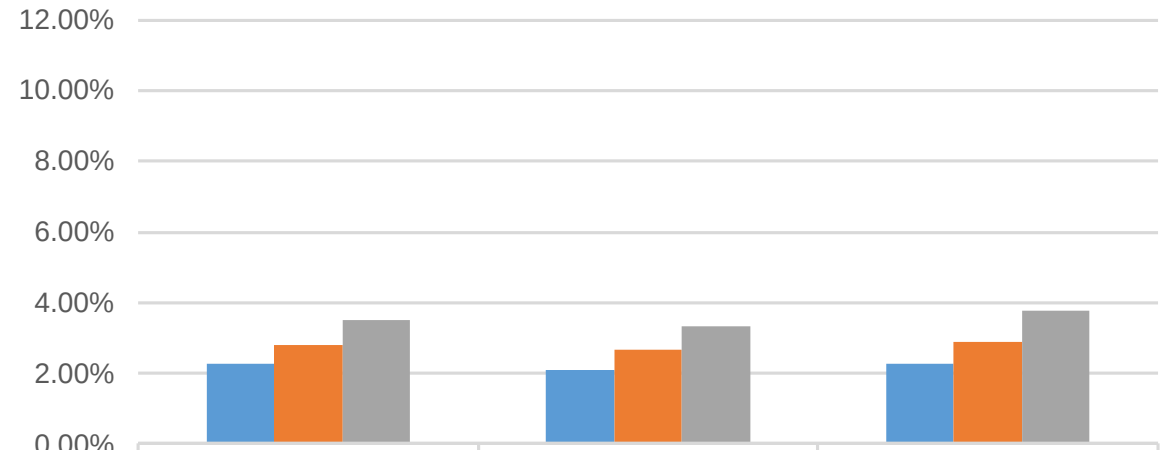
Figure 1B. Overall ACB
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	$6,019	$5,894	$6,129
Medium	$6,084	$6,103	$6,785
State	$5,978	$6,170	$6,454

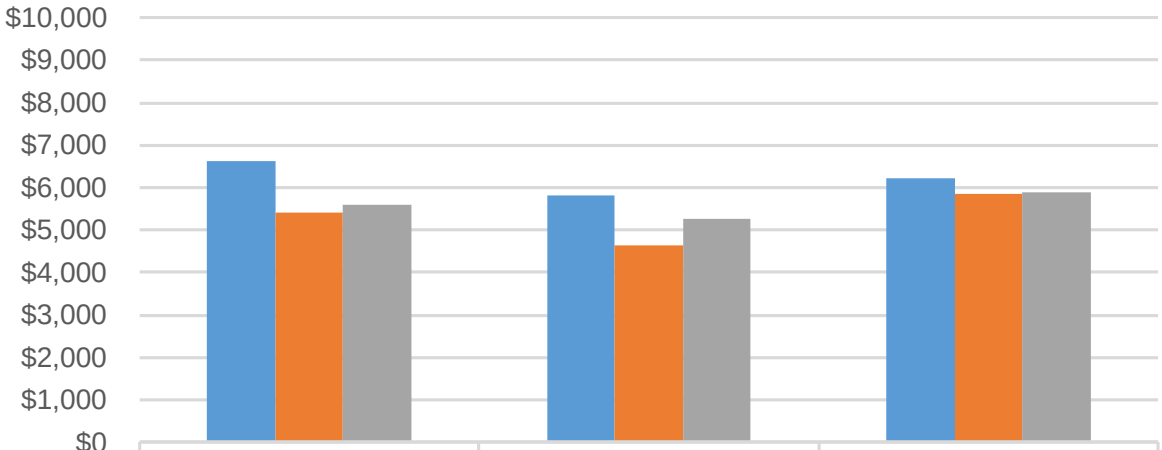
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	2.29%	2.11%	2.26%
Medium	2.80%	2.67%	2.88%
State	3.51%	3.35%	3.78%

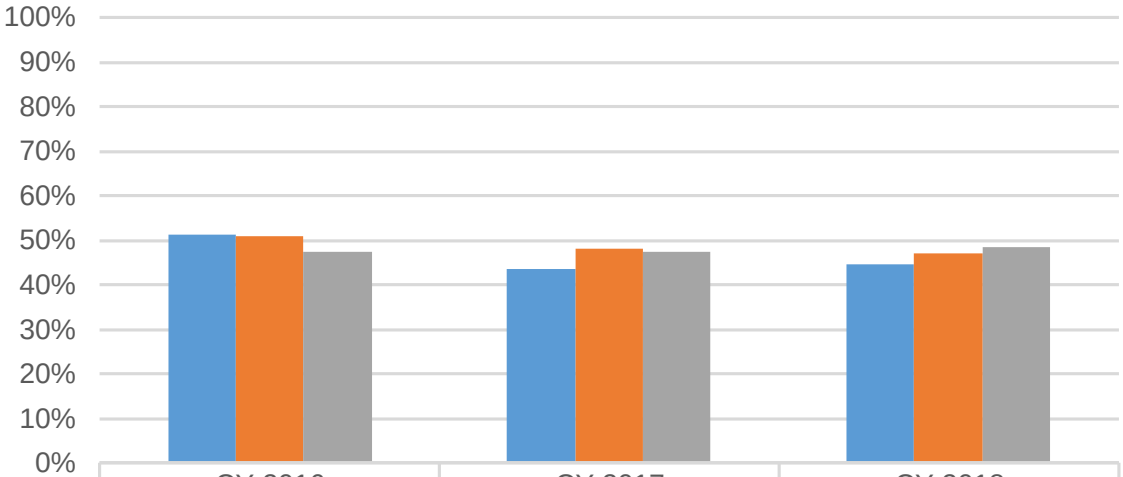
Figure 2B. Latino/Hispanic ACB
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	$6,630	$5,821	$6,219
Medium	$5,406	$4,622	$5,858
State	$5,588	$5,278	$5,904

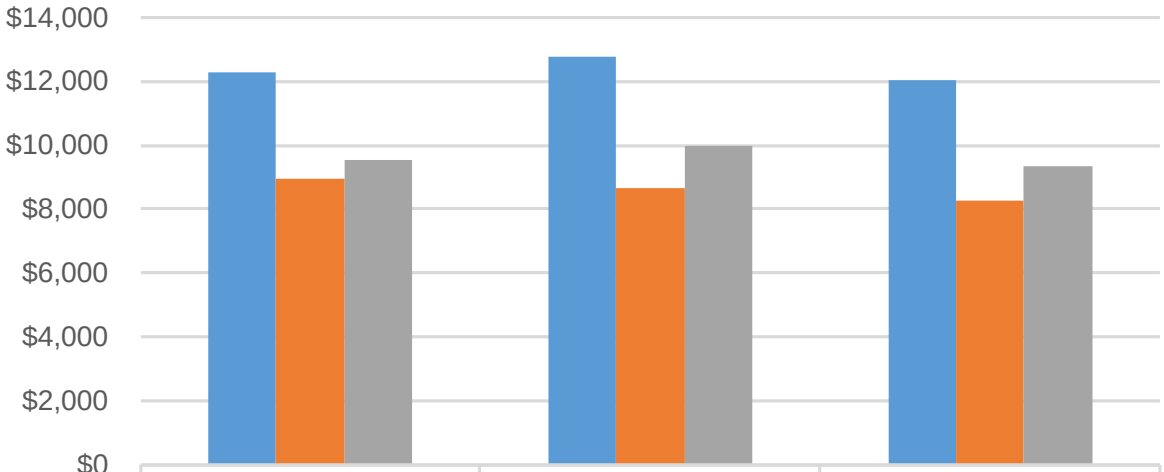
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 3A. FC Penetration Rates
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	51.30%	43.51%	44.49%
Medium	50.81%	48.15%	47.10%
State	47.48%	47.28%	48.41%

Figure 3B. FC ACB
Solano MHP



	CY 2016	CY 2017	CY 2018
MHP	$12,263	$12,786	$12,022
Medium	$8,974	$8,642	$8,276
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2. High-Cost Beneficiaries
Solano MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	162	4,693	3.45%	$53,273	$8,630,231	30.00%
	CY 2017	181	4,938	3.67%	$47,816	$8,654,658	29.74%
	CY 2016	194	5,134	3.78%	$47,517	$9,218,247	29.83%

High Cost Beneficiaries: HCB count and percentage have decreased over the last three years. Average approved claims and HCB% by total claims have increased.

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

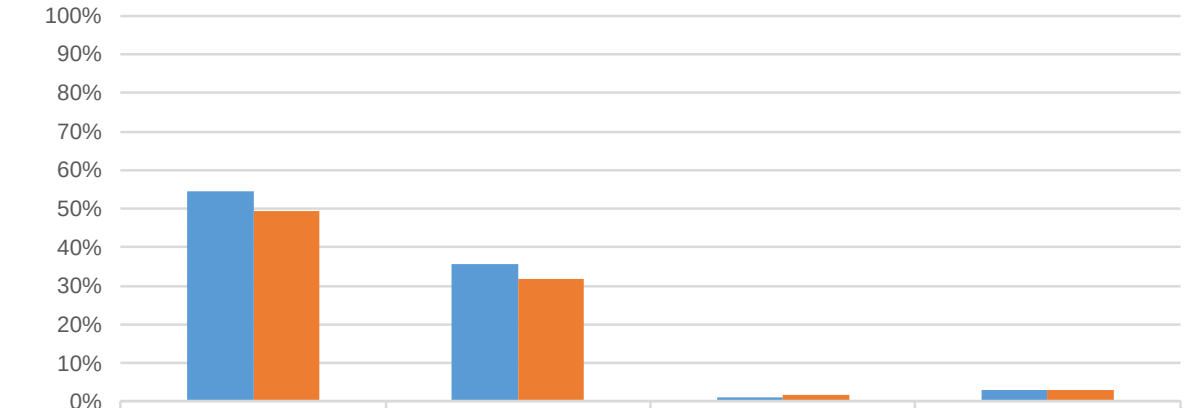
Table 3. Psychiatric Inpatient Utilization - Solano MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	361	743	8.31	$13,227	$4,774,952
CY 2017	352	658	8.53	$11,033	$3,883,540
CY 2016	349	542	8.75	$10,703	$3,735,346

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

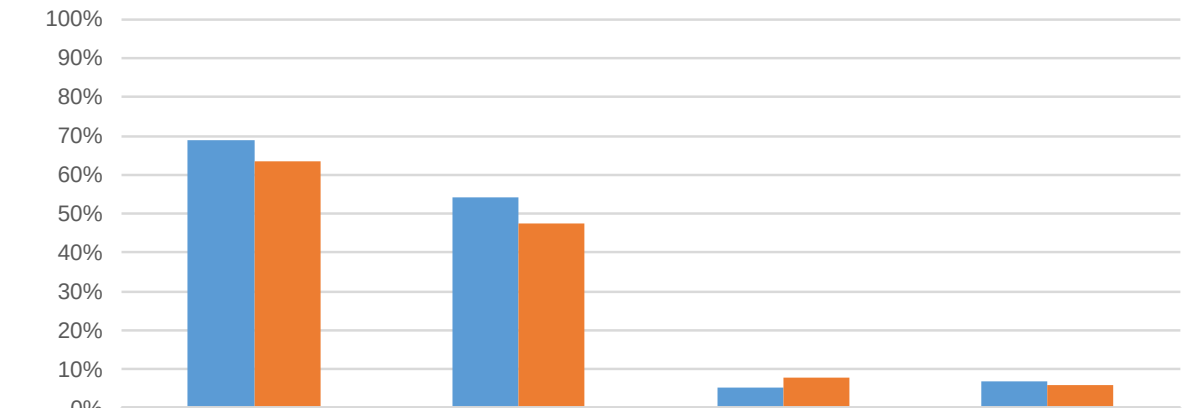
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Solano MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	54%	36%	1%	3%
CY 2018	49%	32%	2%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Solano MHP



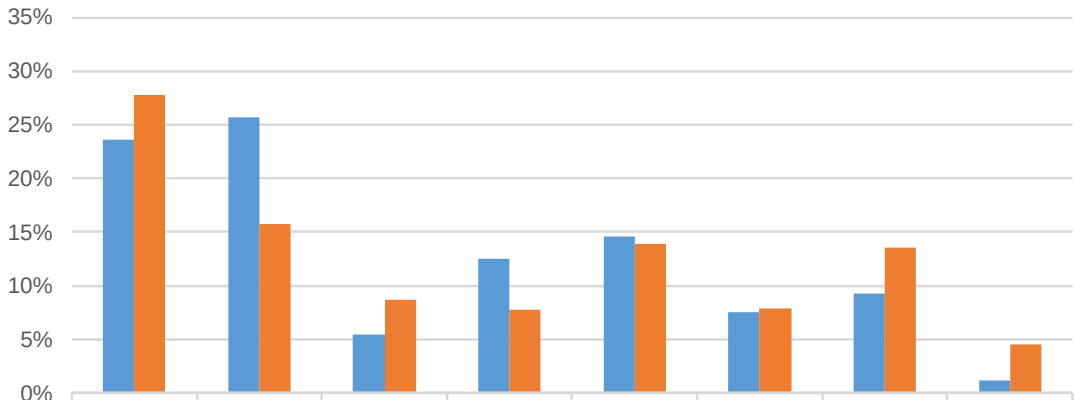
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	69%	54%	5%	7%
CY 2018	63%	48%	8%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

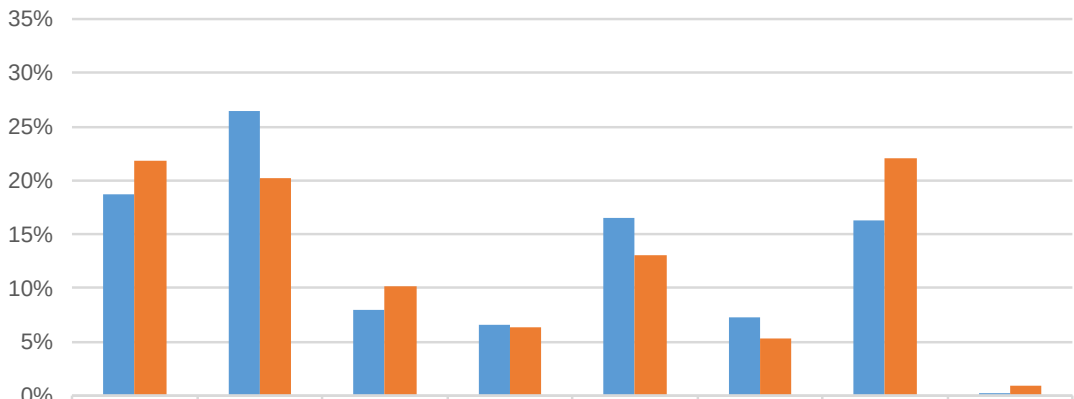
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 25 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Solano MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	24%	26%	5%	13%	15%	8%	9%	1%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B. Diagnostic Categories, Total Approved Claims
Solano MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	19%	26%	8%	7%	17%	7%	16%	0%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

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.” CMS’ EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Solano County MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. For this review the MHP submitted two completed PIPs. These two PIPs were reviewed and validated, as below.

Table 4 lists the PIPs submitted by the MHP.

Table 4: PIPs Submitted by Solano MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Full-Service Partnership Service Improvement
Non-clinical PIP	1	Engagement & Retention Project

Clinical PIP—Full-Service Partnership Service Improvement

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

“Can we increase the number and type of field-based, person-centered, recovery-oriented services to FSP clients in order to improve client engagement in the FSP outcomes such that at discharge at least 75 percent have achieved their goals (among other outcomes)?”

Date PIP began: July 2018

Projected End date: December 2019

Status of PIP: Completed

The MHP noted that Full-Service Partnership (FSP) outcomes indicated a low rate of achievement of goals (25 percent). While there was also concern about inconsistency in the selection of discharge codes, a greater issue about the model of FSP service locally implement was raised. The low engagement in FSP of some of the highest risk

individuals who also have the poorest outcomes emerged. The historic local approach to FSP caseloads, which have been shared by staff dyads, was also seen as limiting the effectiveness of these services. The MHP hypothesized that formal adoption of the Assertive Community Treatment (ACT) model, which also involves changes to the treatment team paradigm and inclusion of nursing, psychiatry, supported employment and substance abuse treatment specialists, would produce better outcomes for this high-needs population. The MHP did not elaborate on why the Forensic FSP delivers low levels of in-community services, but this is another aspect of services that will be addressed by the model change. Adoption of a level of care instrument is also critical to assist with length of stay treatment decisions.

Last year this PIP was rated as active and ongoing.

Suggestions to improve the PIP: This PIP has been terminated, and a new topic is under exploration by the MHP. That said, continuing monitoring of the ACT conversion status is recommended, rigorously tracking model fidelity and adoption of the true team shared caseload model, supported by multiple team meetings weekly. The integration of psychiatry and nursing as a component of the team needs to occur, which implies participation in team meetings. As well, the shift to field-based services should be tracked through an ongoing monthly reporting of location of services.

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

The technical assistance (TA) provided to the MHP by CalEQRO consisted of encouragement to immediately explore replacement topics and contact CalEQRO for TA.

Non-clinical PIP—Engagement & Retention Project

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

“Will the addition of personal engagement & proactive follow up calls for adults in Vallejo lead to an increase rate of service requests to assessment by at least 25 percent in order to better engage clients, especially those from underserved communities?”

Date PIP began: July 2018

Projected End date: December 2019

Status of PIP: Completed

This PIP considered the engagement and retention of adults who are entering the system in the Vallejo adult clinic, which is becoming the largest adult clinic. This was derived from data that reflected a failure to show for an assessment after an initial access call, and the drop-off in service retention after the first assessment service. In-person and phone interviews were conducted to identify the issues relating to not entering or continuing with services. The findings centered on issues relating to lack of engagement and local, cultural disparities that can be remediated by initiating reminder

calls, peer support, and 1:1 engagement through direct contact between clinic personnel and beneficiaries.

Last year this PIP was rated as concept only, and was lacking active interventions. The spectrum of interventions became active during May, June and July of 2019, and included reminder calls and surveys, among other strategies.

Suggestions to improve the PIP: After an initial intervention and data collection period during May and June of 2019, no further evaluation or intervention strategies have emerged. Overall, the MHP has targeted various common barriers that impede engagement and retention. The interventions were conceptualized generally as narratives, and there were numerous changes made to process and supportive interventions. It is possible this PIP would have benefitted from use as several year improvement activity. It might emerge that some key interventions are more effective for individuals who are externally referred versus those who are self-referred.

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

The TA provided to the MHP by CalEQRO consisted of encouragement of the MHP to identify a non-clinical PIP topic based on data analysis findings, and contact the assigned EQR quality reviewer early and often going forward.

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	M	M
2	Study Question	2.1	Clearly stated	M	M

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	PM	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	M	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	PM

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	PM	PM
		8.2	PIP results and findings presented clearly and accurately	PM	PM
		8.3	Threats to comparability, internal and external validity	PM	NM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	UTD
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	UTD
		9.3	Improvement in performance linked to the PIP	M	UTD
		9.4	Statistical evidence of true improvement	PM	UTD
		9.5	Sustained improvement demonstrated through repeated measures	NM	UTD

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	18	15
Number Partially Met	6	3
Number Not Met	1	2

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Unable to Determine	0	5
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**84%**	**66%**

INFORMATION SYSTEMS REVIEW

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

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

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations

	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
Solano	3.00%	3.00%	3.00%	3.00%
Medium MHP Group	N/A	3.30%	2.80%	0.00%
Statewide	N/A	3.40%	3.30%	3.40%

The budget determination process for information system operations is:

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

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

Table 8: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	23.4%

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
Contract providers	76.14%
Network providers	.46%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	Not Available	Weekly
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	N/A	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	Not Available	Monthly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	N/A	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	N/A	Not used
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	N/A	Not used

- Percent Used for Provider Transmission not provided.

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

Number of county-operated sites currently operational: 7

- Number of contract provider sites currently operational: 4

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries

- Telehealth services are available with English and Spanish speaking practitioners (not including the use of interpreters or language line).
- Approximately 5 telehealth sessions were conducted in Spanish.
- Approximately 3,761 telehealth services were provided to 1,006 beneficiaries.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

Fiscal Year	IT FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
2019-20	3	0	0	0
2018-19	3	0	0	0

Table 10: Technology Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2017-18	3	1	0	0

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

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	0.5	0	0	0
2018-19	1	0.5	0	0
2017-18	0.50	0	0.50	0

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

- 0.5 FTE in Table 11 represents multiple staff.
- The MHP reported a 0.5 FTE reduction in analytic staff from FY 2018-19 to FY 2019-20.

Current Operations

- The MHP continues to use Avatar, hosted by Netsmart Technologies, as its EHR. The Avatar system provides Practice Management, Clinical Workstation, and Managed Services.

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 (SDMC) 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**
Avatar	CWS, Practice Management	Netsmart	6	Netsmart
Order Connect	Prescriptions; Labs	Netsmart	6	Netsmart
Perceptive	Document Imaging	Hyland	1	Netsmart
Assessment Engine	Assessment	Netsmart	1	Netsmart

The MHP's Priorities for the Coming Year

- Support of state mandated reporting – CSI Assessment, NACT, CANS/PSC, 274 expansion.
- Completion of 270/271 eligibility checking in AVATAR.
- Implement New Client Service Plan.
- Implement Document Imaging/Scanning Deployment in Avatar.
- Implement Reaching Recovery (LOC/Outcome Measure Portal) through Avatar.
- Improve and implement new Console Widgets.
- Implement Universal Assessment.
- Implement the Alerts module in Avatar.
- Implement the Level of Care/Level of Service module.

Major Changes since Prior Year

- The MHP completed the data warehouse server upgrade and migration.
- The Substance Use Disorder (SUD) Access line merged with the Mental Health (MH) Access line. The SUD and MH screening and triaging functions were combined in the Avatar Access Screening and Referral forms and added multiple related reports.

- The contract with Netsmart was amended to add the RR tools and to allow for establishment of a contingency fund, which will support additional licenses and prescribing tokens if needed. This also allows the MHP to move forward a personal health record (PHR) with MyHealthPointe within a 2-year contract if time/resources permit.

Other Areas for Improvement

- The following items from the prior year's list of MHP priorities have not been completed: (1) Implement 270/271 Eligibility Checking in Avatar; (2) Improve and implement new Console Widgets in Avatar; (3) Implement MHSA Data Collection in Avatar.
- Discussion has occurred regarding strategies to address impending IT staff retirements, and increasing Federal and State data reporting requirements. Also reviewed was how to improve project delays.
- Due to data analytics and staffing capacity issues, some projects and initiatives are delayed, among them: (1) development of the Avatar Special Populations Form (other priority projects stalled progress); (2) focus on the Clinical Quality Improvement initiative; and (3) 21 items on the Avatar wish list and 34 items on the project list.
- The MHP has discussed strategies to address impending IT staff retirements, increasing federal and state data reporting requirements, and strategies to improve project delays.

Plans for Information Systems Change

- No plans to replace current system.

Current EHR Status

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

Table 13: EHR Functionality

		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Alerts				X	
Assessments	Avatar/Netsmart	X			
Care Coordination				X	

Table 13: EHR Functionality					
		Rating			
Function	**System/Application**	**Present**	**Partially Present**	**Not Present**	**Not Rated**
Document Imaging/ Storage	Perspective Document capture	X			
Electronic Signature—MHP Beneficiary	Avatar/Netsmart	X			
Laboratory results (eLab)	Order Connect/Netsmart	X			
Level of Care/Level of Service	Avatar/Netsmart Reaching Recovery			X	
Outcomes	Avatar/Netsmart	X			
Prescriptions (eRx)	Order Connect Netsmart	X			
Progress Notes	Avatar/Netsmart	X			
Referral Management				X	
Treatment Plans	Avatar/Netsmart	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		8	0	4	0
FY 2018-19 Summary Totals for EHR Functionality:		7	0	5	0
FY 2017-18 Summary Totals for EHR Functionality:		7	0	5	0

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

- The MHP implemented Document Imaging/Scanning Pilot.
- Implemented Assessment Engine – PSC35.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimension Report

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14. Summary of CY 2018 Short Doyle/Medi-Cal Claims
Solano MHP

Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**94,824**	**$32,343,326**	**5,393**	**$2,089,783**	**6.46%**	**$30,253,543**	**$26,075,716**
JAN18	9,045	$3,185,641	697	$217,055	6.81%	$2,968,586	$2,381,236
FEB18	8,399	$2,988,587	465	$158,704	5.31%	$2,829,883	$2,329,572
MAR18	9,444	$3,179,786	275	$86,760	2.73%	$3,093,026	$2,750,057
APR18	8,764	$3,128,083	306	$115,525	3.69%	$3,012,558	$2,673,041
MAY18	9,344	$3,048,147	272	$76,933	2.52%	$2,971,214	$2,648,225
JUN18	7,690	$2,486,594	277	$80,799	3.25%	$2,405,795	$2,189,363
JUL18	7,639	$2,535,260	309	$187,113	7.38%	$2,348,147	$2,081,963
AUG18	8,172	$2,816,010	396	$224,348	7.97%	$2,591,662	$2,260,365
SEP18	7,169	$2,587,003	380	$242,392	9.37%	$2,344,611	$1,969,185
OCT18	9,774	$3,590,435	1,846	$651,441	18.14%	$2,938,994	$2,217,465
NOV18	5,544	$1,647,819	92	$27,863	1.69%	$1,619,956	$1,504,124
DEC18	3,840	$1,149,962	78	$20,850	1.81%	$1,129,112	$1,071,120

Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2018 was **3.25 percent.**

During CY 2018 the MHP experienced claims submission delays which resulted in a significant number of claim transactions not being included in the above analysis for CY 2018 results.

Table 15 summarizes the top three reasons for claim denial.

Table 15. Summary of CY 2018 Top Three Reasons for Claim Denial
Solano MHP

Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Service line is a duplicate and repeat service procedure modifier is not present.	2,791	$928,580	44%
Missing, incomplete, invalid place of service.	268	$461,007	22%
Payment denied - prior processing information incorrect. Void/replacement condition.	618	$162,908	8%
TOTAL	5,393	$2,089,783	N/A

The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.

- Denied claim transactions with reasons “Service line is a duplicate and repeat service procedure modifier is not present” and “Payment denied – prior processing information incorrect. Void/replacement condition” are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site beneficiary focus group was conducted as part of CalEQRO's desk review of Solano this year.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries 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 16: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	12

The MHP encourages those requesting services to walk in or call for assistance, primarily focused on the directly operated adult and children's clinics.

The website provides information in English and Spanish regarding initial access, crisis services, and suicide prevention. The second listed sidebar menu option, labeled Access to Care, remains under construction, and the link to transportation was not active as of this review but has since been repaired.

The ordering of website options does not align well with meeting the needs of beneficiaries, interspersing quality and cultural competence with clinical options. Involvement of caregivers and beneficiaries in the review of this structure might provide some helpful guidance as to website structure. The access tracking and reporting does not appear to include results of primary care, and school referral tracking incorporated in the prior Quality Assurance Performance Improvement (QAPI) work plan evaluation.

The Provider Network list currently resides under the Quality Improvement (QI) tab, which may not be the optimal location for beneficiary discovery. Placement on the homepage would better facilitate user access. As well, the Provider Network listing does not include a searchable function that enables a beneficiary to easily select and view only those programs in a specific region of the county.

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
The .pdf brochures on the website provide bilingual information on groups and other very useful resources. These resources, including .pdf flyers, merit prominent display so as to inform potential beneficiaries of the range of services. Prominent display of wellness center options on the homepage may also improve support of individuals seeking treatment or supportive resources.			
1B	Capacity Management	10	8
As part of the CRP, the MHP has identified numerous strategies to attract and recruit clinicians, including those in the education and training process before degree and licensure attainment. There is a focus on bilingual staff, and the MHP reports some progress in this area over the last year. In another area, lesbian, gay, bisexual, transgender, questioning (LGBTQ) training and clinic decorative efforts have improved the MHP's ability to assure individuals that they are welcome and that their needs will be addressed respectfully. To improve access for children and youth, five pilot wellness centers were opened in the schools during the 2019 school year, with plans to open an additional 20 centers. To date, the acceptance of mixed-age wellness centers has not been a success in reaching TAY youth. To help maintain awareness of demand and need trends, a biweekly referral report was created and run effective September 2018. This report assists managing referrals and understanding unutilized capacity availability within the system in consideration of the various program levels of care.			
1C	Integration and Collaboration	24	22
The MHP has recently been involved in the development of school-based wellness centers. Other collaborations include trainings with faith-based programs as partners. The MHP has increased efforts to partner with public health, healthcare providers, and LGBTQ+ providers. There are continued efforts to improve services through development of a mobile crisis program to be run by a contract provider. At the time of this review, previous efforts had been unsuccessful; however, renewed work in this area is anticipated in 2020. Providing Crisis Intervention Training (CIT) for law enforcement is a priority of the department. A total of 292 peace officers participated in the eight-hour Intro to Crisis Intervention Team (CIT) training funded by MHSA. Additionally, in partnership with Fairfield Police Department (FPD) and NAMI Solano, the MHP is developing a comprehensive 40hr			

Table 16: Access to Care Components		
Component	**Maximum Possible**	**MHP Score**
week CIT curriculum based on the Memphis model. This 40-hour training will be offered to all local LEAs including the Sheriff Office (SO) and correctional officers working in the 3 local jails. The MHP plans to implement throughout 2020. In August 2019 three (3) officers from the FPD and one Sherriff deputy were invited to a train-the-trainer session.		

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	16
In this past year, the MHP was able to capture first offered timeliness data to include system-wide walk-ins and contracted EPSDT providers. In addition, Solano reported timeliness data in business days for the first time for FY 2019-20. The previously used outlier cut-off for exclusion of events was 60 calendar days and has been adjusted now to 45 business days to compensate for the switch from calendar to business days. The MHP uses the mandated ten business day standard for first offered appointments, and all tracked subgroups exceeded the 75 percent DHCS performance expectation for meeting standard. Adult services experienced an average (mean) of 1.73 days; children's services averaged 8.7 days; FC averaged 6.07 days. The first kept appointment standard is 10 days, with averages for adults reported as 10.64 days; children, 14.3 days; and FC, 9.47 days. Achievement of the standard was 73.8 percent for adults, 47.94 percent for children and youth, and 63.04 percent for FC.			
2B	Assessment Follow-up and Routine Appointments	8	6
The MHP tracks engagement with treatment following assessment for adults and for children and youth. For continuation from assessment to treatment, the adult goal was 50 percent, and the children's goal was 75 percent. Results were reported quarterly.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
Children's performance on this measure is better than 75 percent. The MHP did not separately track FC and older adults.			
2C	First Offered Psychiatry Appointment	12	9
The MHP reported adherence to the 15-day DHCS Information Notice 18-011 (IN 18-011) standard. This standard requires a mechanism to capture the identification of psychiatry service need. For the children and youth, the accepted standard of care is to provide non-medication interventions first and then consider psychotropics if the response is inadequate. The exceptions are those children and youth who enter services with the MHP already receiving medication interventions. The MHP reported data on adult/older adult or children/youth clinic sites, and provided the average wait times and total events. Overall, youth average access to psychiatry services was 3 months; adult service overall average was 21 days following the access call. The MHP's children's services include some contract agency providers whose beneficiaries are initially seen for an assessment in a directly operated program. This complicates tracking and reporting of psychiatry timeliness. MHP reporting might present more accurate and useful information were psychiatry service timeliness tracked by clinician decision or referral and beneficiary/caregiver request for psychiatry. The MHP's methodology of reporting psychiatry access by site is a logical and effective approach, since access to psychiatry services can be significantly impacted by site-based capacity issues. The MHP omitted reporting the percent of psychiatry referrals that meet the standard, and the other data elements that are included in the timeliness self-report to the EQRO. FC was not broken out. The omitted elements merit being added to the MHP's location focused reporting. The Quality Assessment Performance Improvement (QAPI) plan does not include a goal (or tracking/reporting frequency) for this measure.			
2D	Timely Appointments for Urgent Conditions	18	12
The MHP advised that this metric is calculated using the previous local three-day standard. Those whose urgent service needs require timely response, within hours, are referred to the crisis unit and assessed. The MHP reported that prior-authorized			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
services would meet the same timeliness results represented by the child and youth data. The QAPI Work Plan associates urgent response timeliness with assessment requirements. It is not clear how the MHP categorizes and manages non-crisis urgent care needs once in treatment, as not all urgent service needs occur in the context of initial access. The MHP reported average (mean) urgent care timeliness of 4.25 days for adults, and 7.21 days for children. When converted to hours, these results exceed the 48-hour standard. All discussions regarding urgent care timeliness in Quality Improvement Committee (QIC) minutes and the QAPI work plan identify the three-day local standard. The MHP should consider using the hour-based format and possible elimination of the 96-hour preauthorized element if none of the services require prior authorization.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	9
The QAPI Work Plan and the evaluation of the previous year's performance did not include goals or metric results for post-hospital follow-up. QIC minutes were also silent on the topic. It is unclear from the submissions received where these data are reviewed. The submitted EQR timeliness self-assessment did reflect adoption of the seven-day follow-up standard. There is evidence of tracking to both initial clinical follow-up and psychiatry follow-up (30 days), which is an important enhancement to this type of tracking. The average days to follow-up for adults met the seven-day standard (6.3 days); however, the standard was met only 32 percent of the time. Children and youth averaged 16.74 days and met the standard 48.41 percent of the time. FC data was included in the children/youth data and not available for separate analysis. The MHP includes all hospitals for tracking follow-up and breaks out the data by hospital, which helps to identify any unique issues with hospital discharges that could reflect lack of coordination with the MHP. The MHP also performs comparisons of follow-up rates with readmissions.			
2F	Tracks and Trends Data on Rehospitalizations	6	6
The MHP tracks 30-day rehospitalizations monthly. Readmissions are tracked and trended along with seven-day follow-up percentages. This report also includes a 30-			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
day psychiatric medication service tracking. All hospitals are included. FC data are not broken out; however, the MHP is on track to begin separate data collection. This combined dashboard presents a highly practical approach to the integration of related data. Results reported were 12.06 percent readmissions within 30 days for adults, and 14.65 percent for children and youth. FC data was not broken out from children's services. Reduction of FSP rehospitalizations is an active QI goal.			
2G	Tracks and Trends No-Shows	10	4
The MHP reported no-show events and does not have any standard or goal set. Breakdown by no-show type was not reported. Reporting is limited to directly-operated programs. The MHP provided a break-out by specific staff type, including nursing, clinical staff, and psychiatry. Because clinician use of the scheduler is quite variable, particularly for out-stationed staff, the utility of this reporting is limited to office-based practitioners. The data are broken out by adults and children's services. For all services, the MHP reported overall 20 percent no-shows for psychiatry and clinicians combined. Psychiatry had the highest no-show rates, which were 30 percent for adults and 16 percent for children. This merits further study to identify possible corrective actions. Data for FC youth was not broken-out. In response to the prior year's Recommendation No. 3, the MHP created Report 170X to pull system appointment data from which no-show and cancellations can be tracked.			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Beneficiary Needs are Matched to the Continuum of Care	12	10
The MHP has determined to use RR tools for adult LOC and outcomes. There has been initial training and expansion of the Avatar contract to include integration of the RR tools. As of this review, implementation had yet to occur. There are frequent references to LOC within the MHP's documentation, including acute care, crisis, full-service partnership, outpatient services. The MHP created an eligibility criteria table to assist in determining if applicants are eligible for services and at which program level. This document creates levels from one (FSP) to three, which is designated as a Prop 47 program for complex, multi-diagnosis individuals. The MHP provided evidence of caseload discussions and movement within high-level programs, most apparent in QIC Utilization Management (UM) subcommittee meetings. Plans to expedite step-downs are part of that review. The MHP produces tables of program slots and discusses beneficiaries and efforts to expedite step-downs where appropriate.			
3B	Quality Improvement Plan	10	6
The MHP's created a QAPI plan for FY 2019-20 that was accompanied by an analysis of results of the FY 2018-19 plan. A number of the prior years' goals, particularly those involving timeliness, were carried over. QIC minutes reflect discussion of progress towards QAPI goals. The structure and of the QAPI plan provides strong detail to the priority issues the MHP is tracking. That said, some tracking areas were missing incorporation of actual data in the prior and current plans where there were specific data elements to be tracked. For example, in the evaluation of the FY 2018-19 QAPI Work Plan, the Hispanic Outreach and Latino Access (HOLA), numbers of referrals for SMHS assessment were not reported. Section IV, Beneficiary Outcomes, reflected no data for youth medication monitoring. This was consistent for Q1 through Q4 of FY 2018-19. Another area that did not reflect data was the regional utilization and service penetration by cultural group, which intends to report clients and providers by race/ethnicity and did not present breakout data for all quarters of the FY 2018-19 period. It is understood that the MHP has been under pressure due to fires and local emergencies during this past year; however, these are areas important for consistent reporting and evaluation.			
3C	Quality Management Structure	14	8
The submitted documents reflect the MHP's QI/QA unit interface with other parts of the organization and contract providers on a regular basis. QIC participants include a diverse membership, such as UC Davis, the hospital liaison, a foster parent organization, and line staff. The participation of beneficiaries and family members is			

not clear from the approach used to identify participants in the minutes. The EQRO appreciates the effort to protect the personal history of participants; however, it may also wish to develop an alternate method that assists in identification of individuals with lived experience, perhaps without individual identification.

The theme regarding insufficient numbers of QI staff remains, particularly with analytic positions that are impacting the MHP's ability to perform continuous data analysis and to effectively support improvement projects while meeting needs of compliance for the MHP's operations.

3D	QM Reports Act as a Change Agent in the System	10	8

The MHP utilizes QM reports to review the performance of program elements in the quarterly QIC meetings. Consistently, the MHP reports out on those QAPI elements that have data. Some of these reports contributed to the MHP's PIP selection of study topics such as the engagement and retention non-clinical PIP. The MHP configures some reporting around programs and sites, which details specifically which programs are performing well and which have challenges. Typically, the MHP uses baselines, improvement targets, and progress metrics. In some of the metrics of the QAPI plan, it was not clear if data had been available for all elements for which tracking was forecast.

3E	Medication Management	12	8

The MHP tracks and reports adult poly-pharmacy, supported by policy: MEDS 506 Monitoring the Safety and Effectiveness of Medication Practices. Two Avatar reports consider prescribed medications: Report 339C Youth Medications and Report 349D, Currently Prescribed Poly. FC status has been added to report 339C.

It is not clear if review and tracking of FC youth prescribing includes metabolic monitoring, lab work, and other SB 1291 requirements.

The MHP would be well-served to track and specifically review the SB 1291 requirements in QIC when medication monitoring is discussed.

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	13
The MHP has explored outcome instruments for adult use and continues to use the Adult Needs and Strengths Assessment (ANSA) until the RR instruments are available within Avatar. Some ANSA elements are integrated into the Avatar adult assessment. The MHP administers the adult outcome instrument at intake and annually thereafter. Within children and youth services, the Child, Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist – 35 (PSC-35) were implemented in February 2019. These are administered at intake, every six months thereafter, and at closing. Regular communication of the aggregate results to programs and stakeholders lacks consistent mechanism for reaching all who may be interested.			
4B	Beneficiary Perceptions	10	6
The MHP's Consumer Perception Survey (CPS) results from 2016 are posted on the MHP's website. It includes information about the number of survey participants and distribution by ethnicity, gender, and language. Actual survey results are also reported and support comparison over time. The CPS is administered twice each year to all beneficiaries served during two-week windows. The MHP may wish to ensure that website postings contain the most recent information, such as those from 2017 and 2018. The utility of this information would be improved through the development of an informing mechanism to alert programs and beneficiaries to the existence of new survey results posted to the website. It would be helpful to post this type of notification for beneficiaries at clinics and to routinely notify staff with an alert email. The MHP's QI process provides survey results to programs, which are expected to target low scoring areas with improvement activities.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
The MHP operates three wellness centers; the Fairfield and Vallejo operations are full-time. All are operated by contract entities and staffed by individuals with lived experience. These programs offer peer counseling, wellness and recovery programming, and peer and family support groups. Beneficiaries would benefit from prominent identification of these programs on the MHP's website integration, particularly if listed in the same area as clinical services. Information about these non-clinical resources are not easily found, particularly in the			

current environment whereby many health programs include the term wellness center in their listings.

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		**Maximum Possible**	**MHP Score**
5A	Capability and Capacity of the MHP	30	27
The majority of modalities are provided by this MHP. Day rehabilitation is offered in a contracted special day school program which has been in place for many years. Day treatment intensive is not provided directly or by contract. Psychiatric health facility (PHF) services are provided under contract with Telecare in Vallejo, with a capacity of ten beds.			
5B	Network Adequacy	14	13
Regarding the use of adjunctive service delivery options, the MHP utilizes telehealth, operates three wellness centers, and maintains a provider network for moderate to severe conditions. The MHP has been unable to create a mobile crisis response team but will continue to seek an applicant to provide this important level of care. MH clinics are co-located on sites that have FQHC health clinics; however, plans to integrate care have not been implemented due to capacity issues. While there is some interaction, including informal consultation, formal integration has yet to occur. The MHP is in the initial phase of the process to create behavioral/medical health homes.			
5C	Subcontracts/Contract Providers	16	11
The MHP utilizes a variety of contract providers within both the adult and children's systems of care. The MHP meets with contractors through a quarterly MHSA roundtable discussion. There is evidence of non-MHSA meetings between the MHP and its contractors that support discussions regarding step-down and step-up level of care changes. Contractors also participate in monthly meetings with the Commercial Sexual Exploitation of Children (CSEC) subcommittee and participate on the Cultural Competence Committee (CCC).			
5D	Stakeholder Engagement	12	10

Various forums have an inclusive membership. The Amplify Excellence committee is committed to breaking silos and promoting a shared purpose and vision of teamwork, collaboration, and self-care across all facets of behavioral health; to enhance the collective ability to provide excellent support to each other and to our clients. The Amplify Excellence Meeting has staff and Customer Service Committee participants. QIC and Utilization subcommittees include supervisors and managers.

Beneficiary feedback is used by programs to target improvement activities, which is an expectation conveyed by leadership.

Contract providers are involved in the MHSA Steering Committee, QIC, and CCC, among others. A monthly peer network meeting began in June 2019 for contract and directly hired peers.

5E	Peer Employment	8	6

The MHP has directly hired three full-time peer support specialists for adult outpatient services. There is not a formal career ladder as yet; however, there are multiple levels of compensation. These staff can be accessed by other programs such as ACT and FSPs. The MHP discontinued its previous employment support contract due to lack of satisfactory results. Alternatively, the Individual Placement and Support (IPS) model is being implemented through a Caminar contract expansion. Contracted services, such as wellness centers and FSPs, also utilize peers. The MHP QI subcommittee is working to create a peer pipeline program to provide work experience and an employment path for lived-experience individuals throughout the system.

5F	Peer-Run Programs	10	9

All wellness programs are peer-run and staffed, which involves two full-time and one part-time programs. During the review period, the Fairfield site served 385 unduplicated clients, with 202 attending more than once; of those, 85 percent had a Wellness and Recovery Action Plan (WRAP) plan. The Vallejo site served 119 unduplicated clients, and nearly all were routinely attending; 92 percent had an active WRAP plan. The MHP communicates about the wellness center resource via a flyer and information on the website. EQR team members suggested that greater visibility of wellness center resources would be helpful, perhaps elevating these options to the same level as clinical services.

5G	Cultural Competency	12	11

The MHP has a CRP; for this review the FY 2018-2019 update was submitted. The plan is available on the MHP website and incorporates data across a wide timeline, with some elements from 2018. The scope of cultural responsiveness has broadened to include many aspects of social determinants of care, such as housing and income.

The MHP has implemented a MHSA Innovations project called the Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM). The MHP has partnered with UC Davis to implement the project, which aims to increase culturally and

linguistically appropriate services for unserved and underserved populations, including the Latino, Filipino, and LGBTQ+ communities. The region-specific curriculum incorporates the CLAS standards reflecting the local perspective on culturally responsive practices.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Solano MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP expanded FSP programs and added a new Youth & Family Services program called Youth Access. This program is currently being tested for capacity and efficiency.
- The MHP added a 1.0 FTE Mental Health Clinical Supervisor to oversee implementation of mobile crisis and triage team, although currently no vendors have responded to the crisis RFP.
- The Children's Services Centralized Assessment Team (CAT) assessments were added to the end of the access call rather than transferring the call or calling back. This change has improved assessment engagement.
- Staff were provided training on LGBTQ+ competence and also decorated clinic objects with rainbow stickers. Staff have noted an increase in the number of clients discussing LGBTQ+ issues.
- The former substance abuse Access Line was re-routed so that any Access Line calls are screened by both MH and SUD trained staff. This integration resulted in the ability to embed 4.0 FTE substance abuse counselors into adult and children's clinics to assist with assessment and treatment.
- The MHP launched its social media presence in May 2019. Greater exposure to county behavioral health services and innovations is anticipated.
- Substance use services will eventually transition to oversight by the Partnership Health Plan (PHP). At this time, the mechanics of how the relationship between the MHP and PHP will evolve remains unclear.
- The additional full-time psychiatry and nurse practitioner positions have not yet been filled. During the last year, three existing psychiatry positions have become vacant, adding to the challenges of coverage.

- The MHP has been in the process of creating an out-stationed criminal justice team. Two additional clinicians have been added to support the triage/diversion process. The program includes a drug court case manager, Proposition 47 case manager, embedded probation clinician, and jail liaison.

- By the 2020-21 school year there will be 35 to 40 school-based wellness centers in operation, providing another avenue of support and access to services for this population.

Strengths:

- Two clinicians from the children's FSP program started providing initial clinical assessments of youth during their stay in the crisis unit. This process improves early treatment engagement and follow-up after discharge.

- The Caminar Comprehensive Case Management (CCM) program was expanded to increase its capacity from 100 to 180 and added peer support specialists.

Opportunities for Improvement:

- The MHP's website is not designed to adequately meet the needs of beneficiaries or caregivers. Information not prominently presented includes both the provider network listing and wellness center resources, both of which would be frequently accessed. Non-functional links to resources should be routinely identified and resolved without delay.

- The recent increase in the loss of MHP clinicians is believed to be associated with Kaiser-Permanente and school district increased hiring of clinicians. The MHP is reassessing recruitment and retention efforts, including placing greater emphasis on filling vacant positions. Examining the various aspects of the employee experience, such as the organizational culture, documentation complexity, and workload expectations, might be other aspects worthy of exploration.

Timeliness of Services

Changes within the Past Year:

- The MHP implemented a "Provider of The Day" function, which furnishes urgent psychiatry/prescribing services county-wide for each clinic, through onsite service or telehealth.

- During FY 2019-20, all walk-ins across the system were included in timeliness tracking and data, including contracted children's providers.

Strengths:

- The first offered appointment average (mean) for children and youth was 8.7 days; adults and Foster Care (FC) averaged fewer days. Achievement of the standard is greater than 75 percent across all measured populations.
- The MHP reports first psychiatry appointment timeliness by clinic site and population served.
- The MHP tracks post-hospital discharge follow-up by each hospital and presents separate summary displays for youth and adults, including readmission rates.

Opportunities for Improvement:

- The MHP's reporting of initial psychiatry service timeliness does not reflect the percent of time the standard is met nor the full range of requested data. FC timeliness is not yet reported separately.
- Some provider sites are entering partial or no timeliness data into Avatar.
- Urgent service tracking is limited to those events related to assessment. The MHP reports on this using a previous three-day standard. It is unclear how the MHP responds to urgent service needs during the course of treatment that do not meet crisis criteria.

Quality of Care

Changes within the Past Year:

- The MHP has selected the RR tools to replace the ANSA. The RR tools provide improved outcome tracking and provide assistance with level of care determination. This is not yet implemented; however, training and preparation through a Netsmart contract enhancement is planned to support this decision.
- The MHP appointed an ethnic services manager to prioritize identified disparities, resume the CCC meetings, and provide six cultural competency trainings or events.

Strengths:

- The MHP's QIC has Clinical Quality and Utilization Management subcommittees that examine various aspects of care, including inpatient trends, level of care monitoring, and caseload issues.
- The MHP established a QI Training Vimeo page and began to expand use of video recordings to enhance the effectiveness of training regarding clinical processes, completion of Avatar forms and reports, and awareness of federal and state requirements.
- In order to analyze and assess penetration rates, the MHP improved data reporting on client demographics via the service verification survey process.

- A robust FY 2019-20 CRP (posted on the MHP's website) outlines the priorities and trainings provided to all staff.
- The children's FSP team engaged 98% of its clients to participate in Child and Family Team (CFT) meetings in alignment with Pathways. This increase is attributed to staff developing a better understanding of the importance of CFT meetings and the Intensive Care Coordination (ICC) Coordinator engaging with families prior to the first meeting to explain the CFT process.
- QIC meeting minutes often reflect quarterly review of QAPI goal status.
- QAPI performance elements contain baselines, improvement goals, and tracking methods to measure progress.

Opportunities for Improvement:

- The MHP's adult outpatient clinics were originally sited in partnership with physical health clinics to facilitate BH-primary care integration. To date, the two systems have not integrated in any systematic way. Efforts to provide routine physical health care to adult MHP beneficiaries in an innovative collaborative approach would help to improve the health status of these individuals, who are known to suffer premature death due to chronic, poorly-treated health conditions.
- The MHP currently lacks a mechanism that ensures stakeholders (beneficiaries, staff, and external parties) are informed when new data, such as consumer perception surveys and trends of aggregated outcome data, are received and/or posted on the MHP's website.
- In some of the QAPI performance areas there is data missing in the prior year's plan evaluation, and tracking appears incomplete.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP implemented the Jobs Plus employment program, contracting with Caminar as the provider. There was a 52 percent employment rate from March through June 2019. The Caminar contract expansion, includes the implementation of the Individual Placement Support (IPS) model, a best-practice for employment support.
- The MHP hired 3.0 FTE Peer Support Specialists who are embedded in outpatient and FSP programs.

Strengths:

- The Supporting Recovery through Connections drop-in group, co-led by a mental health specialist and a peer specialist who provide support to individuals who to need to reconnect with services and revisit their recovery plans.

- To support the creation of roles with clearly defined training and responsibilities, a relationship exists between the Crisis Stabilization Unit (CSU) and the peer certification programs that will enable peer employee candidates to acquire experience hours required for certification by working at the CSU.
- Support the Workforce Peer to Peer (P2P) Program provided training, workgroups, and a support webpage to increase staff morale, promote wellness, and improve productivity.

Opportunities for Improvement:

- While the MHP is adding individuals with lived experience to a variety of program elements, it lacks a comprehensive master plan for building this capacity, including the addition of parent partners, adult peers, and TAY peers. The development of career pathways would support efforts to create job categories specific to lived experience.

Foster Care

Changes within the Past Year:

- The MHP has successfully contracted with nine group homes that have converted to Short-Term Residential Treatment Programs (STRTP) located outside of Solano County.
- Recently, the MHP began tracking the first offered appointment for psychiatry using the time at which the identification of need occurred. For children and youth who are not receiving medications at entry, identification occurs approximately three months after starting services. This approach is consistent with best practices in treating children, frequently involving the use of talk, play, or other therapy modalities before considering medications.

Strengths:

- FC data from initial request to first offered appointment falls well within the ten business day standard.
- FC timeliness for first kept appointments (9.47 days) is within the ten business day requirement.

Opportunities for Improvement:

- Achievement of the ten business day standard for first offered FC appointments was reported as met 63.04 percent of the time, somewhat lower than desired.
- The MHP's current reporting of FC initial psychiatric service timeliness is rolled up with children's clinic data and is not separately reported.

- None of the local group homes have successfully accomplished the transition to STRTP. It is not clear if the MHP has identified the barriers to the participation in STRTPs for local group homes.

- While the MHP has a report that tracks prescribing practices for children and youth, there is no specific reporting of all SB 1291 metrics, including metabolic monitoring. This information needs to be monitored and tracked and periodically summarized, with conclusions and recommendations, and shared with prescribers and clinical teams as well as with QIC.

Information Systems

Changes within the Past Year:

- The MHP completed the data warehouse server upgrade and migration.

- The SUD and MH Access Lines merged. The MHP combined SUD and MHP screening and triaging functions in Avatar Access Screening and Referral forms, and added multiple related reports.

- The contract with Netsmart has been amended to add the RR tool and to allow for a contingency fund that will support the addition of more licenses and prescribing tokens if needed. This also allows the MHP to move forward with the MyHealthPointe personal health record within the 2-year contract, as time and resources permit.

Strengths:

- None noted.

Opportunities for Improvement:

- To improve IT capacity throughout, the MHP requires increased information systems human resources. The impending retirement of a key IT staff adds to the importance and urgency of this issue. This issue is needed to address increased Federal and State data reporting requirements, and the need to resolve the delays implementing improvement projects.

- The following items from the FY 2018-19 list of MHP priorities have not been completed: (1) Implement 270/271 Eligibility Checking in Avatar; (2) Improve and implement new Console Widgets in Avatar; (3) Implement MHSA Data Collection in Avatar.

- The projects directly impacted by lack of sufficient data analytic personnel and other staffing capacity include: (1) development of the Avatar Special Populations Form; (2) the Clinical Quality Improvement initiative; and (3) 21 items on the Avatar wish list and 34 items on the project list cannot be acted upon with current staffing.

Structure and Operations

Changes within the Past Year:

- The Health and Human Service (HHS) Department, of which Solano County Behavioral Health Services (BHS) is a division, is undergoing a major reorganization, including a revised reporting structure that incorporates Children's Mental Health in the "Child and Family Services" Division, to better coordinate and serve children and families. BHS has been assigned a key role in leading the HHS efforts associated with homelessness and housing, and CalWorks and Veteran's Services will be included in the BHS Division. Finally, the BHS Director will be designated as the HHS departmental Chief Deputy Director.

- BHS psychiatrists received training to perform a triennial reassessment of need for the nearly 80 percent of MHP beneficiaries who receive only medications services, centralizing the process with the prescribers who also know the beneficiary best. This structure frees other adult clinical staff to perform assessments, outpatient therapy, and case management. Efficacy of this change has not been measured or determined as yet.

- Three peer support specialist positions created in FY 2019 have now been filled. These individuals are embedded in adult outpatient and FSP programs. The children's system teams are seeking to add parent partners (PP) to their services in order to draw from the experiences of those with lived experience.

- School-based wellness centers (approximately 40) are being added to specific school sites in the county, improving the support provided to youth who need mental health services.

Strengths:

- The larger departmental reorganization has the potential to better integrate children and youth services with the agencies most frequently involved and may streamline and improve service coordination for this population.

- Formal inclusion in the new organization of services and housing for the homeless has the potential to improve services for this vulnerable and often difficult to serve population.

Opportunities for Improvement:

- Development of a comprehensive plan for the broad use of peers is critical, including a career ladder within TAY and adult services and parent partners for children and their families.

- It remains unclear how the MHP and DMC-ODS waiver services managed by PHP will operate together. It is important to move ahead and engage PHP in

discussions that allow the MHP to make decisions regarding staffing and program management. This is of particular importance for beneficiaries who have co-occurring conditions.

FY 2019-20 Recommendations

PIP Status

1. Both of the MHP's PIPs were completed before this current review occurred. Conversations between the EQRO and MHP staff included encouragement to immediately pursue development of clinical and non-clinical PIP topics. MHP staff were advised of the EQRO's technical assistance (TA) availability. As per Title 42, CFR, Section 438.330, DHCS contractually requires two active PIPs.

Access to Care

2. Complete review of the website design, and develop a more beneficiary friendly and focused structure. Suggestions include relocating the provider directory to a more prominent position and with enhanced search capabilities, prominent identification of wellness center resources, and regular, periodic testing of links, which will ensure that key resources have active links.

Timeliness of Services

3. Improve the tracking and reporting of initial psychiatry service timeliness to include the percent of time the standard is met and the data range, per IN 18-011.

4. Improve the capture of data for service delivery sites that are currently entering partial or no data into Avatar, to provide more complete assessment timeliness reporting.

5. Obtain consultation from DHCS liaison to determine if the current practice of restricting urgent tracking to intake/assessment is acceptable. Consider expanding the tracking of urgent service needs beyond the assessment window to other times during the treatment process. Update the three day standard and reporting to the 48/96 hour, non-preauthorized/pre-authorized requirements.

Quality of Care

6. Continuously add data to the Quality Assessment Performance Improvement (QAPI) plan through the course of the year as updates and relevant data are received and reviewed. This supports this document being an active source for tracking progress throughout the year.

7. Develop a mechanism to ensure that new information related to Consumer Perception Surveys (CPS) and other system data is posted to the website and a communication strategy is employed. This may include posting messages for beneficiaries and caregivers at clinics and email notifications containing links to other stakeholders.

8. Renew efforts towards the developing and implementing a plan to integrate physical health care with the adult behavioral health (BH) outpatient clinics, to assist in serving a population that often has multiple poorly managed physical health conditions.

Beneficiary Outcomes

9. Complete the implementation of the Reaching Recovery (RR) instruments, and apply the results to informing assessments and level of care determinations.

10. Continue tracking the supported employment results provided by the Caminar expansion contract, including beneficiary satisfaction with services.

11. Begin the process of developing a masterplan for the inclusion of individuals with lived experience in all aspects of MHP service delivery.

Foster Care

12. The MHP to develop a comprehensive reporting process that targets SB 1291 FC prescribing standards, including metabolic monitoring, which is reviewed with prescribers and program clinical staff on a periodic basis throughout the year. This report should include action steps, such as: further investigatory pursuits when the data is unclear, and/or actions taken when standards are not met.

13. All timeliness metrics are to be monitored separately for FC beneficiaries per the IN -9-044

Information Systems

14. The MHP to continue efforts to improve the IT and data analytics staffing capacity to effectively maintain and move the department forward. The inability to complete critical projects and initiatives based on established timelines is evidence of this need.

15. The MHP to review the totality of IT/IS priority listings and assess for each the need to remain on the priorities list and how moving forward can be accomplished.

16. The MHP to complete the following recommendations from the prior year: (1) Implement 270/271 Eligibility Checking in Avatar; (2) Improve and implement new Console Widgets in Avatar; (3) Implement MHSA Data Collection in Avatar. (*These are carry-over recommendations from FY 2018-19*.)

Structure and Operations

17. Continue the process to secure a provider for mobile crisis services.

18. Identify the barriers to workforce stability and develop a comprehensive plan to address these factors, including strategies related to recruitment and retention.

SITE REVIEW PROCESS BARRIERS

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

- The original scheduling of this review was deferred date due to local fires and response to a regional disaster declaration.
- Then regarding the rescheduled review dates, in accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting beneficiary focus groups.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions - Solano County MHP
No onsite sessions were conducted.

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Lead Quality Reviewer
Leda Frediani, Information Systems Reviewer
Diane Mintz, 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 in preparing the recommendations within this report.

Sites of MHP Review

No MHP or contractor sites were visited for this review.

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1. CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Solano MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Medium	541,182	20,317	3.75%	$121,508,029	$5,981
MHP	33,588	1,139	3.39%	$5,267,192	$4,624

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

Table C2. CY 2018 Distribution of Beneficiaries by ACB Cost Band
Solano MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	4,370	93.12%	93.16%	$16,252,349	$3,719	$3,802	56.50%	54.88%
>$20K - $30K	161	3.43%	3.10%	$3,880,844	$24,105	$24,272	13.49%	11.65%
>$30K	162	3.45%	3.74%	$8,630,231	$53,273	$57,725	30.00%	33.47%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Solano County	
PIP Title: Full Service Partnership Service Improvement	
Start Date: 07/01/18 **Completion Date**: 12/31/19 **Projected Study Period**: 18 Months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review**: 04/01/20 **Name of Reviewer**: Robert Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP's clinical PIP is focused on transitioning FSP programs to an evidence-based practice (EBP), Assertive Community Treatment (ACT) model, improving initial engagement, successful discharges involving achievement of treatment goals, and ensuring appropriate lengths of stay.	

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Participants included a peer, adult FSP/FACT team representatives, and MHP leadership.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? While MHP assessment of factors was broad, it may be that these FSPs have such different populations that a single approach may not work effectively across all of these disparate components.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	FSP beneficiary discharge goal attainment percentages (25 percent), were lower than anticipated and much less than anticipated from this intensive service model.

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☐ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The emphasis of this PIP was upon the FSP model in use and how it differs from the best practice ACT model. Considered for this PIP were the caseload sizes that are typically below (8:1) even that of the rigorous/limited census ACT model, which specifies a higher caseload (10:1). The local FSP model does not have staff all delivering team services, but rather through dyads. Dyad units have been formed: licensed clinician paired with unlicensed specialist. The clinician determined what was in the treatment plan, and provided therapy services while non-licensed performed case management and rehabilitation services. Nursing staff and psychiatry were part of some but not all FSP teams. Another aspect of local FSPs is a somewhat strict and limited engagement period following referral. This means that the more reluctant individuals, potentially ones with the highest needs and numbers of acute and crisis events, may not be entered into the FSP. Finally, some of the FSPs have unusually high office-based services, which are not typical of the FSP model.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics: Adults receiving FSP services* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Adult FSP members.

	Totals	**4** Met Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Can we increase the number and type of field-based, person-centered, recovery-oriented services to FSP clients in order to improve client engagement in the FSP outcomes such that at discharge at least 75% have achieved their goals (among other outcomes).	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Among all of the MHP's FSPs, the Forensic ACT program provides significant percentage of office-based services contrary to ACT model literature which presents a 75 percent field-based model.
	Totals	**1** Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other FSP participants	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	FSP Medi-Cal enrollees were the intended population.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP included all individuals open to an FSP program.
	Totals	**2** Met Partially Met Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Engagement in FSP services • Average units of service per week • Field Based Service Provision • Number of Services Per Week Enrolled • Length of Service in FSP at time of discharge • FSP Throughput – discharges/clients served • Successful Outcomes at Discharge • Engaged in employment, volunteer work, or education	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All indicators reflect objective, data-focused elements.
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 beneficiary focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☒ Yes ☐ No Are long-term outcomes implied? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP did focus on outcomes, for example tracking successful discharges. Data from hospitalizations and crisis response events could have also informed the process and helped to determine if adverse events during the course of treatment improved.
	Totals	Met Partially Met Not Met UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP targeted all participants in FSPs, and therefore did not engage in sampling.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **3** NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	• Total units of service provided • Total number of contacts/services provided • Number of clients served • Dates of episode opening and closing • Numbers referred for FSP • Information about whether the client is engaged in employment, volunteer work, or education
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☒ Other: CSI information	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	• Report 324 – can provide details of all services provided within the time frame, as well as admissions and discharges. Total number of services and total units of service can be calculated from this report. • Report 324 – the service detail also includes the location of the service. The total units of service in the field divided by the total units provided results in the percentage provided in the field. Note a limitation in this data in that for the Vallejo FSP the psychiatry units are not included in this data set. • Report 314 – date of discharge for clients who are discharged. Also includes the admission date. In determining the length of stay, this is calculated by the open date or first date of the quarter being analyzed, and the time to the end of the quarter or the close date.

		• Report 314 – this report also shows the status at time of discharge. The denominator includes all cases closed and the numerator includes those clients whose status is "reached goals" or "partially reached goals." • Transitions in Care database on SharePoint provides the data for the Engagement in program indicator: The referrals from TIC serves as the denominator. Clients are included in the numerator and considered engaged if they receive 6+ services within the first 4 weeks of the episode being opened. • Employment status is a CSI field and available in Avatar.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	See 6.2 above, wherein the MHP described the adaptive strategies to address some of the challenges with the data collection.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other: EHR reports and claims data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP included contingencies and implementation strategies in the list of reports utilized for this PIP. The inclusion of contingencies and other concerns with each report/data element was of assistance in understanding the MHP's methodology.
6.6 Were qualified staff and personnel used to collect the data? *Project Co-leads:* Name: Emery Cowan, LPCC, BH Administrator; Kate Grammy, Psy.D., BH Manager	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**6** Met Partially Met Not Met UTD

STEP 7: Assess Improvement Strategies

7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?
 	
Describe Interventions:
• Revised table of discharge reasons. Provided training of codes through QI liaison clinicians.
• Training FSP leaders and staff regarding the approach in ACT. Disseminated all fidelity materials, tools and handout samples and continue quarterly regional meetings with counties and monthly meetings with three Solano teams per the PIP and implementation sessions.
• Shifted from all three teams meeting to discuss clients and make assignments from once per week to:
  ○ FACT twice weekly, and as of June, three times per week.
  ○ Caminar meetings five per week in mornings
  ○ Vallejo meeting twice per week
 	
• Application of a team-approach for resource distribution and prioritization of clients, and intentional specialist interventions. Include psychiatrists when possible. (FACT psychiatrist joins by video-conferencing.)
	☐ Met
	☒ Partially Met
	☐ Not Met
	☐ Unable to Determine
		It is unclear if there were internal FSP team barriers to adoption of the ACT model; and if so, how they would be addressed. Adoption of a new and different model may be associated with resistance and failure to implement. While the fidelity measure helps with the overall assessment of progress, it is also useful to have an active concurrent process that identifies and addresses the challenges experienced by staff in implementing this model change.

• Reduce the number of unique psychiatry providers by identifying the preferred FSP providers.
• Train staff on addressing co-occurring substance abuse issues; including, consultation, and coordinated work with clinicians with SUD expertise.
• Develop specialty roles per the ACT model: vocational specialist, SUD specialist, peer specialist (TBD staff hired), housing specialist.
• Train staff on the ACT fidelity tool and develop methods to overcome barriers to rehabilitation approach for better person-centered planning and community-based interventions.
  • Includes monthly coaching calls monthly for each team
  • All 3 team are utilizing the TMACT Roster and Outcomes Tool to track interventions needed and provided for each member of the team.
• Implement discharge readiness tool so that discharge transitions are appropriately timed.		

	Totals	Met **1** Partially Met Not Met UTD

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP did not specifically articulate a detailed data analysis plan beyond that which is associated with tracking each data element. But both baseline and results data were provided.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	In Section 8, while tables are clearly labeled, none of the tables are accompanied by dates. It is difficult to determine the date results were run.

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: Unknown Indicate the statistical analysis used: Percentage Indicate the statistical significance level or confidence level if available/known: ____percent X Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP listed the results but did not specify dates of the data presented in the tables nor whether the data was related to the initial 19 individuals followed-up or a subsequent cohort.

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:* Improvements are predicated on wide-spread and effective immediate implementation of the ACT model. The MHP recognizes that many elements require time for complete and faithful implementation. As well, during the period of this PIP the FSP programs undergoing transition experienced staffing losses. *Conclusions regarding the success of the interpretation:* Moving from a generalized FSP model to an ACT does take time and commitment of resources for monitoring and tracking. *Recommendations for follow-up:* Continue to track results of transition between generic FSP to ACT.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP showed improvements in: • Engagement in FSP services (+11.7 percent) • Length of FSP service at discharge (+29.21 percent) • Throughput (+5.13 percent) • Successful outcomes at discharge (+51 percent) The MHP showed decreases in performance in: • Average units of service per week (-11.7 percent) • Provision of field-based services (-2.64 percent) • Number of services per week enrolled (-24.89 percent)
Totals	**1** Met **3** Partially Met Not Met NA UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☒ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	See 8.4 above.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☒ Small ☐ Fair ☐ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☒ Weak ☐ Moderate ☐ Strong	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	The PIP ended before multiple periods of data reporting and needed changes to interventions could be identified and applied.
Totals	**3** Met **2** Partially Met Not Met NA UTD	

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

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

Conclusions:

The MHP is aware of inconsistencies within the data results, which may be associated with staffing issues during the PIP period and with issues relating to a change in the model of care, which requires prolonged follow-up, tailoring of additional interventions, and more monitoring.

It would seem imperative that program directors of the FSPs converting to ACT model programs be aligned with this initiative. Support for the changes does require commitment of all staff, from peers to psychiatry. These challenges are similar to those experienced by the original California FSPs when the rigors of ACT fidelity saw many, if not most, using a more flexible approach to these intensive services. Due to that history, there may be additional constraining factors to be discovered and overcome within FSPs that have a long history of non-ACT format operations.

The key promising finding is the achievement of successful outcomes at discharge, at 51 percent improvement.

Recommendations:

The MHP should continue to monitor this change in model and encourage identification of new barriers that would need additional intervention strategies. FSP programs tend to create improved results the closer to ACT fidelity they have.

That some of the programs provided mainly office-based services would seem out of step with customary intensive services programs. This alone could contribute to worse outcomes. Model standardization to a higher degree is an important goal.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☒ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Solano County	
PIP Title: Engagement & Retention Project	
Start Date: July 2018 **Completion Date**: 12/30/2019 **Projected Study Period**: 18 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 04/01/20 **Name of Reviewer**: Robert Walton	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The MHP focused on initial engagement and retention of adult beneficiaries served by the Vallejo Clinic. The study population is limited to individuals who no-show for a scheduled assessment after an access call, and those who fail to show for a treatment appointment following an assessment service. The MHP initiated follow-up with these individuals in person and by phone. The	

MHP determined that improvement in both measures could be achieved with reminder calls, peer support, and 1:1 engagement efforts.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Input on the topic was gained from system users. The surveys of beneficiaries yielded 25 percent experiencing difficulties in their preferred languages. Other issues raised were stable housing, and work.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP's QI process then targeted individuals who had contacted access, received a referral, and had not followed through. Follow-up calls to caregivers/parents were acknowledged as another area of investigation to identify any salient issues not present with other stakeholders.

Select the category for each PIP:

Non-clinical:

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☒ Process of accessing or delivering care
☐ High volume services
☐ High risk conditions

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	**Barriers** • Difficulty remembering appointments • Ambivalence about seeking care • Concerns about seeking care from the County • Complex life issues hindering their ability to follow up with treatment • Assessment function is primarily done by clinicians who will not be the ongoing provider • Wait times in Vallejo adult have been long (50-60 days) for psychiatry
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**4** Met Partially Met Not Met UTD

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will the addition of personal engagement & proactive follow up calls for adults in Vallejo lead to an increase rate of service requests to assessment by at least 25% in order to better engage clients, especially those from underserved communities?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met Partially Met Not Met UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other: Location - Vallejo	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The initial data analysis included all requests for service from the MHP. Once analyzed, the Vallejo adult outpatient clinic was targeted for the initial improvement effort. The rationale for Vallejo adults: least engagement; largest increase in service demand; most culturally diverse community; highest poverty rate.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: Those initially accessing services	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Vallejo adult population. It is important to note that as the MHP initiated interventions, May through June 2019, 19 individuals who had not engaged were contacted for follow-up efforts.

	Totals	2 Met Partially Met Not Met UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Show rate for adult assessments - Vallejo • Show rate for post-assessment psychiatry visit – Vallejo • Wait time for adult psychiatry Vallejo • Rate of beneficiaries with two or fewer services in EQRO approved claims • Disparity in Assessment engagement? compared to White • Disparity in Psychiatry engagement compared to white	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary focused. ☒ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Engagement tracked.

	Totals	**2** Met Partially Met Not Met UTD
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP did not use sampling, instead targeted engagement at the Vallejo adult clinic.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **3** NA UTD	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The data which builds the indicators come from the Report 333, which is used routinely to monitor both timeliness and engagement. This report informs the timeliness across the system that is reviewed at the quarterly QIC.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Report 333.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All new referrals for services.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has noted that a number of iterations of this report have been required in order to obtain the necessary data.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Emery Cowan, LMHC, Co-Lead Eugene Durrah, LCSW, Co-Lead Freddy Ford, LMFT	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**6** Met Partially Met Not Met UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* 1. Inform community of quick pick-up of access calls, and multi-lingual staff answering. 2. Reminder calls 3. Engagement outreach team 4. Training staff with cultural diversity 5. Create more welcoming clinic environments 6. Survey clients before and after assessment 7. Add peer specialist to Vallejo adult team 8. Address transportation barriers 9. Provide family support	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The list of interventions is derived from the MHP's narrative description of various strategies. While the MHP is engaged in a comprehensive approach, it is difficult to determine which interventions are creating the successes. Perhaps, using the feedback of staff and individuals who have initially failed to engage, the interventions could have been broken out in smaller packages, testing out one at a time. The MHP might have opted to identify the highest rated interventions and implemented those first. Then following results analysis could have modified the approach. The tracking of intervention application would also be informative. Many of the approaches are specific actions but it is not clear how consistently these actions are taken to impact the service applicants, and how many beneficiaries are being affected.
	Totals	Met **1** Partially Met Not Met 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?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The analysis tracked the indicator data which showed variable results across all parameters. The MHP also began to explore a number of aspects of the individuals referred. These aspects included self-/other- referrals and the number of times referrals were made to engage with services. The MHP would have also found helpful tracking the number of beneficiaries impacted by this improvement activity. It would appear that follow-up of some backlogged no-shows was part of the intervention test. From the information supplied, it appears that 19 received initial interventions. It would also prove useful to indicate with the statistics the number of each category, such as show rate, post-assessment psychiatry show rate. The MHP reported that it was still pending analysis of comprehensive post-intervention results.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Final data reporting was not completed for this submission. Partial results were presented.

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: Not identified. Indicate the statistical analysis used: Percentage in the initial, provisional submission. Indicate the statistical significance level or confidence level if available/known: NA percent X Unable to determine	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* Final reporting and evaluation incomplete at time of review. *Conclusions regarding the success of the interpretation:* None *Recommendations for follow-up:* None	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	Met **2** Partially Met **2** Not Met NA UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP's PIP involves a number of aspects of a complex undertaking. It appears to be seeking a complete redesign of the intake, engagement and follow-up process. The number of impacted individuals seems unclear, but nonetheless important.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Some initial data were provided; however, final reporting had not occurred as of this review.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
Totals	Met Partially Met Not Met NA **5** UTD	

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Conclusions: The topic of engagement and initial no-shows for assessment and treatment are important issues. The MHP's efforts included a significant redesign of this process. It is difficult to develop one or two interventions that will broadly impact this issue because there are a variety of issue categories that tend to be related to lack of follow-through.
Recommendations: While this activity has ended as a formal PIP, the MHP may want to summarize the final data and perform some internal analysis of which interventions have been associated with greatest improvements. It may also want to create intervention packages specific to various issues, such as those presented by referrals made by others and not the individual. Perhaps there are specific strategies that will improve engagement of these individuals. In addition, there could be a common set of issues for the self-initiator, and interventions geared to those needs could be emphasized. Clearly, this PIP has ended before a great deal of learning could be validated with data. But continued tracking of the indicators may prove useful in the MHPs efforts to improve engagement of the beneficiary pool.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time