Performance Evaluation Report

Family Mosaic Project

July 1, 2011–June 30, 2012

Medi-Cal Managed Care Division
California Department of
Health Care Services

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Performance Evaluation Report – Family Mosaic Project

July 1, 2011 – June 30, 2012

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal program, which provides managed care services to approximately 4.9 million beneficiaries (as of June 2012)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO designates each compliance review standard, performance measure, and quality improvement project (QIP) to one or more domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on Medi-Cal Managed Care (MCMC). Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.

[1] *Medi-Cal Managed Care Enrollment Report—June 2012.* Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx. Accessed on: January 17, 2013.
[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

- Plan-specific evaluation reports include findings for each plan regarding its organizational structure and operations, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

This report is specific to DHCS's contracted plan, Family Mosaic Project ("FMP" or "the plan"), which delivers care in San Francisco County, for the review period July 1, 2011, through June 30, 2012. Actions taken by the plan subsequent to June 30, 2012, regarding findings identified in this report, will be included in the next annual plan-specific evaluation report.

Plan Overview

FMP is a specialty plan which provides intensive case management and wraparound services for Medi-Cal managed care children and adolescents in San Francisco County who are at risk of out-of-home placement. FMP is part of the Child, Youth, and Family System of Care operated by the City and County of San Francisco Department of Public Health, Community Behavioral Health Services. To receive services from FMP, a member must meet specific enrollment criteria, including being a San Francisco resident between 3 and 18 years of age, having serious mental health care needs, and being at imminent risk of (or already in) out-of-home placement. The plan submits appropriate clients to DHCS for approval to be enrolled in FMP's Medi-Cal managed care. Once a client is approved and included under FMP's contract with DHCS, the plan receives a per-member, per-month capitated rate to provide mental health and related wraparound services to these members.

FMP became operational in San Francisco County to provide MCMC services in February 1993. As of June 30, 2012, the plan had 133 MCMC members.[3]

Due to the plan's unique membership, some of FMP's contract requirements have been modified from the MCMC's full-scope health plan contracts.

[3] *Medi-Cal Managed Care Enrollment Report—June 2012*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specify that the State or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers mental health compliance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Assessing Structure and Operations

HSAG organized, aggregated, and analyzed results from DHCS's compliance monitoring reviews to draw conclusions about FMP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Mental Health Compliance Review

For most MCMC plans, medical performance reviews are often a collaborative effort by various State entities. DHCS's Audits and Investigations Division (A&I) and the Medi-Cal Managed Care Division often work with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. Due to the unique nature of FMP's membership and the plan's emphasis on the mental health component of the services it delivers, FMP is not subject to medical performance review audits by DHCS and DMHC. FMP, as part of San Francisco County's mental health plan (MHP), is subject to review by the Division of Program Compliance—Medi-Cal Oversight, Department of Mental Health (DMH).

DMH performs reviews every three years. The most recent DMH audit took place on April 25–28, 2011, with a final audit report issued on March 9, 2012. The review revealed both strengths and areas requiring corrective action.

The 2011 DMH audit focused on the larger San Francisco County mental health plan, and HSAG could not determine whether all of the audit findings related specifically to FMP and Medi-Cal managed care services. HSAG has outlined the areas requiring corrective action below and recommends that the plan review the audit report to identify the findings that may apply to FMP/Medi-Cal managed care and address those issues.

The scope of the audit covered the areas of Access, Authorization, Beneficiary Protection, Funding and Reporting Requirements, Target Populations and Array of Services, Interface With Physical Health Care, Provider Relations, Quality Improvement Program, Mental Health Services Act, and Chart Review—Non-Hospital Services.

San Francisco County MHP was fully compliant in the areas of Beneficiary Protection, Funding and Reporting Requirements, Target Populations and Array of Services (Medi-Cal Specialty Mental Health Services), Interface With Physical Health Care, Provider Relations, Quality Improvement Program, and Mental Health Services Act.

San Francisco County MHP was deficient in the areas of Access, Authorization, and Chart Review—Non-Hospital Services. Listed below are the unresolved deficiencies followed by actions the plan has taken to resolve the deficiencies.

Access

Deficiency

- For initial requests received from members via telephone, in writing, or in person for specialty mental health services, the mental health plan did not maintain a written log of all initial requests via telephone, in writing, or in person for specialty mental health services from beneficiaries. The written log should include the name of the member, the date of the request, and the initial disposition of the request.

Plan Response:

- As part of the process for writing this report, FMP submitted to HSAG a copy of the plan's DMH Audit Plan of Correction, which indicated that the Behavioral Health Access Center (BHAC) has and will continue to provide in-service trainings for staff who respond to requests for services during and after business hours. Each access worker will use a call log checklist to ensure required information is solicited from individuals seeking services. Test calls will be conducted bimonthly in multiple languages, with feedback provided promptly to staff to correct response errors.

Authorization

Deficiency

- There was no documentation to determine if treatment authorization requests (TARs) were approved or denied within 14 calendar days of the receipt of the TAR and in accordance with Title 9 regulations.

Plan Response:

- The plan's DMH Audit Plan of Correction indicated that a policy will be written and given to staff members stating that all TARs must be stamped with the date of receipt. A 100 percent audit of TARs will be conducted monthly to ensure that all TARs have been date stamped.

Deficiency

- The plan did not provide for a second opinion from a qualified health care professional within the plan's network or arrange for the member to obtain a second opinion outside of the plan network at no cost to the member.

Plan Response:

- The plan's DMH Audit Plan of Correction indicated that a policy has been written stating that MHP will provide for a second opinion from a qualified health care professional within the MHP network or arrange for the beneficiary to obtain a second opinion outside the MHP network, at no cost to the beneficiary. Staff at all contract and civil service programs were trained on the policy.

Chart Review—Non-Hospital Services

Deficiencies

- Not all members met all of the reimbursement criteria.
- Assessments were either not completed and/or did not contain areas addressed in the plan's contract with DMH.
- The member's care plans lacked specific observable or quantifiable goals, proposed types of interventions, the duration of the interventions, and documentation of the member's degree of participation and agreement with the care plan.
- The plan's progress notes lacked the date services were provided; the inclusion of clinical decisions and interventions for member encounters; a signature of the staff member providing services including his or her professional degree, license, or job title; and timely completion.

- The plan's charts lacked other documentation including:
  - A process to notify the member that a copy of the care plan is available upon request.
  - Provision of information to members in an alternative format, when applicable.
  - Information on the availability of mental health interpreter services.
  - A process to link members to culture-specific and/or linguistic services.
  - Personal correspondence in the member's preferred language.

Plan Response:

The plan's DMH Audit Plan of Correction indicated the following:

- A comprehensive, multi-component clinical and billing documentation training will be developed and delivered to all clinical staff. The MHP's documentation manual will be updated and made available online. Two levels of documentation training will be provided annually: fundamentals of documentation for staff entirely new to mental health documentation and billing, and advanced documentation training for seasoned clinicians. A training PowerPoint presentation focused on each of the documentation errors resulting in disallowances during the 2011 Medi-Cal review will be developed and presented to all program staff. In addition, each program that had charts included in the audit sample received individualized feedback. Furthermore, a documentation audit tool will be developed and provided to program supervisors for use in conducting internal chart audits.
- A policy will be written indicating that plans of care must be completed within 60 days of episode opening, and will be updated annually. All staff will be trained on this policy. A report will be developed in Avatar, the electronic health record (EHR), listing all plans of care that will be expiring within the following month. Clinical supervisors are instructed to run this report monthly and review with staff to ensure timely updates to plans of care. Timely completion of plans of care will be added as a contract performance objective in FY 2012–13, and will be measured through centralized monitoring reports run through the EHR. With the implementation of Avatar, the plan now has standardized electronic assessments that are mandatory.
- Documentation training will be provided to all clinical staff and will include how to properly complete client plans and write appropriate progress notes in accordance with CCR, Title 9 requirements. Compliance with documentation standards will be reviewed through annual centralized audits of a random selection of electronic charts in each program.
- All prescribers will be reminded of the MHP's Informed Consent for Psychiatric Medications directive, which states that "A new [medication consent] form must be executed when any new medication is added." Audits of a random selection of medication consents will be conducted annually.

- The MHP will develop a policy on the appropriate content of a progress note. Deficient areas will also be addressed in documentation training for all clinical staff. In addition, a random sample of charts in all civil service and contract programs will be audited annually using a chart audit tool developed to monitor adherence with documentation requirements, correspondence between the treatment plan and billed services, and the quality of charting.
- Staff will be instructed in documentation training to use the check box on the new Treatment Plan of Care in the EHR that indicates that the beneficiary was offered a copy of his or her care plan.
- The MHP's Acknowledgement of Receipt of Materials Form will be modified to indicate whether and in what type of alternate format the information was offered.
- The Plan of Care will indicate the language in which services will be provided (if other than English). A check box will be added to the progress note indicating whether an interpreter was used for that session.

Member Rights and Program Integrity Review

MMCD's Member Rights/Program Integrity Unit (MR/PIU) is responsible for monitoring plan compliance with requirements under the DHCS contract, Title 42 Code of Federal Regulations, titles 22 and 28 of the California Code of Regulations, and applicable MMCD All Plan and Policy Letters pertaining to member rights and program integrity. The MR/PIU aids plan readiness through review and approval of plans' written policies and procedures that include the areas of member grievances and appeals; prior-authorization request notifications; marketing (for non-COHS plans); Seniors and Persons with Disabilities Sensitivity training; facility site accessibility assessment; cultural and linguistic services; and program integrity (fraud and abuse prevention and detection). The MR/PIU reviews and approves processes over these areas prior to the commencement of plan operations, during plan expansion, upon contract renewal, and upon the plan's change in policy and procedures. The MR/PIU aids and monitors plan compliance through biennial on-site health plan monitoring visits that include the issuance of formal monitoring reports, provision of technical assistance, and follow-up as needed for the resolution of compliance observations and findings.

For this report, HSAG reviewed the most current mental health compliance audit and MR/PIU plan monitoring reports available as of June 30, 2012. In addition, HSAG reviewed each plan's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to review key activities between formal comprehensive reviews.

MR/PIU conducted a routine monitoring visit of FMP in June 2010, which covered the review period of January 1, 2008, through December 31, 2009. The results of this review were included in

FMP's 2010–2011 plan-specific evaluation report. The review found FMP to be fully compliant with all requirements; no deficiencies were noted.

Strengths

FMP was fully compliant with all areas evaluated by MR/PIU, with no deficiencies found. The plan submitted a corrective action plan for all deficient areas identified in the Department of Mental Health's audit.

Opportunities for Improvement

The plan has an opportunity to ensure that all outlined corrective action plans to address the Department of Mental Health-identified deficiencies are implemented and monitored to ensure the deficiencies are fully resolved.

Conducting the Review

DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

Due to the small size of specialty plan populations, DHCS modified the performance measure requirements applied to these plans. Instead of requiring a specialty plan to annually report the full list of performance measure rates as full-scope plans do, DHCS requires specialty plans to report only two performance measures. In collaboration with DHCS, a specialty plan may select measures from the Healthcare Effectiveness Data and Information Set (HEDIS®)[4] or design a measure that is appropriate to the plan's population. The measures put forth by the specialty plan are subject to approval by DHCS. Furthermore, the specialty plan must report performance measure results specific to the plan's Medi-Cal managed care members, not for the plan's entire population.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012*, provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Performance Measures and Assessing Results

HSAG evaluates two aspects of performance measures for each plan. First, HSAG assesses the validity of each plan's data using protocols required by the Centers for Medicare & Medicaid Services (CMS). This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the plan's performance in providing quality, accessible, and timely care and services to its MCMC members.

Performance Measure Validation

HSAG conducted performance measure validation for the two performance measures that were selected, calculated, and reported by FMP. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures:*

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

A Protocol for Use in Conducting External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). The validation process included three phases:

- The pre-on-site phase included a review of the Information Systems Capabilities Assessment (ISCA) tool completed by FMP, supportive documentation, and source code used to calculate the performance measures; and planning for the on-site visit.
- The on-site visit included system evaluation and demonstration, review of data integration and data control, evaluation of data output files, and primary source verification of performance measure member-level files.
- The post-on-site phase included review of follow-up documentation and preliminary performance measure results, and final approval of calculations and final results.

Performance Measure Validation Findings

Based on the performance measure validation findings, HSAG determined that each performance measure was fully compliant with the written specifications and was calculated accurately. The review team noted that the performance measures were collected and calculated using data extracted from three separate systems and several manual processes that were not well documented.

Performance Measure Results

HSAG presents the performance measure results for each reported measure for the measurement period.

Inpatient Hospitalizations

Measure Definition

Inpatient Hospitalizations measures the percentage of members enrolled into FMP with one or more acute, mental health inpatient hospitalizations during the measurement year. For this measure, a lower rate indicates better performance.

Performance Results

Table 3.1—2011–2012 Performance Measure Rates for Family Mosaic Project—San Francisco County

Inpatient Hospitalizations			
Year	Reported Rates		
	1 Admission*	2 Admissions*	3+ Admissions*
2011 (1/1/2010–12/31/2010)	1.7%	0.6%	0%
2012 (1/1/2011–12/31/2011)	1.5%	0.5%	0%

*There are no minimum performance levels (MPLs) or high performing levels (HPLs) for these measures.

Summary of Results

There was a slight decrease in the rate for 1 Admission and 2 Admissions from measurement year 2010 to measurement year 2011. The admissions rate remained unchanged at 3+ Admissions. No percentage changes were statistically significant.

Out-of-Home Placements

Measure Definition

Out-of-Home Placements measures the percentage of members enrolled in FMP who were discharged to an out-of-home placement (foster care, group home, or residential treatment facility) during the measurement period).

Performance Results

Table 3.2—2011–2012 Performance Measure Rates for Family Mosaic Project—San Francisco County

Out-of-Home Placements*		
	Out-of-Home Placements 2011 1/1/2010–12/31/2010	Out-of-Home Placements 2012 1/1/2011–12/31/2011
Rate	12.2%	6.3%

*There is no MPL or HPL for this measure.

Summary of Results

The rate of *Out-of-Home Placements* dropped from 5.9 percentage points between the 2011 and 2012 measurement years. The percentage decrease in *Out-of-Home Placements* reflected an improvement in performance, although the change was not statistically significant.

Strengths

Both *Inpatient Hospitalizations* and *Out-of-Home Placements* performance measures had improvement in 2012. The plan has demonstrated a trend of improvement since first reporting the measures in 2010.

Opportunities for Improvement

FMP should consider developing a new performance measure to replace the *Inpatient Hospitalizations* measure since the plan's rates for this measure remain high and steady. The new measure should be developed to focus on an area of low performance in need of improvement. In addition, FMP should implement a process to formally document manual processes and HEDIS audit findings, including actions taken to resolve any identified issues.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Technical Report, July 1, 2011–June 30, 2012* provides an overview of the objectives and methodology for conducting the EQRO review.

Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of plans' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using the CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the plan's QIP objectives (QIP results). HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about FMP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Project Objectives

Specialty plans must be engaged in two QIPs at all times. However, because specialty plans serve unique populations that are limited in size, DHCS does not require specialty plans to participate in the statewide collaborative QIP. Instead, specialty plans are required to design and maintain two internal QIPs with the goal to improve health care quality, access, and/or timeliness for the specialty plan's MCMC members. The two QIP topics selected by FMP represent the quality domain of care.

FMP focused its first QIP on reducing out-of-home placements. The plan submitted the initial QIP proposal to DHCS in July 2010. At the initiation of the QIP, the plan reported that 11 of 81 eligible clients (13.6 percent) had an out-of-home discharge living situation code. Research has demonstrated adverse effects on the health and well-being of children and youth who were placed out-of-home in foster care, group homes, and residential treatment facilities, as well as community treatment facilities.

The plan submitted its second QIP proposal in January 2011, which focused on increasing the rate of school attendance for its members aged 6 to 18 years. Using the Child and Adolescent Needs and Strength (CANS) outcome/assessment tool, the plan aimed to reduce the percentage of members identified in the tool as having missed school at least two days per week on average, were generally truant, or refused to go to school. The plan's data clearly showed that school attendance is a marked problem for children and youth within FMP. At the initiation of the QIP, 34 of the 55 completed CANs (62.0 percent) identified school attendance as a serious need requiring action by FMP.

Quality Improvement Project Validation Findings

The table below summarizes the QIP validation results and status across CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for Family Mosaic Project—San Francisco County July 1, 2011, through June 30, 2012

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Internal QIPs				
Increase the Rate of School Attendance	Proposal Resubmission	100%	100%	*Met*
	Annual Submission	58%	73%	*Not Met*
	Resubmission 1	77%	82%	*Not Met*
	Resubmission 2	88%	90%	*Not Met*
	Resubmission 3	88%	90%	*Partially Met*
	Resubmission 4	96%	100%	*Met*
Reduction of Out-of-Home Placement	Annual Submission	78%	70%	*Partially Met*
	Resubmission 1	86%	70%	*Partially Met*
	Resubmission 2	94%	100%	*Met*

[1]**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4]**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2011, through June 30, 2012, showed that FMP's *Reduction of Out-of-Home Placement* QIP initially received a *Partially Met* validation status. As of July 1, 2009, DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. The plan resubmitted the QIP twice before it received an overall validation status of *Met*.

The plan's resubmission of its *Increase the Rate of School Attendance* QIP proposal received a *Met* validation status. The following annual submission of this same QIP initially received a *Not Met* validation status. The plan requested and received technical assistance during the time period of its resubmissions. The plan resubmitted the QIP four times before it received a *Met* validation status.

Table 4.2 summarizes the aggregate validation results for FMP's QIPs across CMS protocol activities during the review period.

Table 4.2—Quality Improvement Project Average Rates* for Family Mosaic Project—San Francisco County (Number = 9 QIP Submissions, 2 QIP Topics) July 1, 2011, through June 30, 2012

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	98%	2%	0%
	II: Clearly Defined, Answerable Study Question(s)	89%	11%	0%
	III: Clearly Defined Study Indicator(s)	94%	6%	0%
	IV: Correctly Identified Study Population	93%	7%	0%
Design Total		**94%**	**6%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	74%	2%	24%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total**		**82%**	**2%**	**17%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation**	57%	30%	14%
	IX: Real Improvement Achieved	75%	0%	25%
	X: Sustained Improvement Achieved	Not Assessed	Not Assessed	Not Assessed
Outcomes Total		**61%**	**23%**	**16%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.

**The stage and/or activity totals may not equal 100 percent due to rounding.

For the *Increase the Rate of School Attendance* QIP, the plan progressed to the phase of reporting baseline data and was assessed through Activity VIII. For the *Reduction of Out-of-Home Placement* QIP, the plan had progressed to the point of reporting Remeasurement 1 data; therefore, the QIP was assessed through Activity IX.

FMP demonstrated the proper application of the design stage, scoring 94 percent of the applicable elements for the four activities *Met*. In its *Reduction of Out-of-Home Placement* QIP, FMP did not completely/correctly define the study question, study indicator, or study population until its second resubmission of the QIP.

For the implementation stage, FMP was scored lower in Activity VI for its *Increase the Rate of School Attendance* QIP for not clearly describing the data collection process. Initially, the plan's documentation did not clearly describe the method of data collection and appeared to omit the manual data collection process. In its second resubmission, the plan clearly identified that only administrative data were used in the project. The plan did not provide complete documentation of the administrative completeness calculations or the timeline for the data collection until the first resubmission of the QIP.

For the outcomes stage of its *Increase the Rate of School Attendance* QIP, FMP was scored down in Activity VIII for not providing a complete data analysis plan that included the type of statistical testing that would be used to determine statistically significant differences between measurement periods and not discussing how the results would be compared to the goals. The plan documented a complete data analysis plan in its third resubmission; however, it had still not established a project goal. Additionally, the plan did not document or interpret the baseline results until the fourth resubmission.

For the outcomes stage of its *Reduction of Out-of-Home Placement* QIP, FMP was scored down in Activity VIII for initially not discussing factors that could affect the validity of the results. Additionally, the plan did not compare the results to a project goal. The plan corrected both of these deficiencies in its first resubmission of the QIP. For the same QIP and activity, FMP did not discuss whether there were factors that affected the comparability of measurement periods; this was not addressed in any of the plan's resubmissions. Additionally, the plan did not provide an interpretation of the results and the overall study until its first resubmission. FMH was scored down in Activity IX for not achieving a statistically significant improvement of the project outcome.

Neither QIP included a second remeasurement period; therefore, HSAG could not assess for sustained improvement. Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Quality Improvement Project Outcomes and Interventions

Table 4.3 summarizes QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods.

Table 4.3—Quality Improvement Project Outcomes for Family Mosaic Project—San Francisco County July 1, 2011, through June 30, 2012

QIP #1— Increase the Rate of School Attendance				
QIP Study Indicator	**Baseline Period 1/1/10–12/31/10**	**Remeasurement 1 1/1/11–12/31/11**	**Remeasurement 2 1/1/12–12/31/12**	**Sustained Improvement¥**
Percentage of 6 month and discharge CANS assessments scored "2" or "3"^	61.8%	‡	‡	‡
QIP #2—Reduction of Out-of-Home Placement				
QIP Study Indicator	**Baseline Period 1/1/09–12/31/09**	**Remeasurement 1 1/1/10–12/31/10**	**Remeasurement 2 1/1/11–12/31/11**	**Sustained Improvement¥**
Percentage of members who are discharged to out-of-home placement^	13.6%	12.2%	‡	‡

^A lower rate indicates better performance.

¥ Sustained improvement is defined as improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

* A statistically significant difference between the measurement period and prior measurement period (p value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

Increase the Rate of School Attendance QIP

For the *Increase the Rate of School Attendance* QIP, FMP had only progressed to the point of reporting baseline data; so HSAG could not assess for real or sustained improvement. Additionally the plan had not identified a goal for the project. A critical analysis of the plan's improvement strategy led to the following observations:

- The plan conducted committee meetings to identify barriers and develop interventions. Based on these meetings, the plan implemented two potentially strong interventions to improve school attendance. However, the implementation of the interventions was documented as October 1, 2011. The interventions will have limited impact on the CY 2011 outcome due to their late implementation.
- FMP did not include an evaluation plan for each of its interventions. With the implementation of any intervention and especially for multiple interventions, the plan should ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the

intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance.

Reduction of Out-of-Home Placement QIP

For the *Reduction of Out-of-Home Placement* QIP, the plan set the project objective as a 10 percent decrease of the out-of-home placements. From baseline to the first remeasurement period, the plan achieved the objective; however, the decrease was not statistically significant. An analysis of the plan's improvement strategy identified some weaknesses which may have led to the lack of improvement in the outcome:

- FMP conducted 100 percent file review of the clients who were out-of-home placements at discharge. Meetings with all involved staff were held to identify barriers and develop interventions. The plan developed two potentially strong interventions to address the priority barriers. However, the plan implemented the first intervention in July 2010 and the second intervention in September 2010. Due to the delayed implementation, the effect of the interventions was minimized for the first remeasurement period.
- The plan noted numerous changes and challenges affecting the plan throughout CY 2010 and therefore also affecting aspects of the interventions. FMP discussed some of the difficulties with the implementation of the interventions; however, it did not provide any data to support the observations.
- The plan should break down the interventions into measureable components. Providing an evaluation of the components would support decisions to modify or discontinue aspects of the interventions and provide the rationale if the interventions should be continued.

Strengths

FMP selected two QIP topics that are specific and important to the specialty Medi-Cal managed care population with serious emotional disturbances and mental health challenges in their childhood and adolescence. Additionally, FMP demonstrated an understanding of the design stage and received *Met* scores for 94 percent of the applicable elements for the four activities.

The plan conducted appropriate barrier analyses and identified potentially strong interventions for both QIPs. The plan's improvement strategies were focused and targeted.

Opportunities for Improvement

FMP should refer to the QIP Completion Instructions and address any deficiencies noted in the prior QIP Validation Tool before it completes its annual QIP submission. Additionally, if the plan has any questions regarding QIP activities or prior validation scores, it should request technical assistance before the QIP is submitted, especially if it is a required resubmission of a QIP.

The plan should implement its interventions at the beginning of the measurement period to maximize the time the interventions have to affect the outcomes. The plan should document a method to evaluate each intervention as well as provide the results of the interventions' evaluations for each measurement period.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each plan's performance measure rates and QIP performance uniformly when providing an overall assessment of above average, average, or below average in the areas of quality, access, and timeliness domains of care. A score is calculated for performance measure rates, QIP validation, and QIP outcomes as measured by statistical significance and sustained improvement for each domain of care. A final score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the plans' medical performance and MR/PIU reviews, when applicable, to determine overall performance within each domain of care. Since FMP is contracted by DHCS to provide mental health care coordination services, DHCS uses the results from the mental health audit instead of performing its own medical performance review. HSAG used the more current mental health audit in lieu of the medical performance audit to assess the plan's overall performance.

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for its MCMC members through the provision of health care services and the plan's structural and operational characteristics.

DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to beneficiaries by a plan. In addition, DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

The plan showed average performance based on FMP's 2012 performance measure rates (which reflect 2011 measurement data) and the results of compliance monitoring reviews as they related to measurement and improvement. Although there are no external benchmarks available for comparison of the performance measure results, the rate for out-of-home placements continues to show year-over-year improvement and showed meaningful improvement despite a non-statistically

significant change. The plan was also successful with proposing a new QIP topic addressing school attendance, an area identified by the plan as needing improvement.

The most recent MR/PIU review found FMP fully compliant with all areas evaluated; however, the DMH audit conducted in 2011 revealed several deficiencies related to chart documentation that can impact the quality of care. Specifically, the review showed that an assessment was either not being completed or was not reflective of the required areas, the care plan did not include objective and measureable goals, and progress notes did not contain the required documentation.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for plans to ensure access to and the availability of services to members and uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. Medical performance reviews, MR/PIU reviews, performance measures, and QIP outcomes are used to evaluate access to care; however, in the case of FMP, the results from the mental health audit were used in lieu of the medical performance review.

The plan demonstrated average performance based on a review of 2012 performance measure rates related to access and results of the compliance monitoring reviews regarding availability and accessibility of care.

FMP was fully compliant with cultural and linguistic standards evaluated by the MR/PIU, reflecting no access-related concerns in that area; however, the more recent DMH audit noted some areas of access deficiency. The plan did not maintain a written log of initial requests from members, which could impact their ability to access requested services. In addition, the plan did not provide members with information about the availability of interpreter services; did not provide information to members in an alternative format, when applicable; did not have a process to link members to cultural-specific and/or linguistic services; and did not provide correspondence in the members' preferred language.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management.

FMP was fully compliant with all timeliness-related standards when evaluated by MR/PIU review including the prior authorization process and procedures for collecting and resolving member grievances. The more recent DMH audit in 2011 found two deficiencies in the areas of timeliness for not making authorization decisions within the required time frames and for not providing members with information about their right to a second opinion.

Follow-Up on Prior Year Recommendations

DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2010–2011 plan-specific evaluation report. FMP's self-reported responses are included in Appendix A.

Recommendations

Based on the overall assessment of FMP in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Ensure that all corrective action plans to address the applicable DMH-identified deficiencies are implemented and monitored to ensure the deficiencies are fully resolved.
- Improve documentation of data systems used to produce performance measure rates among the various systems used.
- Develop a new performance measure to replace the *Inpatient Hospitalizations* measure since the plan's rates for this measure remain high and steady. The new measure should be developed to focus on an area of low performance in need of improvement.
- Implement a process to formally document manual processes and HEDIS audit findings, including actions taken to resolve any identified issues.
- Refer to the QIP Completion Instructions and address any deficiencies noted in the prior QIP Validation Tool before completing the annual QIP submission.
- Plan QIP interventions at the beginning of the measurement period to maximize the time the interventions have to affect the outcomes.
- Document a method to evaluate each intervention, as well as provide the results of the interventions' evaluations for each measurement period.

In the next annual review, HSAG will evaluate FMP's progress with these recommendations along with its continued successes.

Appendix A. Grid of Plan's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

for **Family Mosaic Project**

The table (grid) on the following page provides EQR recommendations from the July 1, 2010, through June 30, 2011, Performance Evaluation Report, along with FMP's self-reported actions taken through June 30, 2012, that address the recommendations. Neither Health Services Advisory Group, Inc. nor any State agency has confirmed implementation of the actions reported by the plan in the grid.

Table A.1—Grid of FMP's Follow-Up on EQR Recommendations From the July 1, 2010–June 30, 2011 Performance Evaluation Report

2010–2011 EQR Recommendation	FMP's Self-Reported Actions Taken Through June 30, 2012, That Address the EQR Recommendation
Conduct periodic, internal reviews to ensure compliance with the DMH and MR/PIU standards.	Per MR/PIU audits, FMP has been fully compliant with all areas. FMP does conduct internal reviews to ensure compliance both for MR/PIU and DMH. The DMH final compliance report and SF plan of correction were sent to DHCS and HSAG.
Ensure consistent measurement of each performance measure, maintaining complete documentation of all steps taken for data collection and measure calculations.	FMP has demonstrated consistent measurement of each performance measure including documentation. The FMP QI team reviews every closed /discharge medical record to ensure that the living situation code has been entered.
As QIPs progress, ensure QIP documentation meets validation requirements and obtain technical assistance as needed.	FMP has been obtaining technical assistance as needed from HSAG. Both QIPs have been validated by HSAG on initial submission as well as annually.