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

ALAMEDA MHP FINAL 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) 2018-19 findings of an EQR of the Alameda 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 — Large

MHP Region — Bay Area

MHP Location — Oakland

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 21,657

MHP Threshold Languages — Spanish, Cantonese, Vietnamese, Mandarin, Tagalog

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.caleqro.com.

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: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs. The MHP is contractually required to meet this requirement going forward. During the review there was a discussion regarding with PIP development process, and this was continued via email after the review. The MHP has been encouraged to reach out for technical assistance (TA) as soon as new clinical and non-clinical PIP ideas are developed.

Status: Met

- The MHP submitted two PIPs, both of which were determined to be active and ongoing.
- The clinical PIP is scheduled to be completed by the end of December 2019, and the non-clinical PIP will continue for another year with new interventions added.
- PIP TA during the onsite review included a detailed discussion of potential new clinical PIP topics including ongoing periodic profiling of diagnoses and medication prescribing practices by race/ethnicity; mobile crisis team

effectiveness at clinical diversion to outpatient services; timeliness of clinical services to improve beneficiary outcomes; protocols and clinical tools for effective and appropriate transitions between levels of care to improve beneficiary outcomes; improving beneficiary outcomes by ensuring correct discharge coding and analyses; addressing stigma for the Asian/Pacific Islander (API) population through the use of physical health service facilities and non-traditional settings; and addressing the low penetration rates for seniors (60 years and older).

- PIP TA was provided by CalEQRO on several occasions throughout the year via telephone and email, in preparation for ensuring that the MHP has two active PIPs. In addition, the MHP requested ongoing PIP TA from CalEQRO in the coming year.

Access Recommendations

Recommendation 2: Consider opportunities to increase the vertical integration of Full Service Partnership (FSP) and levels of care within each site, such as when rebidding or expanding services. This can create opportunities for greater efficiency and improved outcomes for consumers who may then move between service levels at a convenient location and familiar staff, without the risks associated with the change of physical program sites.

Status: Met

- The MHP has been discussing this recommendation since it was brought forth last year and is determining how to create the levels of care within each site since FSPs are mostly based on specific populations (i.e. homeless, forensic, youth, child, and older adult).
- Currently, the MHP has several sites with vertical integration:
    - Townhouse, a wellness center operated by Bay Area Community Services which hosts an FSP, a service team, and a reentry treatment team, and
    - Eastmont, a county-operated clinic that hosts an FSP.
- Many of the MHP's contracted providers work in the community, so beneficiaries do not necessarily go to one location for services.
- The Adult System of Care (ASOC) is planning to work with the Network Office in early 2020 to add vertical integration to all provider contracts for outpatient services, and to all county operated clinics.

Recommendation 3: Identify additional approaches to improving recruitment and retention of staff at all levels, focusing on supporting the educational advancement of unlicensed staff and creatively working to address the scheduling and economic needs of applicants and existing staff.

Status: Met

- The MHP launched an internal “Climate Change Initiative” in late 2018 in response to findings from a staff survey which identified concerns about morale and lack of opportunities for advancement. A training and engagement series was initiated to address retention and advancement of staff, including Understanding Emotional Intelligence, Project Management, Transformative Leadership, and an on-line soft skills curriculum.

- The MHP is collaborating with the Alameda Council of Community Mental Health Agencies (ACCMHA), an organization of many of the larger community-based providers in the county, to address staff turnover more broadly. ACCMHA drafted a white paper on addressing turnover at contract provider agencies, which it shared with MHP leadership and CalEQRO.

- Initiatives to recruit and retain staff include:

    - Mental Health Services Act funding to sponsor 20-24 contracted provider staff who reflect the cultural and linguistic diversity of Alameda County to pursue a master’s degree in social work;

    - Multiple programs are supporting peer specialist training and certification, including a forensic focus in adult case management programs. A total of 20 peers received training on forensic support, funded through the Office of Consumer Empowerment;

    - Staff with consumer and family lived experience have been added to the crisis teams, constituting a third of the newly tripled teams;

    - Sponsoring an internship program for local school districts and colleges through the Workforce Employment and Training program including career shadowing and training to build interest at an earlier stage for behavioral health, and working with California State University-East Bay on an infant and early childhood mental health program to attract staff interested in serving this population;

    - Creating a new Mental Health MHSA-funded program with Laney College and Chabot College (California Community Colleges) to expose students to mental health advocacy, and develop mental health navigators;

    - Initiating a community psychiatry residency program through which residents at Stanford University and University of California, San Francisco can rotate;

    - Initiating a physician’s assistant rotation program with Santa Clara University; and

    - Providing more information on the MHP website regarding workforce opportunities.

- Despite all of these efforts, the entire system of care (SOC), both county and contracted providers, continues to struggle with staff retention and recruitment of qualified new staff that mirror the diverse community being served. Much of this has to do with the cost of living in the Bay Area, which is beyond the control of the MHP and its partners.

Recommendation 4: Evaluate the development of a bifurcated differential which separates language from culture, and supports an incentive for each separately. Study the competitiveness of the differential level with other similar types of agencies to determine if the compensation is adequate to impact recruitment and retention needs.

Status: Met

- The MHP is exploring the idea of a bifurcated differential. However, potential legal barriers have been identified in employment law.
- The MHP is checking with county counsel for further information.
- In addition, further research is being conducted with other California counties implementing similar practices to determine how they addressed these legal challenges.

Timeliness Recommendations

Recommendation 5: Develop the mechanisms for tracking all network adequacy timeliness measures, and incorporate a process that through the year periodically produces performance data that is furnished to Quality Improvement (QI) and leadership teams, is evaluated and is used in resource allocation determinations.

Status: Met

- The MHP developed a comprehensive policy entitled, “Timely Access to Service Standards and Tracking Requirements” signed June 2019 and effective immediately. The policy establishes the timely access to service standards for the MHP and for the Drug Medi-Cal Organized Delivery System (DMC-ODS), and uses the standards developed by DHCS in the Mental Health Substance Use Disorder Information Notice (MHSUD IN) 18-011 to meet federal network adequacy requirements. The policy clearly defines the terms used (e.g., beneficiary, returning client, urgent services) in order to ensure consistency of application.
- The Information Systems (IS) Department has developed several new monitoring reports to track network adequacy timeliness. One report measures timeliness by reporting unit for new clients, and will be sent to all contract providers on a monthly basis to use for ensuring compliance with DHCS-mandated Client Services Information (CSI) Timeliness Assessment data reporting.

- New timeliness data collection processes have been developed, and the MHP is training its staff and contracted partners on its use. Data collection is being conducted retroactively, where possible.

- The QI Department is beginning to aggregate the performance data and share it with MHP leadership teams for review and evaluation. However, the data is not yet complete enough to use for program and systems management and resource allocation determinations.

- **Recommendation 6:** Ensure the timeliness tracking includes all beneficiaries who initially access services, whether or not the request occurs at provider sites or the Access Center.

Status: Met

- In January 2019, the MHP centralized the initial screening and referral process for new intakes and existing beneficiaries, which now all come through the Access Call Center. Previously, there were many intake and referral points in the system, both county and contracted, leading to challenges with appropriate level of care determination, timeliness, and service capacity.

- As of March 2019, timeliness tracking is now system-wide and includes all beneficiaries who initially request and access services. The MHP monitors all new clients for timeliness and network adequacy by utilizing CSI Timeliness Assessment data, and by analyzing new client data from the MHP's claims processing system (InSyst).

- **Recommendation 7:** The MHP needs to develop a system-wide protocol that explicitly addresses the issues of urgent medication and clinical needs of its beneficiaries. This protocol should directly and clearly impart expectation of response by programs, and when referral to emergency departments or crisis teams are appropriate. Tracking, reporting and regular evaluation of the data is imperative.

Status: Met

- The MHP adopted the state definition for urgent services, and embedded the definition in the new network adequacy policy entitled, "Timely Access to Service Standards and Tracking Requirements".

- As of July 2019, the MHP has newly begun to implement a new policy and process for tracking urgent appointments system-wide.

- The MHP developed a protocol to strengthen care coordination across programs and departments, and to promote appropriate crisis system utilization and the provision of ongoing services.

- In July 2019, the MHP created its first walk-in urgent medication clinic, and has since expanded to two additional clinics. Expansion to a final clinic is scheduled

by the end of 2019, at which time urgent walk-in medication assistance will be available at all ASOC county clinics Monday thru Friday from 8:30 am to 5:00 pm. The newly developed protocol for use of the urgent medication clinics is being further updated to reflect when individuals need to be referred to emergency departments or crisis teams, as appropriate. The MHP currently tracks the use of these clinics; however, evaluation has not yet begun as the service is still in the early phase of implementation. The MHP plans to submit results-based accountability measures for these clinics, and review the data on a quarterly basis.

- The MHP increased the use of telehealth to more effectively serve beneficiaries. However, it is too soon to evaluate the effectiveness or impact of these additional services. The telehealth policy has been updated.

Quality Recommendations

- **Recommendation 8:** The MHP needs to adequately staff and empower the compliance/QI that provides updates on required compliance areas, with a priority of merging processes when new compliance areas are identified. Elimination of redundancies has the potential of improving the beneficiary experience of the treatment process and also increasing the availability of staff clinical hours.

Status: Partially Met

- QI metrics and activities are currently indistinct from quality assurance and utilization management, and are focused heavily on compliance issues.

- The Data Services Team, previously Decision Support, was under quality management but has been moved to IS. QI is informally involved with the Data Services Team, under which the decision-making occurs regarding which reports and dashboards need to be developed. This lack of a formal structure for ongoing collaboration has led to multiple situations where data dashboard and report developments needed to be changed/improved to be responsive to the MHP's needs for both quality and compliance. This was evident in several sessions throughout the review, and was discussed at length with contract providers who received instructions that were then superseded a month later causing significant administrative challenges and staff frustration, with additional costs incurred.

- QI currently has one designated full-time equivalent (FTE), with two additional FTEs borrowed from other areas. Much of the analytic staff needed to support the final rule implementation and whole person care have been shuffled between departments and divisions. In such a large and complex system of care, the MHP needs to build sufficient QI staffing and data analytic capacity necessary to fulfil the quality improvement requirements (separate and distinct from quality assurance/utilization management [QA/UM]) for both mental health and DMC-ODS.

- The QI work plan, and Quality Improvement Committee (QIC) standing agenda, does not yet include a comprehensive list of quality management metrics, or an analysis of disparities in services by site/region/population served.

- The MHP is hoping to move to a continuous quality improvement (CQI) approach in the coming year.

Recommendation 9: The MHP's efforts to prepare for DMC-ODS waiver needs and Final Rule/Network Adequacy requirements has had a considerable impact on QI and compliance resources. Efforts to functionally integrate process and documentation streamlining efforts require consistent, dedicated staffing, that can be sustained in the presence of competing demands. In addition, identification of QI/QA MHP representatives that are empowered to meet simultaneously with contract agency QI and line staff at program sites will help to identify and clarify policy change areas and furnish feedback that can assist in prioritizing streamlining and efficiency actions.

This recommendation is a carry-over from FY 2018-19.

Status: Partially Met

- In March 2019, the Alameda County Board of Supervisors approved 28 Final Rule and nine DMC-ODS positions, and hiring has been staggered over three quarters by the MHP's Human Resources Department. These positions will be spread across finance, contracts, Quality Management (QM) and Information Systems (IS). Although the analysis supported the hiring of more than 45 FTEs, particularly during the initial implementation phase, the MHP's final rule workgroup agreed to aggressively reduce the FTE count in favor of expected optimum productivity.

- However, there are no positions designated specifically for QI, which is significantly understaffed and yet heavily involved in monitoring and analyzing quality and timeliness metrics for network adequacy implementation in mental health and DMC-ODS programs, along with driving quality and performance improvement activities where necessary.

- Alameda County QA Department is developing online trainings that will be available to all staff, clinicians, and managers at any time. The number of training videos and topics available to providers will be expanded and updated in 2020.

Recommendation 10: The QI work plan (QIWP) and process would benefit from greater identification of measurable objectives, such as timeliness measures that incorporate baseline data and target goals for improvement. The resultant data needs routine, periodic review by the QIC or relevant subcommittees, or blended forums of leadership and QI.

Status: Partially Met

- In the past year, the MHP updated the QI work plan to include quantifiable goals and objectives, and corresponding indicators.

- While this is an improvement over the previous year, the work plan does not yet include a comprehensive list of specific quality management metrics and performance measures, or an analysis of disparities in services by site/region/population served. QI metrics and activities need to be separate and distinct from quality assurance and utilization management, which focus on compliance issues.

- A complete evaluation was carried out on the previous year's work plan, detailing the status of each goal along with the specific activities, and those not completed have been carried forward to this year's work plan.

- The QIC met 9 out of 12 months in the past year, with a documented agenda and minutes for each meeting. While the data from the previous EQRO report was discussed, QIC meeting minutes do not regularly (at least quarterly, but preferably monthly) reflect the inclusion of quality management data generated and analyzed by the QI staff, or an in-depth discussion of the progress being made towards the newly quantified goals and objectives in the updated QI work plan.

- **Recommendation 11:** The MHP's compliance and communication activities need to involve MHP QI direct presentation to clinic/program sites, partnering with contract agency QI staff, which provides the ability to clarify protocol changes and clarification of complex issues, as well as receive feedback.

Status: Partially Met

- The roles of QA and QI are separate and distinct, and while they need to work closely together, clinical staff need both areas of expertise to be available on an ongoing basis.

- QA staff support documentation training and oversight, while QI is involved with ensuring that quality of clinical care, system-wide outcomes, and performance measures are being met.

- QA and QI staff need to closely collaborate, working together with both county-operated staff and contract provider QA and QI staff to ensure consistency of messaging and avoiding duplication of efforts.

- QA is providing TA and training on documentation standards for Medi-Cal, focusing on reducing disallowance rates in state audits. Of note, the MHP denied claims rate (1.96 percent) for CY 2018 was much lower than the statewide average claim denial of (3.25 percent) for the same time period.

- Staff in county and contracted clinics have expressed the need for dedicated QA and QI staff to provide ongoing support.

- QA staffing will be increasing in 2020, allowing for improved communication and compliance activities.

- QA is creating online training videos available to county and contracted clinic staff 24/7.

Beneficiary Outcomes Recommendations

- **Recommendation 12:** Consider opportunities to integrate mandated outcome instruments and other requirements– such as the Child and Adolescent Needs and Strengths (CANS-50) and Adult Needs and Strengths Assessment (ANSA) – for integration with the initial assessment and assessment update, which creates a more coherent workflow.

Status: Met

- In reviewing the workflow for initial intakes, the MHP found that only licensed staff were administering the CANS-50, which was prolonging the time it took for completion of the initial screening and assessment process, including documentation. To be eligible to administer the CANS-50, providers must be certified through the Praed Foundation, and recertification is required annually; however, licensure is not a requirement. Therefore, the MHP updated this system and its policies to allow non-licensed staff to complete the CANS-50, while licensed staff continue to administer the initial assessment.

- As of November 2018, the biopsychosocial evaluation is no longer required when beneficiaries move from one level of care to another, or to another provider within the system of care. In addition, beneficiary treatment plans are now attached to reporting units allowing for the same treatment plan to be utilized for the duration of treatment/open episode throughout the system of care.

- In September 2019, the MHP opened a new crisis stabilization unit (CSU) (Amber House), implementing a 2-page form for intakes, and an algorithm for referrals which includes response time standards.

- As of October 2019, the behavioral health screening tool has been integrated into the initial assessment process, thereby further reducing duplicative efforts.

- **Recommendation 13:** The MHP must develop an effective mechanism for the support of youth transitioning into adult services. This includes development of a beneficiary and care-giver supportive approach that assists each family throughout the process to the completion of an open adult episode. As described to the review team, this is a disheartening process, one fraught with potential poor outcomes for the caregiver family and for the youth.

Status: Met

- The MHP created a protocol specifically for Transition Age Youth (TAY) who are entering the ASOC as they turn 25 years old. This protocol is initiated 2 to 3 months prior to the beneficiary turning 25 years old, and begins with a referral to the Access Call Center and a determination of level of care (LOC) needs within the ASOC. During the transition period, both the existing and new adult providers

can bill for services on the same day. These TAY beneficiaries are not closed to the Child and Young Adult System of Care (CSOC) until at least one face-to-face appointment is held between the two teams, and often two or more appointments are held with the new treatment team and the new prescriber. If a beneficiary becomes disengaged from the new adult team, then the CSOC TAY Team reengages to provide additional support for a more successful transition with another clinician, provider, or level of service.

- The MHP holds meetings twice a year with the largest TAY providers. Meetings with smaller contracted providers for TAY services take place at their request.

- **Recommendation 14:** The MHP and its providers need to explore attitudes and provide refreshed training that helps practitioners welcome the input of beneficiaries' wishes to explore alternatives to medications, whenever feasible. This may require special attention with those agencies serving API beneficiaries, and particularly with physician/prescriber staff.

Status: Not Met

- The MHP did not address this recommendation over the past year.

- Participants in the Cantonese-speaking consumer and family member focus group reported that they were not included in the decision-making regarding their medication and treatment options.

- **Recommendation 15:** Continued efforts to connect and gain input from peer support specialists and other employed people with lived experience remains a priority for this MHP to pursue, building upon the successful work with Pool of Consumer Champions (POCC) members.

Status: Met

- The Office of Consumer Empowerment (OCE) continues to connect with and gain input from POCC members.

- The OCE collaborated with the QI team to create a new QIC beneficiary subcommittee that reviews and provides feedback, from a beneficiary perspective, on issues including system-wide policies and procedures, and PIPs.

- The OCE manager met with youth peer support specialists from Seneca, the Mental Health Association for Chinese Americans, and other programs to gain input on the needs of TAY beneficiaries.

- The OCE created the Sally's Place Peer Respite Advisory Council to connect with and gain input from peer support specialists and guests from Sally's Place Peer Respite. The Advisory Council met in April and October of 2019, and members included beneficiaries, peer respite staff and other peer employees. The council developed the mission and values statement for Sally's Place.

- The OCE holds a weekly call with Sally's Place Peer Respite staff to address program and training needs.

Recommendation 16: The MHP's efforts to effectively re-engage lived experience stakeholders from POCC merits continuation and expansion to target the inclusion of other lived-experience staff, such as peer support specialists and family advocate representatives employed both directly by the MHP and by contact agencies.

This recommendation is a carry-over from FY 2018-19.

Status: Met

- The OCE meets monthly with peer support specialists from contracted agencies including PEERS, Alameda County Network of Mental Health Clients, Black Men Speak, Bonita House (Casa Umbutu) and La Familia.
- During 2019, the OEC met monthly with DMC-ODS leadership and staff to enhance the BestNow training program by integrating substance use disorder (SUD) peer support curriculum into the mental health peer support specialist course material.
- Regular meetings with family advocate representatives are facilitated through the Office of Family Empowerment (OFE).
- The TAY Committee includes one peer employee.

Foster Care Recommendations

- **Recommendation 17:** Completion of the Therapeutic Foster Care (TFC) request for proposals (RFP) process and selection of the Foster Family Agency (FFA) agencies that will be involved, providing TA as required.

Status: Met

- In May 2019, the MHP contracted with one agency, Alternative Family Services, for the provision of TFC. To date, five parents have been trained, with an additional five needed. The agency is working on additional recruitment.
- In October 2019, a new referral process and protocol, developed jointly by the MHP, Child Welfare Services (CWS) and probation, was finalized for TFC services.

Recommendation 18: Continue involvement in the Short-Term Residential Therapeutic Program (STRTP) process, providing monitoring and TA throughout the selection and utilization of contracted programs.

Status: Met

- The MHP has existing contracts with several out-of-county STRTPs and one STRTP in Alameda County. The MHP is currently in the process of contracting with one recently licensed Alameda County STRTP.

- The MHP provides TA to several group homes on the low-confidence STRTP lists from the state, in collaboration with partners CWS. This includes reviewing the mental health program proposals and highlighting areas that the state has identified as "red flags". However, the MHP defers program approval/certification and ongoing review/TA to the state.

- The MHP regularly participates in TA calls organized by the state. With the help of CWS, the MHP has initiated TA calls for Alameda County group homes that need support in the STRTP process.

- Alameda County lost several culturally relevant group homes that were unable to transition to STRTPs due to the significant state requirements and low administrative capacity. This has been a significant loss for the community, as some older youth who were stable are now doing poorly, causing anger and frustration for all concerned. Stakeholders discussed the missed opportunity to have allowed these youth to age-out of their existing placements by permitting these group homes, which were unable to transition, to remain open until these youth reached maturation.

Information Systems Recommendations

- **Recommendation 19:** Pursue development of a reporting function that will provide information on the follow-up care of children and youth prescribed stimulants, per the Healthcare Effectiveness Data and Information Set (HEDIS) Attention Deficit Disorder (ADD) standard.

Status: Partially Met

- The MHP's Medical Director is in the process of establishing a reporting function to provide ongoing follow-up of children and youth prescribed stimulants for ADD throughout the SOC.

- In September 2018, the MHP began transitioning one CSOC medication support service from a contract provider site to a county-operated clinic in order to more closely monitor psychiatric and stimulant medication use in children under 18 years old. This process was completed in December 2018.

- **Recommendation 20:** Continue to expand Yellowfin roll-out to remaining contract providers as resources permit. Provide training and TA to ensure successful use of the data.

Status: Partially Met

- The MHP conducted a pilot project with four contract providers, during which they were able to connect seven users with aggregate data.

- The pilot phase is currently paused which prevented setting up client-level access for those users.

- **Recommendation 21:** As the InSyst system replacement RFP process launches it is critical to identify the core project team as soon as practical. The core team leadership needs to include at least four roles: The Executive Sponsor, Overall Project Director/Manager, Clinical Project Manager, and Technology Project Manager. Additional subject matter expertise to be assigned as the project plans develop and unfolds.

Status: Met

- The MHP did identify and assign core leadership roles to specific individuals. The core leadership team includes seven roles.

- The MHP engaged a third-party vendor to develop an RFP for a new EHR and billing system. Xpio Health, LLC was selected to provide project management, EHR strategy, and procurement expertise.

Structure and Operations Recommendations

Recommendation 22: Advocate with DHCS for rapid access to Medi-Cal claiming information regarding prescribing, and lab claiming data for all Alameda MHP beneficiaries with a rolling three-month post claim window.

Status: Removed

- This recommendation has been removed by CalEQRO, as it is currently unachievable by the MHP.

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 Alameda MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	49,706	11.4%	3,586	16.6%
Latino/Hispanic	130,377	29.9%	5,960	27.5%
African-American	77,723	17.8%	6,337	29.3%
Asian/Pacific Islander	100,989	23.1%	1,699	7.8%
Native American	1,150	0.3%	103	0.5%
Other	76,348	17.5%	3,972	18.3%
Total	**436,290**	**100%**	**21,657**	**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.				

Penetration Rates and Approved Claims per Beneficiary

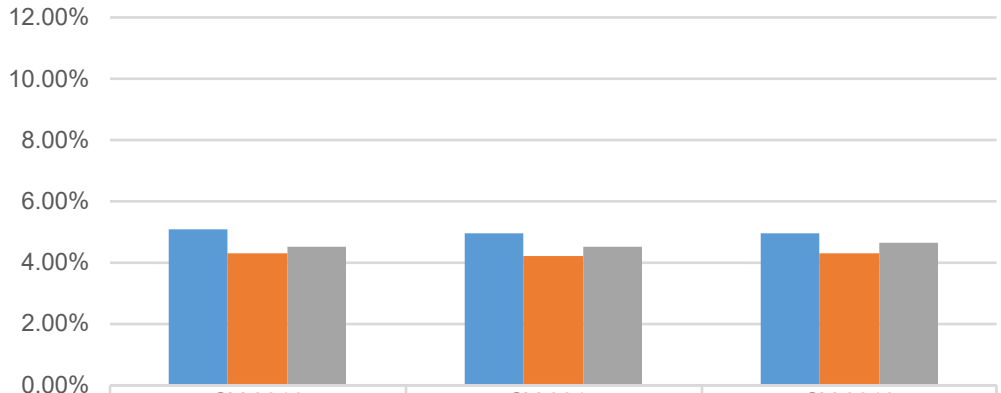
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated 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 Alameda MHP uses a different method than that used by CalEQRO.

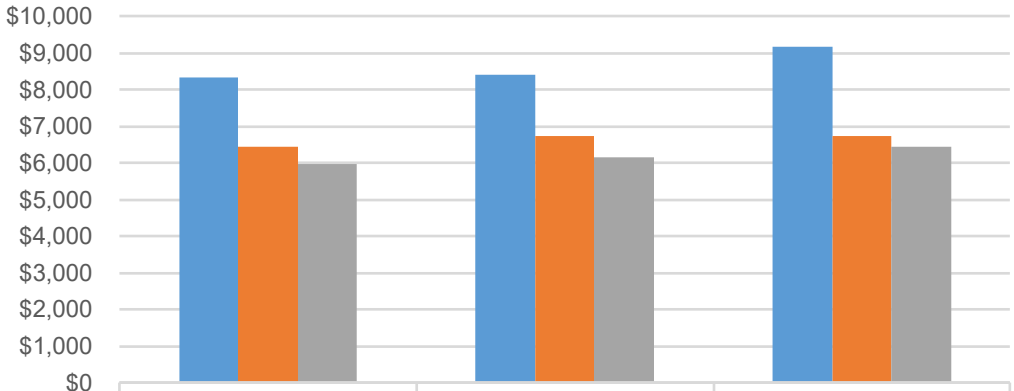
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A. Overall Penetration Rates
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	5.07%	4.93%	4.96%
Large	4.30%	4.19%	4.31%
State	4.53%	4.52%	4.66%

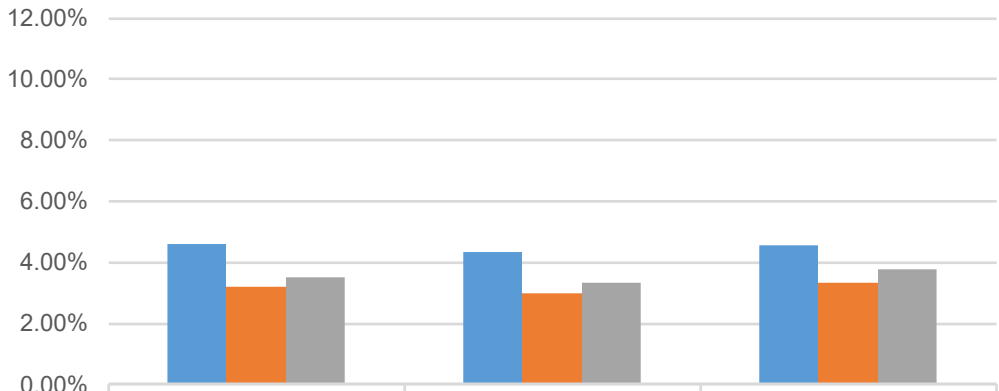
Figure 1B. Overall ACB
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	$8,324	$8,395	$9,168
Large	$6,430	$6,723	$6,750
State	$5,978	$6,170	$6,454

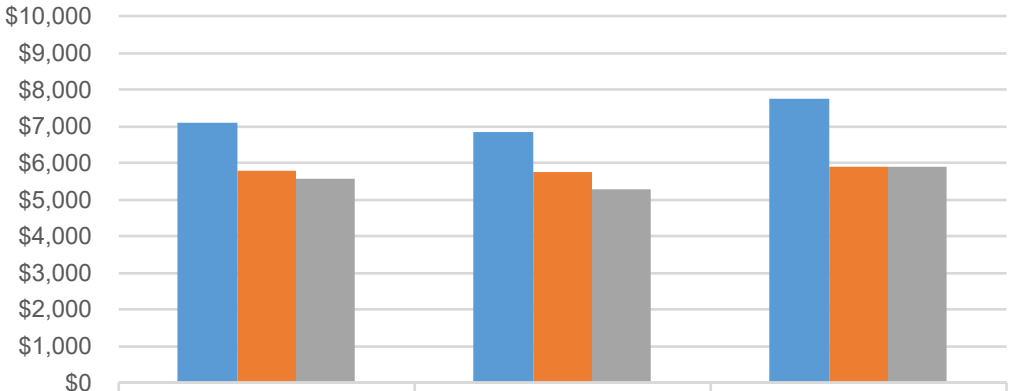
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	4.61%	4.34%	4.57%
Large	3.21%	2.97%	3.33%
State	3.51%	3.35%	3.78%

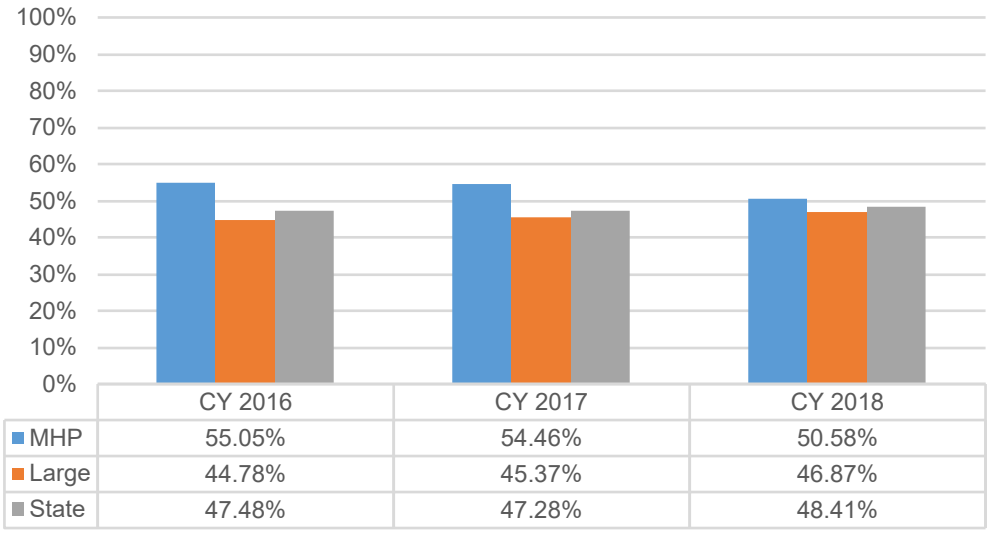
Figure 2B. Latino/Hispanic ACB
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	$7,089	$6,834	$7,763
Large	$5,785	$5,758	$5,884
State	$5,588	$5,278	$5,904

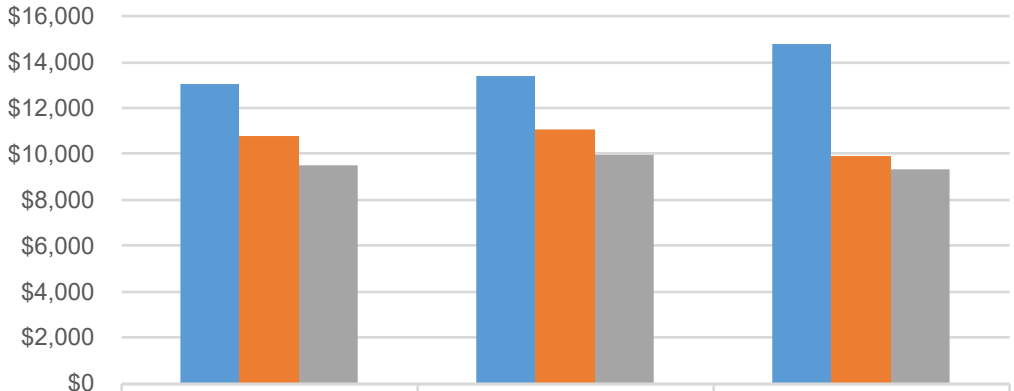
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A. FC Penetration Rates
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	55.05%	54.46%	50.58%
Large	44.78%	45.37%	46.87%
State	47.48%	47.28%	48.41%

Figure 3B. FC ACB
Alameda MHP



	CY 2016	CY 2017	CY 2018
MHP	$13,042	$13,396	$14,803
Large	$10,805	$11,064	$9,895
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
Alameda 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	1,413	21,657	6.52%	$54,245	$76,648,595	38.60%
	CY 2017	1,183	21,991	5.38%	$50,715	$59,996,380	32.50%
	CY 2016	1,383	22,992	6.02%	$52,167	$72,146,450	37.70%

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.

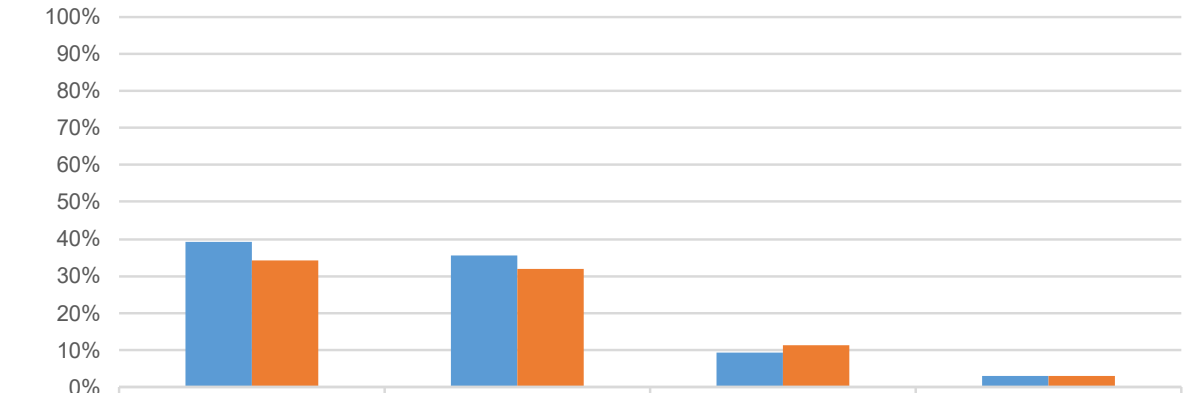
Table 3. Psychiatric Inpatient Utilization - Alameda MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	2,150	5,610	6.71	$13,580	$29,196,526
CY 2017	2,207	5,684	6.39	$10,834	$23,910,126
CY 2016	2,063	5,702	6.87	$12,068	$24,896,518

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

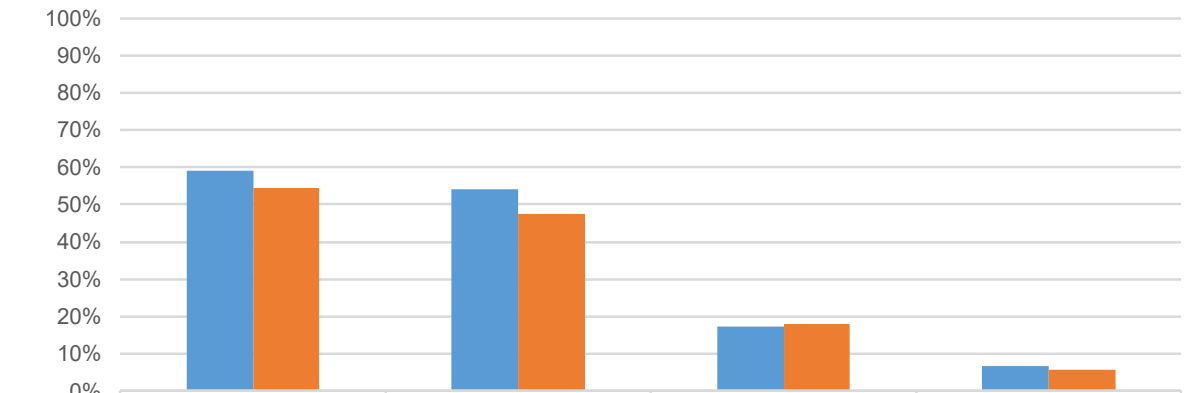
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	39%	36%	9%	3%
CY 2018	34%	32%	11%	3%

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



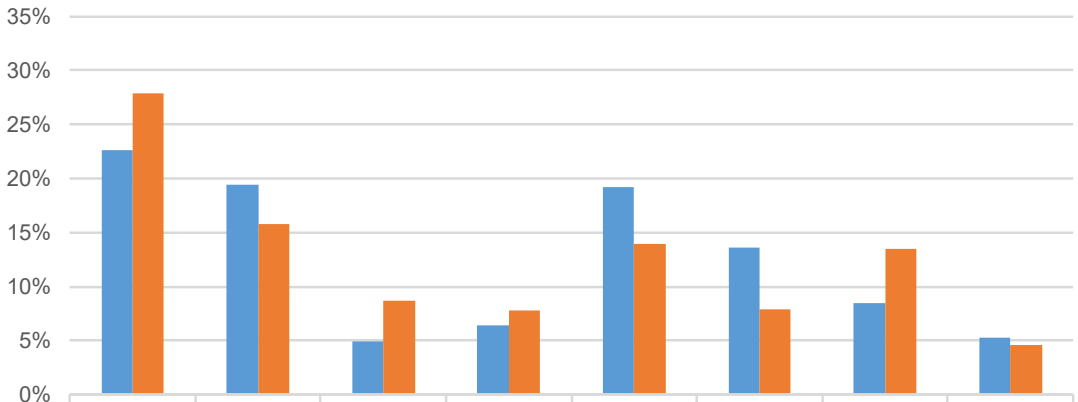
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	59%	54%	17%	7%
CY 2018	55%	48%	18%	6%

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.

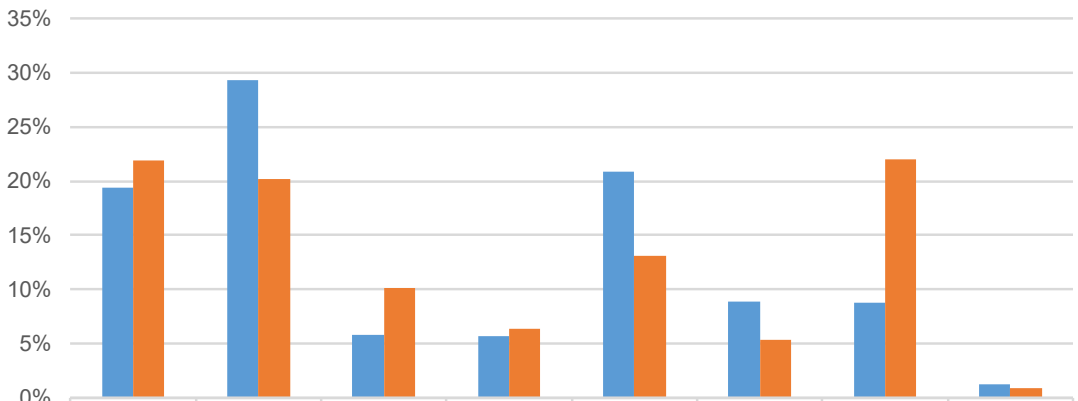
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 16 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Alameda MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	23%	19%	5%	6%	19%	14%	8%	5%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	19%	29%	6%	6%	21%	9%	9%	1%
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.

Alameda MHP PIPs Identified for Validation

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

Table 4 lists the PIPs submitted by the MHP.

Table 4: PIPs Submitted by Alameda MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Incorporating Reentry Peer Specialists into Treatment Teams
Non-clinical PIP	1	Using Language Assistance Lines to Improve Penetration

Clinical PIP—Incorporating Reentry Peer Specialists into Treatment Teams

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

"Does incorporating reentry peer specialists in interdisciplinary case management teams for justice-involved beneficiaries improve their treatment outcomes overall by 20 percent?"

Date PIP began: July 2018

Projected End date: December 2019

Status of PIP: Active and ongoing

The goal of this clinical PIP is to improve treatment outcomes for justice-involved reentry beneficiaries in outpatient treatment and case management programs, including engagement in treatment, reduced psychiatric hospitalizations, increased retention in treatment programs, and reduced further incarceration. The MHP sought and received

funding for this new reentry treatment and case management program through the California Proposition 47 grant in late 2017.

This PIP focuses on integrating reentry peer specialists into treatment and case management teams that work directly with reentry beneficiaries. While mental health peer specialists have participated at varying levels in MHP programs, the staffing of this program is novel in that it pairs peer specialists with clinicians in the case management and treatment of the beneficiaries. In addition, this program requires that the peer specialists themselves have prior justice involvement and/or have been systems-impacted by the criminal justice system (i.e. have a family member who was involved in the criminal justice system).

The three primary agencies implementing this PIP include the MHP, Bay Area Community Services (BACS) and La Familia Counseling Services (La Familia). The MHP oversees the design, implementation, and data analysis for this project, while BACS and La Familia each launched a “reentry treatment team” including peer case managers, with a caseload of 80 clients in North and South Alameda County, respectively.

The MHP developed a multi-functional team with an array of stakeholders including those with lived experience. The PIP topic was substantiated through the use of relevant data and a full literature review. The study question is clearly stated and measurable. The study used objective, clearly defined and measurable indicators. The PIP has one intervention which focuses on an interdisciplinary treatment team approach that includes a reentry peer specialist (with previous justice involvement) to provide case management for justice-involved reentry beneficiaries.

MHP staff reviewed the indicators drawn from administrative data on at least a quarterly basis to determine the impact of the interventions, enabling them to provide feedback to service providers at the weekly/biweekly meetings and discuss the underlying basis for the performance outcomes including whether interventions or data collection methods needed to be adjusted. All indicators showed positive and statistically significant results. The MHP stated that the significant improvement in performance outcomes indicates that the reentry treatment teams were very successful in producing favorable results.

Due to the early positive results of these interventions, the MHP has integrated reentry peer specialists as core team members in the other recently developed new reentry outpatient treatment and case management teams, including a team serving beneficiaries on Probation (capacity 120 beneficiaries), a team focused on providing culturally responsive services to African American beneficiaries who are justice involved (capacity: 20 beneficiaries), and two teams focused on serving individuals with mild to moderate mental illness (capacity: 160 clients).

Suggestions to improve the PIP: The MHP should complete this PIP by December 31, 2019 as planned. A new clinical PIP topic should be developed and implemented as this current PIP comes to a close in order for the MHP to have two active PIPs throughout the year.

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 several PIP TA calls during the year, with multiple PIP draft iterations reviewed leading up to the onsite review. In addition, during the onsite review, a PIP session was held to further discuss the progress made to date, and how it will be wrapped up in the next two months. Discussion on potential new clinical PIP topics included ongoing periodic profiling of diagnoses and medication prescribing practices by race/ethnicity; mobile crisis team effectiveness at clinical diversion to outpatient services; timeliness of clinical services to improve beneficiary outcomes; protocols and clinical tools for effective and appropriate transitions between levels of care to improve beneficiary outcomes; improving beneficiary outcomes by ensuring correct discharge coding and analyses; addressing stigma for the API population through the use of physical health service facilities and non-traditional settings; and addressing the low penetration rates for seniors (60 years and older).

Non-clinical PIP—Using Language Assistance Lines to Improve Penetration

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

“Will increased access to language interpretation services through implementation of a language line across the entire specialty mental health system improve access to care by:

- Increasing the Medi-Cal outpatient penetration rate for beneficiaries with a primary language other than English from 2.4 to 2.88 percent;
- Increasing the Medi-Cal outpatient penetration rate for API beneficiaries who speak a primary language other than English from 1.02 to 1.25 percent;
- Improving connection rates for referrals for primarily non-English-speaking beneficiaries from 50.3 to 60 percent;
- Increasing the number of providers serving each non-English API language by 20 percent, and;
- Increasing the median number of API beneficiaries with a primary language other than English served per provider by 20 percent.”

Date PIP began: June 2019

Projected End date: December 2020

Status of PIP: Active and ongoing

The goal of the non-clinical PIP is to examine whether providing a language assistance line for all providers and all services will improve the penetration rates for beneficiaries

who primarily speak a non-English threshold language, especially for APIs and/or those who speak an API language.

The MHP has five non-English threshold languages (Spanish, Cantonese, Vietnamese, Mandarin, Tagalog), in addition to numerous other primary languages spoken by beneficiaries. Nearly 40 percent of Alameda County Medi-Cal beneficiaries speak a language other than English as their primary language. The penetration rate for beneficiaries speaking a primary language other than English is less than half of the penetration rate for English-speaking beneficiaries. Overall, the penetration rate was 5.7 percent for primarily English-speaking vs. 2.7 percent for beneficiaries who are not primarily English-speaking. The outpatient penetration rate was 4.3 percent for primarily English-speaking vs. 2.4 percent for beneficiaries who are not primarily English-speaking.

Currently, 106 different organizational providers are contracted to provide services through the Alameda MHP, comprising approximately 84 percent of services provided.

The new language line provides on-demand access to over 200 languages, ensuring that all beneficiaries will have access to some level of interpretation at their appointments.

The PIP topic was selected using stakeholder input. The MHP developed a multi-functional team with an array of stakeholders including those with lived experience (Consumer QI Workgroup, and Family QI Workgroup). The study population for this PIP is all beneficiaries who speak a primary language other than English (n=195,186). The study question is clearly written and measurable. The indicators are objective, clearly defined and measurable. However, the PIP lists the following problems which are not being measured (less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction). The data analysis plan lacks a specific timeline and frequencies for data collection and analysis. The interventions lack sufficient detail to explain how each will be carried out. What is involved in implementing the language line? Is this a new contract that is being developed? How will it be rolled out? Is this a phased approach? Is there hardware and/or software involved? Intervention three lacks a start date.

Suggestions to improve the PIP: The PIP is active and ongoing, and should be continued for another year. However, the PIP needs to measure the issues raised to ascertain whether introducing the language line is enough to impact the problems. Measuring whether beneficiaries are offered the use of the language line would also be helpful. Beyond the language line, or in addition to it, the MHP may wish to consider adding other interventions to help address the problems listed and to improve penetration rates (e.g., less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction).

Additional detail is needed to fully explain what the interventions are, how they will be done, when, by whom, how often, and if there is a phased approach. All of the interventions need to have a start date. The data analysis plan needs to include a specific timeline and frequencies for data collection and analysis.

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 several PIP TA calls during the year, with multiple PIP draft iterations reviewed leading up to the onsite review. In addition, during the onsite review, a PIP session was held to further discuss the progress made to date, and how to improve the PIP in the next year, as discussed above. The non-clinical PIP needs to have at least one new intervention started within the next year for this PIP to continue and be considered active.

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
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	PM	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	PM
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	PM
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	M	PM
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	PM
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	NA
		8.2	PIP results and findings presented clearly and accurately	M	NA
		8.3	Threats to comparability, internal and external validity	M	NA

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		8.4	Interpretation of results indicating the success of the PIP and follow-up	M	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	M	NA
		9.3	Improvement in performance linked to the PIP	M	NA
		9.4	Statistical evidence of true improvement	M	NA
		9.5	Sustained improvement demonstrated through repeated measures	M	NA

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	24	12
Number Partially Met	1	4
Number Not Met	0	0
Unable to Determine	0	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	16
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**98%**	**87.50%**

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
Alameda	2.43%	2.33%	2.50%	1.34%
MHP Large Group Size	N/A	2.70%	3.00%	2.72%
Statewide	N/A	3.40%	3.30%	3.40%

- Budgeted IT support has remained stable for three years but has lagged similar size (Large Group) support over that period of time.

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	19.1%
Contract providers	80.0%
Network providers	0.9%
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	95%	Daily
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	N/A	Not used
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	5%	Daily
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

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

Number of county-operated sites currently operational: 1

Number of contract provider sites currently operational: 2

Identify primary reason for using telehealth as a service extender:

- ☒ 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

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	28	13	2	4
2018-19	29	2	0	1
2017-18	28	0	1	2

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	8	2	4	0
2018-19	11	5	2	5
2017-18	13	3	0	2

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

- Table 10: In March 2019, the Alameda County Board of Supervisors approved 28 Final Rule and nine DMC-ODS positions, and hiring has been staggered over three quarters by the MHP's Human Resources Department. These positions will be spread across finance, contracts, QM and IS. Of the total, IS received 13 new positions.
- Table 10: Recruitment is underway to fill the four unfilled positions.
- Table 10: Some technology positions are being filled by temporary employees.
- Table 10: Includes staff who provide Help Desk support.
- Table 11: Four AC3 positions are in the process of transition and being returned to the AC3 unit along with associated duties and responsibilities.
- Data analytical staff work assignments are dedicated to specific roles. Of the eight FTE positions, three are assigned to support QM; four support IS activities; and one position supports the Health Agency, Office of the Medical Director.

Current Operations

- The MHP continues to rely on multiple legacy systems to support clinical, program, QI, and managed care operations. See table 12 for details.
- The MHP engaged a third-party vendor to develop an RFP for new EHR and billing system. Work is under way, with the expectation to release the RFP in CY 2020. Xpio Health, LLC conducted on-site assessments and is facilitating a series of work sessions with designated subject matter stakeholders to document and prioritize the features and functions that must be present in the new system.

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
InSyst	Practice Management	The Echo Group	29	MHP/County ISD
Clinician's Gateway	Clinical Record	Krassons, Inc.	12	MHP/County ISD
Imaviser	Document Imaging	Krassons, Inc.	10	MHP/County ISD
RxNT	E-Prescribing	Networking Technology, Inc.	10	Vendor
eCura	Managed Care	InfoMC	20	MHP/County ISD
Objective Arts	CANS-50, ANSA, PSC-35	Objective Arts	4	Vendor/County

The MHP's Priorities for the Coming Year

- Continue to work with The Echo Group IS vendor to test and implement CSI Timeliness enhancements in InSyst.
- Issue the RFP to replace InSyst system with and new EHR and billing system.
- The Apttus Phase II plan will be completed and the contracts Apttus app will go-live in 6 to 8 months.
- Develop Salesforce community web portal for MHP/SUD provider data review for monthly attestation.
- Develop forms and applications for Salesforce (CRM).
- Implement ANSI x12 – EDI 274 dataset for NACT data submissions.
- Develop reports for timeliness monitoring.
- Facilitate Windows 10 Implementation.
- AC3/Thrasys – Community Health Record (CHR)/Data Warehousing.
- AC3/Thrasys – CHR Power BI Dashboards and KPI Development.

- Network Adequacy Reporting Tool (NACT) – MHP and SUD
- Mobile desktop support: Schedule weekly clinic visits to support off-site county staff.
- Develop a process and technology tool to maintain and update staff and provider information for the Final Rule (Provider Directory and NACT).
- Maintain and recruit IT staff.
- Configure firewall and network appliance to allow users outside of the firewall to access network resources.
- Implement beneficiary E-Signature via signature pads, starting with a pilot project for the Medication Consent template in MHP.
- Complete the implementation of the appointment scheduling application, which is currently in development.
- CANS-50/ANSA/PSC-35 assessment revisions, as requested by the MHP SOC and to adapt to changing state requirements.
- Incorporate the lab results function in Clinicians Gateway. Enable placing lab orders and receiving test results electronically via Clinicians Gateway. This is currently in testing.

Major Changes since Prior Year

- Successfully updated InSyst operating system to the latest version, 10.4.
- Prepared training materials and trained staff on CSI Timeliness Assessment requirements.
- Successfully submitted NACT Quarterly Data Submission for CY 2019, first and second quarters.
- AC3/SHIE – The HCSA AC3 Care Connect Unit launched the Community Health Record (CHR).
- Implemented beginning phase of timeliness using e-forms to meet the June 2019 state deadline requirement and August 2019 submission requirement.
- Published Provider Directory and Rendering Service Providers on the public website to meet NACT requirements.
- For mental health program expansion, the MHP configured the system, created accounts and trained organizations for seven new Underserved Ethnic and Linguistic Populations (UELP) programs, six new FSP programs, and two new

housing support programs. Adapted templates are being designed to meet the needs of the UELP programs and housing data collection.

- Successfully collecting and submitting CANS-50 and PSC-35 data to DHCS.
- Launched emergency medication tele-health clinic utilizing off-site prescriber to review charts and prescribe via tele-medicine intranet connection. Developed specialized templates to collect data.

Other Areas for Improvement

- Communications and project planning with legacy IS vendors is critical to maintain operational functionality, as these systems do require support to implement ongoing state-mandated system improvements.
- As the MHP will be relying on legacy IS systems for quite some time, the MHP is encouraged to explore innovative strategies using Yellowfin application to develop data dashboards that will further support clinic operations for both county programs and contract providers.
- The MHP needs to develop a communication strategy that keeps staff, contract providers and stakeholders informed of ongoing project developments and organizational priorities to support both the Reimagining Alameda County Behavioral Health Initiative and the development of the EHR RFP.

Plans for Information Systems Change

- The MHP is actively searching for a new system. The project plan is in place and the project team has been assigned and is active.

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	Clinician's Gateway	X			
Assessments	Clinician's Gateway	X			
Care Coordination	Clinician's Gatewau	X			
Document Imaging/ Storage	Clinician's Gateway/ Imaviser	X			

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Electronic Signature—MHP Beneficiary			X		
Laboratory results (eLab)				X	
Level of Care/Level of Service	Clinician's Gateway	X			
Outcomes	Clinician's Gateway/ Objective Arts	X			
Prescriptions (eRx)	Clinician's Gateway	X			
Progress Notes	Clinician's Gateway	X			
Referral Management	Clinician's Gateway	X			
Treatment Plans	Clinician's Gateway	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		10	1	1	0
FY 2018-19 Summary Totals for EHR Functionality*:		9	0	3	0
FY 2017-18 Summary Totals for EHR Functionality:		6	3	3	0

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

- Beneficiary electronic signature function is in testing/pilot phase, and is expected to go-live by early CY 2020.
- E-Lab orders function is in testing phase, and is expected to go-live during CY 2020.

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:

Local SQL Database, supported by MHP staff.

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
Alameda MHP

Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**677,568**	**$211,059,060**	**13,208**	**$4,127,166**	**1.96%**	**$206,931,894**	**$192,332,678**
JAN18	66,171	$19,764,047	1,873	$630,091	3.19%	$19,133,956	$17,518,828
FEB18	64,343	$18,544,016	1,947	$469,515	2.53%	$18,074,501	$16,728,577
MAR18	71,755	$20,422,195	1,276	$333,481	1.63%	$20,088,714	$18,521,558
APR18	63,139	$18,915,511	1,030	$309,596	1.64%	$18,605,915	$17,231,548
MAY18	70,996	$20,265,061	1,129	$290,083	1.43%	$19,974,978	$18,747,598
JUN18	51,691	$16,454,505	932	$302,428	1.84%	$16,152,077	$15,413,327
JUL18	40,527	$15,218,131	634	$285,375	1.88%	$14,932,756	$13,697,370
AUG18	46,502	$16,143,238	798	$327,757	2.03%	$15,815,481	$14,588,561
SEP18	48,943	$16,319,496	849	$312,189	1.91%	$16,007,307	$14,810,631
OCT18	59,144	$18,646,895	987	$316,177	1.70%	$18,330,718	$17,123,974
NOV18	49,213	$15,934,607	851	$263,916	1.66%	$15,670,691	$14,510,690
DEC18	45,144	$14,431,358	902	$286,558	1.99%	$14,144,800	$13,440,016

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.**

- The MHP denied claims rate (1.96 percent) for CY 2018 was much lower than the statewide average claim denial of (3.25 percent) for the same time period.

Table 15 summarizes the top three reasons for claim denial.

Table 15. Summary of CY 2018 Top Three Reasons for Claim Denial Alameda MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	6,602	$1,646,863	40%
Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code.	4,757	$1,538,820	37%
Payment denied - prior processing information incorrect. Void/replacement condition.	817	$358,001	9%
TOTAL	13,208	$4,127,166	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 reason description – Medicare or Other Health Coverage must be billed before submission of claim are generally re-billable within the State claim resubmission guidelines. Denied claim transactions with reason {insert denial reason description(s) from Table 15} are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted three 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

CalEQRO requested a group of 10-12 Spanish-speaking parents/caregivers of child/youth beneficiaries who are mostly new clients who have initiated/utilized services within the past 15 months.

The group consisted of Latino/Hispanic female parents/caregivers who were over 25 years old and included both English and Spanish speakers. However, none of their child/youth beneficiaries were new clients who initiated services within the past 15 months.

The focus group was held at La Familia, 24301 Southland Drive, Suite 300, Hayward, CA 94545.

Number of participants: Three

There were no participants who entered services within the past year. Participants described their experience as the following:

Participants' general comments regarding service delivery included the following:

- Participants initially learned about services through family members, La Familia staff, and the Access Call Center.
- Services and information was reportedly available in both English and Spanish, and participants were aware of services through the MHP, Alameda County Social Services, CalWORKS and Alameda County Public Health. Information is obtained from therapists, bulletin boards in the clinics, and through the MHP's website, which was reported to be easier to navigate due to the recent improvements.
- Therapy is available as needed, and children are seen once or twice a week at their schools, which is reportedly sufficient. While one family encountered challenges in initially changing a therapist that was not a good fit for their child,

the issue was eventually resolved and the family is now very pleased with the therapeutic relationship and the results.

- None of these families reported using psychiatry or medication services.
- Reminder calls or texts were received prior to appointments, and if appointments were missed participants received a follow-up call to reschedule.
- While all have been offered group therapy, only one participates. However, all participate in family therapy every other week.
- Participants were aware of a number to call for urgent services, but mostly have not needed it.
- Families reported being involved in treatment and care planning for their children.
- Services were found to be very helpful and of high quality, and participants stated that their children's mental health issues were improving.
- The new Southland location of La Familia was reported as a better location for accessing services, and transportation is not a barrier.
- All participants had completed satisfaction surveys, but stated that they never received information about the results. Only one parent had been asked to participate in a parent feedback meeting, but lacked the time to do so. None of the participants were aware of the MHP's QIC or Cultural Competence Committee (CCC) meetings.

Participants' recommendations for improving care included the following:

- Additional support groups are needed for young children below the age of ten years, particularly for anxiety and depression.
- The MHP should reinstate previously existing parent workshops that explained which resources were available for their children, as these were very helpful.
- Schools need additional focus on mental health education, particularly around stigma.
- Additional outreach is needed for the homeless, particularly for families who are homeless.
- To further address stigma, there is a need for a center or place for children with special needs to feel safe while participating in social activities and mental health education.

Interpreter used for focus group one: Yes Language: Spanish

CFM Focus Group Two

CalEQRO requested a culturally diverse group of TAY and adult beneficiaries who were new to services and have been hospitalized/ discharged and returned to outpatient services within the past 15 months.

The group was mostly consistent with that requested by CalEQRO, and included male and female English-speaking TAY and adult beneficiaries 18 years and older, both Hispanic/Latino and African American.

The focus group was held at in the Alvarado Niles Room, Suite 400 at Alameda County Behavioral Health located at 2000 Embarcadero Cove, Oakland, CA 94606.

Number of participants: Five

The three TAY and adult participants who were new to services and had been hospitalized/discharged and returned to outpatient services within the past 15 months described their experiences as the following:

- After being released from John George Psychiatric Hospital, support was provided for these participants, and none were released at inappropriate times (e.g., middle of the night) or without some kind of support system and transportation in place. BACS was a key provider in helping to get these specific beneficiaries connected to services, and participants stated that the BACS case managers made the process easy for them.

- Discharge medications were provided upon release from the hospital, and follow-up appointments (e.g., psychiatry and therapy) were scheduled within a few days of discharge.

Participants' general comments regarding service delivery included the following:

- Information about mental health services was obtained while in Santa Rita Jail, and through BACS, and participants were aware of service availability in both English and Spanish. Participants reported receiving written information on and support from available services and programs through Alameda County Public Health and Social Services, and CalWORKs.

- Hospitalization and outpatient services were coordinated, and participants either have a new appointment or were seen within a week post-discharge and weekly thereafter, which was felt to be sufficient.

- Psychiatry and medication services, including written information on medications, were provided monthly post-discharge, and participants reported that this was very helpful with their recovery.

- Reminder calls were received prior to appointments, and if appointments were missed then participants received a follow-up call to reschedule, or were visited by a case manager.

- All were offered group and family therapy, but reportedly refused these services. There was no participation in support groups, by choice.
- Urgent care and services were available as needed, often the same day, and participants knew whom to call when necessary (e.g., therapist or case manager). They were all aware of and had the numbers for the warm line and the crisis line.
- Participants reported being involved in treatment and care planning, but were unaware of whether their primary care doctor and psychiatrist communicated about their treatment.
- None of these participants attended a wellness center.
- Bus passes and rides are provided through case managers, and transportation is not a barrier.
- Two of the participants had completed a satisfaction survey, and none of the participants were aware of the MHP's QIC or CCC meetings.

Participants' recommendations for improving care included the following:

- Participants stated that it doesn't matter what suggestions are made as nothing will come of it, and therefore declined making any recommendations.

Interpreter used for focus group two: No Language: N/A

CFM Focus Group Three

CalEQRO requested a group of 10-12 Cantonese-speaking adult beneficiaries who are mostly new clients who have initiated/utilized services within the past 15 months.

The group consisted of Cantonese-speaking male and female adults.

The focus group was held at the Rolland & Kathryn Lowe Medical Center, Asian Health Services at 835 Webster Street, Oakland, CA 94607.

Number of participants: Three

The three participants who entered services within the past year described their experiences as the following:

- Participants initially learned about services through a social worker or case manager, and services and written information were available in Cantonese.
- Initial assessment appointments were scheduled within a week to a month, and it took up to a month for an initial psychiatric appointment.

Participants' general comments regarding service delivery included the following:

- Social workers and/or case managers are seen weekly to every other week, with some staff turnover experienced by participants. Some found it helpful to have a family member attend sessions with them.
- Psychiatry services were utilized monthly to quarterly, and medication services were found to be helpful.
- None of the participants reported being involved in treatment and care planning, or medication services. None were aware of whether their primary care doctor and psychiatrist communicated about their treatment.
- One participant stated that the staff was caring and supportive, and they felt able to talk openly, while another felt unsupported, unsafe and fearful.
- None of the participants were aware of a warm line or crisis line to call if needed, and only knew to call 911.
- One participant had heard about a place to do crafts, but none were aware of or utilized a wellness center.
- None of the participants reported completing a satisfaction survey, and none were aware of the MHP's QIC or CCC meetings.
- Transportation was not reported to be a barrier to services.

Participants' recommendations for improving care included the following:

- More meetings like this one should be held to benefit us, so we can learn what the community can do for us, and we can provide our suggestions about how to improve things.
- It would be helpful to have a hotline or crisis number to call, just in case.

Two interpreters were used for focus group three. Language: Cantonese

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	13
In January 2019, the MHP centralized the ASOC initial screening and referral process for new intakes and existing beneficiaries, which now all come through the Access Call Center. Previously, there were many intake and referral points in the adult system, both county and contracted, leading to challenges with appropriate level of care determination, timeliness, and service capacity. The CSOC continues to have multiple contracted Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs that each have their own front door and as such, manage their own screenings and referrals. Stakeholders reported that the Access Call Center staff are very helpful; however, the center remains understaffed which is problematic for the service teams when making referrals. In addition, LOC determinations are not consistently accurate and the staff need a standardized system and improved training and tools to better determine LOC for new beneficiaries, particularly for homeless individuals. To help address disparity in access for the API community, the MHP expanded Access Call Center services through Asian Health Services, an API contracted provider. The MHP monitors the number of calls received, wait times, dropped calls, and referrals to mental health services through various venues including calls to the			

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
Access Call Center, walk-ins, school referrals, and primary care referrals, among others. The MHP added some telehealth services in the past year, and will be adding video translation services in the next fiscal year. The MHP has five threshold languages including Spanish, Cantonese, Vietnamese, Mandarin and Tagalog. The MHP has a new language line contract that provides on-demand access to over 200 languages, ensuring that all beneficiaries will have access to some level of interpretation at their appointments. The MHP's non-clinical PIP focuses on use of the new language line. CFM focus group participants reported being able to access services and written information in English, Spanish and Cantonese. However, in line with last year's EQRO findings, none of the Cantonese-speaking CFM focus group participants were aware of a warm line or crisis line to call in case of an urgent need.			
1B	Capacity Management	10	9
The MHP assesses the cultural, ethnic, racial, and linguistic needs of its Medi-Cal eligibles for the purpose of identifying strategies and resources to address disparities in access. While the MHP has implemented some strategies to address these disparities, additional efforts need to be made to ensure equity. In addition, evaluating the impact of these strategies is necessary. The MHP monitors penetration rates and needs to drill down into their data to disaggregate beyond age, race and gender, using the data for determining QI projects and expansion of services to address parity. This includes all timeliness metrics to better understand and direct service improvements. The MHP monitors system demand, caseloads by provider type and service location, and productivity. However, the entire SOC is struggling with recruitment and retention challenges, particularly for bilingual and bicultural licensed clinicians who mirror the community served, primarily due to the high cost of living the Bay Area. In September 2018, the MHP began transitioning one CSOC medication support service from a contracted provider to a county-operated clinic. This process was completed in December 2018.			
1C	Integration and Collaboration	24	24
The MHP provided multiple examples of integrated and collaborative programs and services with partnering agencies and community-based organizations. These included primary care, hospitals, law enforcement agencies, schools, faith-based			

Table 16: Access to Care Components		
Component	**Maximum Possible**	**MHP Score**
organizations, public health, managed care organizations, and employment and housing agencies, among others. To more closely align the MHP and the managed care plan (Alameda Alliance), quarterly meetings were initiated in the past year, attended by operational and executive leads and the directors from both entities. The MHP is leading the Justice-Involved Mental Health Task Force, a county-wide effort to implement a Sequential Intercept Mapping system that will divert individuals with behavioral health issues from entering the criminal justice system and being incarcerated. The six action areas being focused on are data sharing, diversion and alternatives, judicial training and advocacy, housing, peer advocate recruitment and training, and a forensic inpatient unit. Funding has been dedicated to providing an overnight safe space for persons with behavioral health needs who are exiting from Santa Rita jail between the hours of 11:00 p.m. and 6:00 a.m. The project will be staffed by peer navigators, mental health clinicians, and nursing staff, and services will be provided in a customized trailer stationed on the jail parking lot/campus beginning January 2020.		

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	9
The MHP has a standard of ten business days from initial request to first offered appointment. As of July 2019, the MHP has newly begun to implement a new policy and process for tracking this metric system-wide (in both county-operated and contract provided services). Preliminary data on 239 new services over the past four months meets the standard 83.05 percent of the time (89.23 percent for adults, 79.88 percent for child, and 100 percent for foster care youth). However, the data is incomplete as the MHP is in the process of working with providers to implement the new data collection strategy.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
The MHP does not track timeliness for initial walk-in appointments.			
2B	Assessment Follow-up and Routine Appointments	8	5
The MHP has a standard of 14 business days from initial request to first kept appointment. The MHP meets this standard 57.4 percent of the time (58.6 percent for adults, 51.9 percent for children, and 56.1 percent for foster care youth). This data is tracked system-wide. The MHP does not track the length of time between first and second clinical service appointments.			
2C	First Offered Psychiatry Appointment	12	12
The MHP has a standard of 15 business days from initial request to first offered psychiatry appointment. The MHP meets this standard 52.4 percent of the time (51.4 percent for adults, 66.7 percent for children, and 87.5 percent for foster care youth). This is an improvement over last year (33.6 percent overall, with improvements in all disaggregated categories). This data is tracked system-wide.			
2D	Timely Appointments for Urgent Conditions	18	13
As of June 2019, the MHP has newly begun to implement a new policy and process for tracking urgent appointments system-wide, and training of providers was carried out in July and August. The MHP is in the process of building provider-level accountability reports that identify missing timeliness data for new beneficiaries. In addition, the MHP is developing dashboards for monitoring new timeliness metrics, including disaggregation by various demographics and geography. Preliminary data is presented below; however, the data is incomplete as the MHP is in the process of working with providers to implement the new data collection strategy. The MHP has a standard of 48 hours for urgent appointments that do not require prior authorization. While the MHP meets this standard 96 percent of the time for adults, it does not meet the standard at all for children (n<11). The MHP has a standard of 96 hours for urgent appointments that require prior authorization; however, the MHP is not yet tracking this metric but plans to do so in the coming year.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
All after-hours calls are rolled over to the crisis line, which is answered within a few rings by a clinician. For non-urgent calls, callers are given the option of calling the Access Call Center during business hours or having an Access Call Center clinician return their call the following business day. CFM focus group participants reported that urgent care services were available as needed, often the same day.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP has a standard of seven days for follow-up post hospital discharge. The MHP meets this standard 33.7 percent of the time (29.8 percent for adults, 52.6 percent for children, and 46.1 percent for foster care youth). This data is tracked system-wide.			
2F	Tracks and Trends Data on Rehospitalizations	6	5
The MHP has a hospital readmission rate of 18.7 percent within 30 days (20.2 percent for adults, 11.4 percent for children, and 26.5 percent for foster care youth). This data is tracked system-wide.			
2G	Tracks and Trends No-Shows	10	5
The MHP does not have a standard for no-show rates for psychiatrist or other clinicians. The no-show rate for psychiatrists is 11 percent (eight percent for adults, 21 percent for children). This metric is not tracked for foster care youth. The no-show rate for clinicians is 11 percent (five percent for adults, 19 percent for children). This metric is not tracked for foster care youth. This data is tracked for county-operated clinics only. The MHP does not track no-show rates for psychiatry or for clinicians system-wide.			

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	6

In January 2019, the MHP centralized the ASOC initial screening and referral process for new intakes and existing beneficiaries, which now all come through the Access Call Center. Previously, there were many intake and referral points in the adult system, both county and contracted, leading to challenges with appropriate level of care determination, timeliness, and service capacity. The CSOC continues to have multiple contracted EPSDT programs that each have their own front door and as such, manage their own screenings and referrals.

Stakeholders reported that the Access Call Center staff are very helpful; however, the center remains understaffed which is problematic for the service teams when making referrals. In addition, LOC determinations are not consistently accurate and the staff need improved training and tools to better determine LOC for new beneficiaries. Also mentioned was the difficulty determining LOC needs exclusively over the phone and the need for face-to-face screening for some beneficiaries.

The CANS-50 and ANSA tools are being used at initial intake along with the clinical assessment, and outcomes data is held in the Objective Arts platform from which reports can be generated. However, without a functional EHR, the data warehouse lacks sufficient beneficiary-level clinical data elements to measure and monitor clinical performance. Clinicians reported that the CANS-50, Pediatric Symptom Checklist (PSC-35) and ANSA are of limited use in transitioning beneficiaries in addition to being a barrier to building a therapeutic alliance, as many beneficiaries' status does not change significantly in the short-term making the tool redundant. Clinical supervisors reported that recertification of these tools is causing great anxiety among clinical staff who often fail as the material is very subjective. Improved training of Access Call Center staff and clinicians is needed on how to use the CANS-50, PSC-35 and the ANSA to drive clinical treatment and LOC changes at the individual level.

Clinicians reported that they are transitioning beneficiaries to lower LOC more quickly, in alignment with agency goals. However, sufficient options for lower LOC are not plentifully available in Alameda County causing beneficiaries to cycle through MHP services more frequently.

QI efforts need to be primarily data driven, and since the MHP is hoping to move to a CQI approach in the coming year, routinely evaluating the entire beneficiary experience would be the next step. Specifically, QI should evaluate data from initial access through clinical service delivery (length of stay, number of services, changes in LOC/programs, retention rates) to discharges (reasons for discharges, and beneficiary outcomes including treatment plan goal achievement) and beneficiary disposition (returning to outpatient or crisis/hospitalization services) within a given

timeframe post discharge (three months, six months, one year). This data could then be compared to beneficiary perceptions of the care received, with improvements in engagement following. In addition, QI should determine the number/percent of referrals to lower LOC including mild-to-moderate services, and how many engaged successfully vs. disengaged and returned for higher levels of service through the MHP.

3B	Quality Improvement Plan	10	7

In the past year, the MHP updated the QI work plan to include quantifiable goals and objectives, and corresponding indicators. While this is an improvement over the previous year, the work plan does not yet include a comprehensive list of quality management metrics, or an analysis of disparities in services by site/region/population served. A complete evaluation was carried out on the previous year's work plan, detailing the status of each goal along with the specific activities, and those not completed have been carried forward to this year's work plan.

The QIC met 9 out of 12 months in the past year, with a documented agenda and minutes for each meeting. While the data from the previous EQRO report was discussed, QIC meeting minutes do not regularly (at least quarterly, but preferably monthly) reflect the inclusion of quality management data generated and analyzed by the QI staff, or an in-depth discussion of the progress being made towards the newly quantified goals and objectives in the updated QI work plan.

3C	Quality Management Structure	14	5

QI metrics and activities are separate and distinct from quality assurance and utilization management, which focus heavily on compliance issues. QI currently has only one designated FTE, with two additional FTEs borrowed from other areas. In such a large and complex system of care, the MHP needs to build sufficient QI staffing and data analytic capacity necessary to fulfil the quality improvement requirements (separate and distinct from QA/UM) for both mental health and DMC-ODS.

The Data Services Team, previously Decision Support, was under quality management but has been moved to information systems. In addition, much of the analytic staff needed to support the final rule implementation and whole person care have been shuffled between departments and divisions.

QI is informally involved with the Data Services Team, under which the decision-making occurs regarding which reports and dashboards need to be developed. This lack of a formal structure for ongoing collaboration has led to multiple situations where developments needed to be changed/improved to be responsive to the MHP's needs for both quality and compliance. This was evident in several sessions throughout the review, and was discussed at length with contract providers who received instructions that were then superseded a month later causing significant administrative challenges and staff frustration, with additional costs incurred.

The MHP is in the process of restructuring the executive leadership team, and has created a new Plan Administrator position that will be filled in December 2019 to oversee operations and quality management. The MHP is planning to fill the QM Director position by April 2020 pending the hiring of the new Plan Administrator who will oversee the updating of the job description for, and the recruitment and hiring of, the new QM Director. The previous QM Director retired in September 2019, and in the interim the MHP's Deputy Director is the Acting QM Director.

3D	QM Reports Act as a Change Agent in the System	10	6

The MHP is in a state of transition, with new leadership, a shifting executive structure, and an impending strategic planning process scheduled for next year.

QI has been heavily focused on compliance issues, and somewhat indistinct from QA, while both are housed under QM. In addition, QI activities and PIPs have not been primarily data driven, and the MHP is hoping to move to a CQI approach in the coming year. To this end, multiple efforts have been made to create a data warehouse, and develop reports for data analytics, quality management and performance improvement. Additional work is needed to routinely evaluate the outcomes of these individual program and system-wide efforts.

3E	Medication Management	12	9

The MHP has a medication monitoring process that includes randomly sampling ten percent of each physician's caseload, independent of site of practice. Charts are reviewed at each practice site once per quarter. The screening criteria used is the "Standards for Psychotropic Medication Practices", as approved by the MHP's Psychiatric Practices Committee. Findings are recorded in an electronic database that generates reports for oversight of and feedback for clinicians. Deviations from the standards generate a request from the Medical Director to correct deficiencies within a specific timeframe. The pharmacist may choose particularly concerning cases of deviation for review the following quarter.

The MHP is engaged in a quality improvement project that aims to improve psychiatric treatment for children and youth, specifically developing processes to increase comprehensive treatment planning and strategies that ensure safe and quality use of psychotropic medications. While it was initiated for foster care youth, this initiative has now been expanded to include all children referred for medication evaluations.

In September 2018, the MHP began transitioning one CSOC medication support service away from a contract provider to a county-operated clinic in order to more closely monitor psychiatric medication use in children under 18 years old. This process was completed in December 2018.

While the MHP tracks and trends HEDIS and other national measures related to diagnoses, medication practice, and care standards, supervisors and clinical line staff were not familiar with these metrics.

None of the CFM focus group participants were aware of whether their primary care doctor and psychiatrist communicated about their treatment.

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	12

To support level of care determinations and service planning, and to facilitate quality improvement initiatives that monitor service outcomes system-wide, the ASOC uses the ANSA, and the CSOC uses the PSC-35, the early childhood CANS for ages 0-5 years, the children and youth CANS for ages 6-17 years, and the TAY CANS for ages 18-24 years. These tools are used during the initial assessment (completed within the first 60 days of opening a new case), and every six months thereafter until discharge.

In early 2019, the MHP updated the previous 96 item CANS to the CANS-50 in order to reduce duplicative efforts and to better align with the state requirements. However, clinicians reported feeling that the CANS-50 and PSC-35 requirements are of limited clinical use, and interrupt the therapeutic process with beneficiaries while taking significant time to complete.

Outcomes data is held in the Objective Arts platform, from which reports can be generated (e.g., Average Impact Report). The MHP is in the early stages of establishing a regular process for extracting and analyzing system-wide outcome data to facilitate QI efforts for clinical services and beneficiary outcomes. However, no comprehensive analyses have yet been completed.

Evidence-based practices and accompanying fidelity tools are used throughout the SOC. The ASOC uses Assertive Community Treatment, Individual Placement and Support, Housing First Model, Motivational Interviewing Enhanced Treatment, Trauma Informed Service Strategies, Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Seeking Safety, Feedback Information Treatment, and others. The CSOC uses Multi-dimensional Family Therapy, Multi-systemic Therapy, Child Parent Psychotherapy, Circle of Security, Forensic Assertive Community Team, Motivational Interviewing Enhanced Treatment, Transition to Independence, Gender Responsive

Strategies, Trauma Focused Cognitive Behavioral Therapy, Dynamic Mindfulness, Therapeutic Foster Care, and others.

CFM focus group participants reported that outpatient therapy, psychiatry and medication services are helpful for their recovery, and that they were improving.

4B	Beneficiary Perceptions	10	6

Due to the low numbers of CFM focus group participants, CalEQRO was unable to obtain sufficient beneficiary feedback on this review.

The MHP administers the Consumer Perception Survey twice a year, and compares the most recent findings against prior data. While it is included as a contractual requirement, uneven participation from providers and low survey returns makes it difficult to draw conclusions. However, overall responses are positive, and analysis has demonstrated that participant responses generally reflect penetration rates. Stakeholders throughout the SOC reported that they generally have not received feedback regarding the CPS findings.

The Family Sub-committee of the Joint Partnership Meeting for Katie A. implementation revised the annual Child and Family Team (CFT) meeting survey used to evaluate youth and family satisfaction. The survey is currently being implemented.

4C	Supporting Beneficiaries through Wellness and Recovery	4	4

The MHP has six peer-run wellness centers located throughout the county. These drop-in centers are open to the public.

In January 2019, the MHP opened Sally's Place, the first respite home in the county.

Beneficiaries are made aware of these facilities through the Access Call Center, clinical staff and case managers, outreach and engagement efforts, and written materials (e.g., flyers and brochures) located at many contract provider locations.

CFM focus group participants requested additional support groups and venues for children to feel safe addressing stigma, anxiety and depression.

Transportation was not reported as a barrier to treatment by CFM focus group participants.

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		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	30
The MHP offers a full spectrum of specialty mental health services and corresponding levels of care including outpatient, urgent, crisis services, residential, medication support, and others.			
5B	Network Adequacy	18	18
In March 2019, the Alameda County Board of Supervisors (BOS) approved 28 new Final Rule positions, for which the hiring has been phased in throughout CY 2019. The MHP is updating policies and protocols for organizing and tracking credentialing. Alameda Alliance is a possible partner as they are already engaged with these activities, and the MHP is looking for a new vendor to assist them. The MHP established a new work group that meets monthly to address Notices of Adverse Benefit Determination (NOABD). A new policy has been finalized and signed in Spring 2019. Grievances that are under appeal are investigated and tracked manually using a spreadsheet. The MHP is using a Concurrent Review Hybrid review process, with training and support for medical staff. Policies are currently in draft form. An automated Excel spreadsheet is used to track network adequacy data, and a checklist has been developed to ensure that data is complete and accurate. The MHP is expanding the reimbursement rate for individual provider networks, aiming for equity with other Bay Area counties. Stakeholders reported feeling overwhelmed with the documentation requirements, and requested additional training and support.			
5C	Subcontracts/Contract Providers	16	8
Currently, 106 different organizational providers are contracted to provide services through the Alameda MHP, comprising approximately 84 percent of services provided. The MHP holds monthly contract provider meetings, and a dedicated contract liaison is assigned to contract provider. Contractor providers reported that the connection with MHP leadership has improved. However, the lack of contract flexibility, and conflicting and inaccurate information and			

tools received and superseded by various contract officers, finance, UR and QI staff is causing significant administrative challenges and staff frustration. This has also led to additional costs being incurred. Contract providers requested that they be included in initial discussions as well as planning activities for system-wide changes that will impact their operations and services, which is particularly import since they comprise such a large percent of all services rendered. In addition, improved coordination and information-sharing is necessary between the various operational departments within the MHP. Advanced notice of operational and clinical changes is also requested.

The workforce crisis is being heavily felt by contract providers who are experiencing turnover rates around 25-30 percent, and vacancy rates that are leading to an impending cliff beyond which programs will need to downsize or be closed. A rate increase of five percent was approved in July 2019, but has not yet been signed.

As agencies are competing with each other for the limited available clinicians, agencies are using interns, non-licensed staff and peer employees to expand their workforce and capacity, where possible. However, attempting to serve the highest acuity specialty mental health beneficiaries with the least trained staff while ensuring quality of care is challenging.

Agencies are forming new relationships with local colleges and universities for succession planning.

When stepping beneficiaries down to a lower LOC, continuity of care is a challenge due to inadequate capacity of the managed care plans (Beacon for Alameda Alliance, and Anthem Blue Cross), particularly for non-English-speaking beneficiaries. Currently it is taking about one month to be seen through the managed care plans, and during the interim beneficiaries require continued services to ensure successful transitions. For homeless beneficiaries, a warm handoff rather than just a paper referral is particularly important.

Many of the contract providers are doing double entry of data into multiple systems without an electronic interface.

The MHP's reports and data analyses are increasingly inclusive of data from contract providers, network providers, and directly operated programs.

The MHP demonstrated in QIC minutes that at least 20 contract provider staff regularly attend monthly QIC meetings, constituting over 50 percent of the attendees which is important in such a large and diverse SOC with 84 percent of services rendered by this group. In addition, contract providers are involved in all PIP work groups and are the primary implementers of services for the clinical PIP and much of the non-clinical PIP. Contract providers are routinely involved in regular CCC meetings, as documented in the minutes.

5D	Stakeholder Engagement	12	4

Stakeholders throughout the SOC reported a general lack of awareness of or participation in system planning efforts, including attending QIC and/or CCC meetings, and the pending strategic planning process. While QIC staff have made multiple attempts to collaborate with the Office of Consumer Empowerment, the POCC and other departments, additional communication on policies and planning efforts by leadership is needed for county and contracted staff and stakeholders systemwide.

A shift has occurred in the past year with more leadership participation in quarterly county clinic meetings, which was reportedly very much appreciated.

While the MHP has an OCE that works with POCC members and peer employees, during the onsite review peer employees recommended that they be fully included in executive and leadership meetings to leverage their strengths and experience, and ensure their contributions are integrated into system planning and implementation. The TAY Committee includes one peer employee. While no peer employees reported attending the QIC or CCC meetings, stating that the timing and location prohibited their attendance, QIC meeting minutes consistently list one or two peer/family attendees. However, this is insufficient to represent a collective voice for substantial peer involvement.

Stakeholders reported that there is limited engagement or beneficiary involvement in MHP committees and system planning. None of the CFM focus group participants were aware of the MHP's QIC or CCC meetings.

5E	Peer Employment	8	7

There are limited designated positions within the MHP (approximately five). A career ladder is in place, but beneficiary employees would like to see that ladder increased. There are management and supervisory positions designated within the system. The MHP collaborates with peer agencies including POCC with 1,600 members in Alameda County, and Peers Envisioning and Engaging in Recovery Services (PEERS). Peer employees recommended creating leadership and supervisory positions for them, and educating clinicians and providers regarding POCC programs and successes.

Three years ago, the MHP had a peer advisory group, which is being relaunched through the TAY program with the CSOC.

Peer employees reported making a livable wage through these positions, and resources for peers are available to help them achieve success. However, additional training is needed.

Peers reported mixed experiences with feeling respected throughout the SOC; however, the new MHP Director recently met with several peer employees who appreciated this direct communication and stated that previously it was top down. The

POCC provides training for MHP leadership on how to best interact with and utilize peer staff.

5F	Peer-Run Programs	10	10

The MHP has six peer-run drop-in wellness centers located throughout the county.

The new peer respite home opened in January 2019, Sally's Place, is a 6-bed facility that is fully peer-run and peer-supervised, and offers four phases of staff support that progress throughout the stay. The respite home is open to the public Monday thru Friday, 24 hours a day. This alternative to traditional psychiatric crisis care provides short-term stays (up to 14 days) to help beneficiaries move forward with their recovery. The facility has three shifts of rotating, culturally diverse staff who are all persons with lived experience, and many are bilingual. These staff positions are paid and fully benefited, with eight full-time and one part-time staff members currently employed, and an additional three per-diem staff available on-call. The program works closely with the MHP's Access Call Center and service teams, re-entry systems, referral systems, and with other community-based organizations. Peer advocates connect beneficiaries to county services while staying at the respite home, and follow-up care provides continued support after discharge.

5G	Cultural Competency	12	7

The Office of Ethnic Services is run by the Ethnic Services Manager who oversees two additional FTEs. The Ethnic Services Manager facilitates the CCC and its sub-committees, along with the integration of National Standards for Culturally and Linguistically Appropriate Services (CLAS) and other cultural competence policies and training throughout the SOC. CLAS Standards are now a requirement as stated in every new provider and agency contract, with corrective actions issued when contracted agencies do not comply.

The MHP has a functioning Cultural Competence Committee that in the past year was changed from meeting monthly to meeting every other month. The CCC has a standing agenda and documented meeting minutes. The CCC has had three sub-committees that met quarterly - governance, compliance, and communications. The governance sub-committee, which has now been dissolved, was responsible for implementing the structure of the CCC and revising the CCC charter, which has been completed. The compliance sub-committee provides oversight for cultural and linguistic grievances, ensuring that they are adequately addressed. The communications sub-committee developed a new webpage that provides detailed information and links for cultural competence issues, services and activities.

The cultural competence work plan is currently being updated to create strategic alignment with other goals within the agency, and is in draft form with incomplete data. The MHP is encouraged to develop quantifiable goals and objectives in the CC work plan, with data metrics included in the CCC standing agenda and discussed at regular meetings, reflected in the minutes. In addition, strong linkages should be

made with the QIC, leveraging the goals and objectives in the CCC and QI work plans. Two QIC staff are members of the CCC, and the Ethnic Services Manager is a member of the QIC.

The MHP is focusing on systemic change, using penetration rates to examine and address disparities within the communities served. In Spring 2019, the MHP facilitated meetings with leadership and staff to explore the mental health needs of African American beneficiaries. FY 2016-2017 data showed African Americans were 19 percent of all Medi-Cal beneficiaries, but comprised 32 percent of those who utilized the behavioral health system, mainly in the most restrictive settings such as jails, emergency hospitals and crisis stabilization facilities. This disproportionality is compounded by the fact that the MHP has insufficient services available to adequately address the mental health needs of African Americans in a culturally congruent and affirming manner. While informal efforts have been made, they have not been tracked or measured, and there has been no overarching plan with specific strategies.

All bilingual staff providing interpretation services are required to be trained and (re)certified annually, and currently the training is only available once per year and needs to be made available more frequently.

The non-clinical PIP focuses on language access.

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

In January 2019, the MHP centralized the ASOC initial screening and referral process for new adult intakes and existing beneficiaries, which now all come through the Access Call Center.

- In September 2019, the MHP opened a new CSU (Amber House), implementing a 2-page form for intakes, and an algorithm for referrals which includes response time standards.
- As of October 2019, the behavioral health screening tool has been integrated into the initial assessment process, thereby further reducing duplicative efforts.

Strengths:

- The MHP updated the workflow and policies for initial intakes, allowing non-licensed staff to complete the CANS-50, while licensed staff continue to administer the initial assessment.
- Services and written information was reportedly available in multiple threshold languages, and venues (e.g., website, bulletin boards, flyers, and clinical staff).

Opportunities for Improvement:

- Stakeholders reported that the Access Call Center remains understaffed causing bottlenecks in the system and challenges for service teams making referrals.
- CFM focus group participants requested additional support groups and venues for children to feel safe addressing stigma, anxiety and depression.

Timeliness of Services

Changes within the Past Year:

- The MHP has a standard of ten business days from initial request to first offered appointment, and as of July 2019 has begun implementing a new policy and process for tracking this metric system-wide.
- As of June 2019, the MHP has newly begun to implement a new policy and process for tracking urgent appointments system-wide, with training of providers carried out in July and August.
- The MHP is in the process of building provider-level accountability reports that identify missing timeliness data for new beneficiaries.
- The MHP is developing dashboards for monitoring new timeliness metrics, including disaggregation by various demographics and geography.
- The QI Department is beginning to aggregate the network adequacy timeliness performance data and share it with MHP leadership teams for review and evaluation. However, the data is not yet complete enough to use for program and systems management and resource allocation determinations.

Strengths:

- The overall percent of beneficiaries meeting the 15 business day standard for initial request to first psychiatry appointment has improved in the past year (from 33.6 percent to 52.4 percent) with improvements in all disaggregated categories.
- CFM focus group participants reported that outpatient therapy, psychiatry and medication services are available as often as needed.

Opportunities for Improvement:

- The MHP has a standard of seven days for follow-up post hospital discharge, and meets this standard only 33.7 percent of the time.
- The MHP has a hospital readmission rate of 20.2 percent for adults and 26.5 percent for foster care youth.
- No-show data is tracked for county-operated clinics only, not system-wide. In addition, the MHP does not have a standard for no-show rates for psychiatrists or other clinicians.

Quality of Care

Changes within the Past Year:

- In the past year, the MHP updated the QI work plan to include quantifiable goals and objectives, and corresponding indicators.
- The Quality Management Director retired in September 2019.

Strengths:

- A complete evaluation was carried out on the previous year's work plan detailing the status of each goal along with the specific activities, and those not completed have been carried forward to this year's work plan.

Opportunities for Improvement:

- QI metrics and activities are currently indistinct from quality assurance and utilization management, and are focused heavily on compliance issues.
- QI currently has only one designated FTE, with two additional FTEs borrowed from other areas.
- QI is informally involved with the Data Services Team, under which the decision-making occurs regarding which reports and dashboards need to be developed.
- The QI work plan does not yet include a comprehensive list of quality management metrics, or an analysis of disparities in services by site/region/population served.
- The QIC meeting agenda and minutes do not regularly (at least quarterly, but preferably monthly) reflect the inclusion of quality management data generated and analyzed by the MHP, or an in-depth discussion of the system-wide progress being made towards the newly quantified goals and objectives in the updated QI work plan.
- County clinics have expressed the need for dedicated QA and QI staff to provide ongoing support. QA and QI staff need to closely collaborate, working together with both county-operated staff and contract provider QA and QI staff to ensure consistency of messaging and avoiding duplication of efforts.
- During the onsite review, no peer employees reported attending the QIC or CCC meetings, stating that the timing and location prohibited their attendance. While QIC meeting minutes consistently listed one or two peer/family attendees, and the MHP is working to improve attendance and participation, this remains insufficient to represent a collective voice for substantial peer involvement.
- Stakeholders throughout the SOC reported that there is limited engagement or beneficiary involvement in MHP committees and system planning. None of the CFM focus group participants were aware of the MHP's QIC or CCC meetings.

Beneficiary Outcomes

Changes within the Past Year:

- Non-licensed staff are now allowed to complete the CANS-50.

Strengths:

- To support level of care determinations and service planning, and to facilitate quality improvement initiatives that monitor service outcomes, the ASOC uses the ANSA, and the CSOC uses the CANS-50. This system was updated in the past year to better align with state requirements, and the MHP is in the early stages of system-wide implementation, including establishing a regular process for extracting and analyzing outcome data to review with county and contracted providers.

- CFM focus group participants reported that outpatient therapy, psychiatry and medication services are helpful for recovery, and that they were improving.

Opportunities for Improvement:

- CANS-50 and ANSA data held in the Objective Arts platform is just beginning to be aggregated and no comprehensive analyses have yet been completed as the MHP is in the early stages of system-wide implementation.

- Due to the low numbers of CFM focus group participants, CalEQRO was unable to obtain sufficient beneficiary feedback on this review.

- None of the CFM focus group participants were aware of whether their primary care doctor and psychiatrist communicated about their treatment.

- The MHP has not yet responded to the previous recommendation to explore attitudes and provide refresher training for practitioners regarding input of beneficiaries' wishes to explore alternative treatments beyond or in lieu of medication support. Stakeholders reported that this was the case with prescribers for the API community.

Foster Care

Changes within the Past Year:

- Since February 2019, the MHP has been experiencing challenges in identifying subclass members via the monthly data exchange process with CWS. This is due to an internal IT issue at CWS, who is working on a resolution with their IT Department. In the interim, both agencies have jointly developed a manual work-around solution to ensure that all children and youth continue to receive services as required.

- As of February 2019, foster care Team Decision Making (TDM) meetings were changed to CFTs for all foster youth (as opposed to only for Katie A. sub-class members). This has resulted in improved staff, family and child satisfaction, smoother case management, and improved outcomes for court hearings.

- In May 2019, the MHP contracted with one agency, Alternative Family Services, for the provision of TFC. To date, five parents have been trained, with an additional five needed. The agency is working on additional recruitment.

- In September 2019, the MHP conducted an audit of all Katie A. providers, reviewing CFT sign-in sheets, agendas and case plans. Needed corrections on documentation were addressed with providers, as necessary.
- The MHP, in partnership with CWS and probation, is in the process of separating the previously developed Katie A. manual into individual policies and procedures for the various components of Continuum of Care Reform (CCR).
- The formalized Memorandum of Understanding (MOU) between the MHP and CWS has been in the process of being updated over the past year, and is pending signatures from the directors. The updated MOU will span CY 2018-2021.
- In October 2019, a new referral process and protocol, developed jointly by the MHP, CWS and probation, was finalized for TFC services.

Strengths:

- As per SB 1291 (Chapter 844; Statutes of 2016), the MHP has policies and protocols in place, and is tracking the psychotropic medication and HEDIS measures as required. The MHP routinely downloads Alameda County data from the EPSDT Performance Outcomes System (POS) Data Dashboards, and uses it for quality management of foster care services.
- The MHP disaggregates foster care youth data for all timeliness metrics except no-shows.
- As per AB 1299 (Chapter 603; Statutes of 2016), the MHP has policies and protocols in place for Presumptive Transfers, and is routinely tracking and analyzing this data in coordination with CWS, making program improvements where necessary.
- The MHP has existing contracts with several out-of-county STRTPs and one STRTP in Alameda County. The MHP is currently in the process of contracting with one recently-licensed Alameda County STRTP.
- The MHP participates in a quarterly Joint Partnership Meeting with CWS to manage all major program and operational issues related to Katie A. implementation. Additional stakeholders attend the meeting including contract provider representatives, youth advocates, parent advocates, and family partners.
- The MHP participates in quarterly regional CCR meetings with nine Bay Area counties to discuss topics including Presumptive Transfer challenges and streamlining policies and protocols, TFC, STRTPs, among others. Participants include staff from the MHP, CWS and probation departments from all nine counties.

Opportunities for Improvement:

- None

Information Systems

Changes within the Past Year:

- The Alameda County Board of Supervisors authorized an additional thirteen IS staff positions during the April 2019 meeting, representing approximately a 30 percent increase of FTE positions. Most of the new positions have been filled.

Opportunities for Improvement:

- Expand the Yellowfin roll-out for contract providers as soon as practical. Provide training and TA to ensure successful use of the data.

Structure and Operations

Changes within the Past Year:

- The MHP experienced multiple leadership changes in the past year, and newly hired:
    - Dr. Karyn Tribble, Alameda County Behavioral Health (ACBH) Director (September 2019)
    - Dr. Ravi Mehta, Health Care Services Agency (HCSA)/MHP Compliance and Privacy Officer (September 2019)
    - Jerri Randrup, HCSA Public Information Officer (September 2019)
    - Nathan Hobbs, SUD Administrator (June 2019)
    - Cecilia Serrano, Finance Director (April 2019)
    - Lisa Carlisle, CSOC Director (March 2019)
- The MHP had several retirements in the past year:
    - Rudy Arrieta, QM Director (September 2019), and has continued as a consultant to the MHP.
    - Jeff Rackmil, CSOC Director (March 2019)
    - Leda Frediani, Finance Director (December 2018)
- The MHP is in the process of restructuring the executive leadership team, and has created a new Plan Administrator position that will be filled in December 2019 to oversee operations and quality management. This position will function as a second Deputy Director, with the existing Deputy Director managing the clinical systems of care.

- The MHP is planning to fill the QM Director position by April 2020 pending the hiring of the new Plan Administrator who will oversee the updating of the job description for, and the recruitment and hiring of, the new QM Director. In the interim, the MHP's current Deputy Director is the Acting QM Director.

- In March 2019, the Alameda County BOS approved 28 Final Rule and nine DMC-ODS positions, and hiring has been staggered over three quarters by the MHP's Human Resources Department. These positions will be spread across finance, contracts, QM and IS.

- The MHP engaged in a number of initiatives designed to serve as a foundation for what will be a formal strategic planning process in the next calendar year, focusing on three primary strategic areas: alignment, communication and organizational structure. Ensuring that cultural competence is a foundation for these activities will further strengthen this endeavor.

Strengths:

- To more closely align the MHP and the managed care plan (Alameda Alliance), quarterly meetings were initiated in the past year, attended by operational and executive leads and directors from both entities.

- The MHP's website was redesigned in an effort to be more efficient and visually pleasing, and to improve ease of use and provision of information for the community, beneficiaries, and general site users.

- The MHP is in the initial steps of redesigning the payment structure for FSP provider contracts to better align with overall program goals, shifting from reimbursement of services based on volume to incentivizing quality. The Executive Payment Transformation Steering Committee and workgroups identified four quality outcome measures for inclusion in the FY 18-19 incentive design initiative.

Opportunities for Improvement:

- There are no new positions designated specifically for QI, which is significantly understaffed and yet heavily involved in monitoring and analyzing quality and timeliness metrics for network adequacy implementation in mental health and DMC-ODS programs, along with driving quality improvement activities.

- The MHP currently lacks a communication strategy and plan to support the new EHR and billing system RFP, which is needed as the project will be a multi-year effort and ongoing communications with staff, providers and stakeholders is critical.

- The MHP currently lacks a communication strategy to inform staff and stakeholders about the Reimagining Alameda County Behavioral Health Initiative as elements are being implemented.

- Contract providers need to be active partners, on a regular basis, with MHP leadership, QI, UR and other departments, contributing to system operations and service delivery.
- Stakeholders throughout the SOC reported a lack of beneficiary and family representation for system planning and implementation at all levels, particularly from communities of color and ethnicities that do not generally participate.
- During the onsite review, peer employees recommended that they be fully included in executive and leadership meetings and committees to leverage their strengths and experience, and ensure their contributions are integrated into system planning and implementation.

FY 2019-20 Recommendations

PIP Status

- None

Access to Care

1. Evaluate Access Call Center staffing capacity and response times, adding additional staff as needed.
2. Develop and implement a level of care screening tool/checklist and protocol for Access Call Center staff to use to ensure consistency of call responses and appropriate level of care referrals.

Timeliness of Services

3. Complete the implementation of the new timeliness policy and data tracking processes for network adequacy across the entire system of care, including the production and furnishing of performance data reports to Quality Improvement (QI) and leadership teams for use on system and program management and resource allocation determinations. (*This is a follow-up recommendation from FY 2018-19.)*
4. Increase the percent of beneficiaries meeting the 7-day post-hospitalization follow-up standard.
5. Evaluate the reason(s) for the high hospital readmission rates for adults (20.2 percent) and foster care youth (26.5 percent).
6. Establish a standard for no-show rates for psychiatrists and clinicians, implementing it system-wide.

Quality of Care

7. Build sufficient dedicated QI and data analytic staffing and capacity necessary to fulfil the quality improvement requirements (separate and distinct from Quality Assurance/Utilization Management [QA/UM]) for both mental health and the Drug Medi-Cal Organized Delivery System (DMC-ODS) in this large and complex system of care (SOC). Consider reviewing the QI department structures and functions in similarly-sized Bay Area MHPs. (*This is a follow-up recommendation from FY 2018-19.*)
8. Develop a formal structure for ongoing collaboration between QI and the Data Services Team, with full concurrence on decision-making regarding report and dashboard development and ongoing continuous system-wide quality improvement efforts. *(This is a follow-up recommendation from FY 2018-19.)*

9. Develop a collaborative workflow between QA and QI, working together with both county-operated staff and contract provider QA and QI staff to ensure consistency of messaging and avoiding duplication of efforts. (*This is a follow-up recommendation from FY 2018-19*.)

10. Further expand the QI work plan to include a comprehensive list of quality management metrics and an analysis of disparities in services by site/region/population served.

11. Update the Quality Improvement Committee (QIC) standing agenda to include routine (at least quarterly, preferably monthly) review, analysis, and discussion of a comprehensive list of quality management metrics along with their application for continuous system-wide quality improvement, separate and distinct from utilization management and compliance requirements.

Beneficiary Outcomes

12. Implement the newly developed process for routinely extracting, aggregating and analyzing Child and Adolescent Needs and Strengths (CANS-50) and Adult Needs and Strengths Assessment (ANSA) outcome data, using it to guide system-wide quality improvement initiatives that monitor service outcomes in county and contracted programs and services.

13. For the onsite review in FY 2020-21, ensure that the number and new beneficiary status of consumer and family member (CFM) focus group participants matches that requested by CalEQRO.

14. The MHP and its contracted provider agencies need to explore attitudes and provide refresher training for practitioners in order to improve their receptivity to beneficiary input regarding treatment alternatives to medication, whenever feasible. This may require special attention with those agencies serving Asian Pacific Islander (API) beneficiaries, and particularly with physician/prescriber staff. (*This is a follow-up recommendation from FY 2018-19*.)

Foster Care

- None

Information Systems

15. Implement plans to expand the Yellowfin roll-out for contract providers as soon as practical. Provide training and TA to ensure successful use of the data.

Structure and Operations

16. Further improve two-way communication throughout the system of care (SOC), ensuring opportunities for dialogue and consistent messaging with county-operated and contracted staff and leadership. This is particularly important with

regards to ongoing changes in policies/protocols for contract providers, and transparency/inclusion in the upcoming strategic planning process.

17. Implement a communication strategy and plan to support new EHR and billing system request for proposals (RFP) as the project will be a multi-year effort and ongoing communications with staff, providers, and stakeholders critical to support successful project implementation.

18. Improve representation of beneficiaries and families in system planning and implementation throughout all levels within the SOC, focusing particularly on representation from communities of color and ethnicities that do not generally participate.

19. Include peer employees in executive and leadership meetings and committees to leverage their strengths and experience, and ensure their contributions are integrated into system planning and implementation.

20. Create additional peer employee positions throughout the SOC to enhance service quality and capacity, thereby leveraging the knowledge and lived experience of these new staff members, with the added benefit of reinforcing their wellness and recovery.

SITE REVIEW PROCESS BARRIERS

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

- The CFM focus groups are an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. Due to the low numbers of focus group participants, CalEQRO was unable to obtain sufficient beneficiary feedback on this review.
    - The CFM focus groups had very few participants (from 3 to 5).
    - The parents/caregivers focus groups did not include any adults of child/youth beneficiaries who had initiated services within the past 15 months, which was requested by CalEQRO.
    - Both the time and location of the Cantonese-speaking focus group was changed prior to the review in order to accommodate more participants; however, only three attended.

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 F: 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 – Alameda MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Groups
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Hands-On Observation
Telehealth
Access Call Center Site Visit
Wellness Center Site Visit
Contract Provider Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Della Dash, Lead Quality Reviewer
Cyndi Lancaster, Quality Reviewer
Mark Refowitz, Information Systems Reviewer
Bill Ullom, Chief Information Systems
Gloria Marrin, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

Alameda County Behavioral Health
2000 Embarcadero Cove
Oakland, CA 94606

Alameda County Behavioral Health
1900 Embarcadero Suite
Oakland, CA 94606

Contract Provider Sites

Sally's Place Peer Respite Home
1525 B Street
Hayward, CA 94541

La Familia
24301 Southland Drive, Suite 300
Hayward, CA 94545

Asian Health Services
310 8th Street, Room 101
Oakland, CA 94607

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Almanza	Jamie	Director	BACS
Alvarado	Rebecca	Manager, Clinical Care Management Projects	ACHCSA
Amin	Krishna	MFT, Clinician	EBAC – Oakland
Anderson	Kaye	Clinical Supervisor	BACS
Anderson	Gary	SUD Program Coordinator	Options Recovery
Arenius	Gregory	ISA	ACBH
Arrieta	Rudy	QM Director (retired), Consultant	ACBH
Aslami Tamplen	Khatera	Consumer Empowerment Director	ACBH
Baker	Vanessa	Program Specialist, LPS	Alameda County Social Services
Becton	Neisha	CEO	Pathways to Wellness
Becwar	Allison	CEO	Lincoln
Benefield	Lara	Clinical Therapist	CHAA
Benjamin	Danielle	Information Systems Support	ACBH
Berger	Sandra	Program Director	A Better Way
Bernhisel	Penelope (Penny)	Clinical Program Supervisor	ACBH
Biblin	Janet	Quality Improvement	ACBH
Boles	Abner	Consultant – AA Holistic Web Complex	Business Solutions Design
Brown	Renikia	Clinician	ACBH
Brunswick – Guerry	Danielle	Mental Health Coordinator, Alameda Collaborative Courts	Telecare
Bryant	Gimone	Clinician	ACBH
Bunce	Dale	POCC Membership Committee	ACBH
Burton	Carol	Former Interim Director, Consultant	ACBH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Byron	Shamilla	ACCESS Clinical Review Specialist	ACBH
Calderon	Christopher	Bilingual Clinician	Seneca – MST
Cantress-Kinzfoyl	Regina	Clinical Supervisor	Fred Finch-STAY
Capece	Karen	Division Director, UM	ACBH
Carlisle	Lisa	CYASOC Director	ACBH
Carroll	Tony	CHW	ACHCSA
Castellanos	Karla	POCC – TAY Committee Peer Specialist	ACBH
Castilla	Michael	Program Specialist	ACBH
Cerna	Luis	IBHCC	Tiburcio Vasquez
Chambers	Dean	Critical Care Manager	ACBH
Chapman	Aaron	Medical Director	ACBH
Chau	Mandy	Interim Cost Reporting Manager	ACBH
Chawla	Colleen	Director	HCSA
Choo	Alyssa	RN Care Coordinator	ACBH
Coady	Kim	Interim QA Administrator	ACBH
Cooper	John	Director of Behavioral Health	Alta Bates Hospital
Courson		Natalie	IS Deputy Director
Cross	Traci	Network Office	ACBH
Daswell	Mongof	Family Member/Family Support	NAMI and MHAAC
DeVoss	Luann	Clinical Director, Youth and Family Division	UCSF Benioff Children's Hospital
Diedrick	Sheryl	Information System Analyst	ACBH
Durkee	Jessica	Director	Side by Side
Eady	Rashad	Program Specialist	ACBH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Eaves	Damon	Assistant Director, Children and Youth System of Care	ACBH
Edwards	Valerie	Director, Care Connect	ACHCSA
Elliott	Ann	Critical Care Manager	ACBH
Engstrom	John	QI Manager	ACBH
Escobar	Selina	Program Manager	Anthem Blue Cross
Facher	Nancy	Director of Behavioral Health	La Clinica
Flores	Linda	Tri-City	ACBH
Fuller	Faith	Consultant, FAS Services	ACBH
Furuzawa	Adriana	Division Director	Fred Finch/Felton Institute
Godsey	Kate	Clinical Director	Villa Fairmont, Telecare
Grolnic-McClurg	Steven	Mental Health Manager	City of Berkeley
Hall	Lorenza	Management Analyst	ACBH
Hananouchi	Sandy	MBC Admissions Coordinator	MBC
Hazelton	Tracy	MHSA Director	ACBH
Hein	Claudia	Mental Health Therapist	Family Paths
Hobbs	Nathan	Director SUD	ACBH
Holt	Tawny	MDFT Clinician	Lincoln
Huerta	Alisa	LMFT/FSP	BACS
Hunt	Linda	Clinical Supervisor	ACBH
Iannuzzi	Christi	Director of Implement	Alameda Care Connect
Jackson	Summer	Contractor	ACBH
Jenison	Majda	Network Office	ACBH
Johnson	Michelle	POCC-TAY Committee	La Familia (per diem)

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Jones	Kate	Director AOASOC	ACBH
Jones	Yvonne	Adult Forensic BH Director	ACBH
Jones	Sharon	Program Specialist	ACBH Network
Joyce	Bridget	IBH Care Coordinator	Native American Health Center
Judkins	Andrea	Senior FFS	ACBH
Kaplan	Leslie	Clinical Director	Telecare
Kessler	Michael	Program Specialist, Older Adults	ACBH
Kiefer	Andrea	TBS and KTA Coordinator	ACBH
Kim	Annie	Director	FERC/MHAAC
Kolda	Deanna	CRS - QA	ACBH
Lai	Sophia	Sr. Program Specialist QI	ACBH
Larkin	Skyler	Mental Health Clinician	Westcoast Children's Clinic
Lee	Sun Hyung	Program Specialist, Interim Division Director, TAY	ACBH
Lewis	Clyde	EPSDT Coordinator	ACBH
Lewis	Stephanie	Crisis Services Division Director	ACBH
Lewis	Michelle	Behavioral Health Clinical Manager OCSC	ACBH
Lim	Joyce	Clinical Supervisor, Human Services Department	City of Fremont
Litman	Marissa	Clinician	Lincoln
Lopez	Rickie	FSO – Network Office	ACBH
Louie	Jill	FSO - Budget	ACBH
Lynch	Jeanie	Administrator	Stars Community Services
Maddela	Maria	Clinical Program Manager	Kidango
Marshlans	Susanna	Regional Vice President	Counseling Inc.

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Martinez	Alicia	Clinical Director	Gladman
Mayfield	Amber	Clinical Director	Telecare STEPS
Mc Griff	Julia	Clinician	ACBH
McDougal	Audrey	Clinician	Stars Community Services
McKetney	Chuck	Director HIS	HCSA
Medina	Daniela	MSW, Intern, Care Connect	ACHCSA
Mehta	Ravi	Compliance Officer	HCSA
Meier	Courtney	Program Manager	The Hume Center
Meinzer	Chet	ISM	ACBH
Mieses	Lourdes	Mental Health Therapist	Fred Finch Youth Center
Miller	Laura	Chief Medical Officer	Community Health Center Network
Moncrief	Michele	Consumer Empowerment Department	ACBH
Moore	Lisa	FSO – Provider Relations	ACBH
Moore	Crystal	Clinical Supervisor	West Coast Children's Clinic
Moreno-Derks	Matthys	Program Manager	BACS – Amber House
Mukai	Christine	CANS Coordinator	ACBH
Mullane	Jen	Assistant Director, Adult/Older Adults	ACBH
Murphy	Christina	Program Supervisor	Sally's Place Peer Respite
O'Brien	Steve	Chief Medical Officer	Alameda Alliance
Orozco	Gabriel	Management Analyst	ACBH
Orozco	Tiffany	Clinician	ACBH
Orphanos	Maureen	Manager	ACBH
Ortiz	Aaron	Director	La Familia

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Osborn	Scott	Regional Exec Dir	Seneca
Osborn	Scott	Regional Executive Director	Seneca
Padilla	Margie	Early Childhood Division Director	ACBH
Palomino	Yessenia	Adult Employment Specialist	La Familia
Patel	Kruti	Clinical Supervisor/Manager	Family Paths
Perales	Joseph	Clinical Director	La Clinica
Peterson	Camille	Information Systems Analyst	ACBH
Powlen	Karin	Director of Social Services	Villa Fairmont, Telecare
Ramsay	Marielle	Mental Health Clinician	A Better Way
Ratner	Robert	Housing Services Director	HCSA/ACBH
Raynor	Charles	Director of Pharmacy	ACBH
Razzano	Theresa	Division Director	ACBH-Voc Svcs
Rios-Parada	Ramon	Program Specialist	La Familia
Rivas	Patricia	ACCESS ASM	ACBH
Romano	Dennis	Exec. Dir.	ACCMHA
Rosso	Stephanie	Interim Director	UCSF Benioff Children's Hospital
Rowe	Kathryn	ISA	ACBH
Saechao	Kao	Director, Mental Health Services	Asian Health Services
Sakhai	Roya	Executive Director	Multilingual
Saler	Barbara	Access Clinical Program Manager	ACBH
Sales	Cameren	Information Systems Specialist	ACBH
Sammis	Jeff	Supervisor, QA	ACBH

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Sanders	Laura	Deputy Director, Human Resources	HCSA
Sanders	Tony	QA	ACBH
Schrick	Juliene	Program Specialist	ACBH
Schulz	Henning	Division Director – Case Management	ACBH
Schwartz	Katherine	Executive Director	AFS
Scoryanarayana	Kripa	AS II	ACBH
Serrano	Cecilia	Finance Director	ACBH
Shah	Kalyani	Interim Associate Director	Felton Institute
Shepard	Teresa	QA/Training Director	EBCRP/Lifelong
Shookley	Candace	ACCESS Clinical Review Specialist	ACBH
Silver	Barbra	Executive Director	Family Paths
Singh	Harjit	Care Management Lead	John George Psychiatric Hospital
Singleton Banks	Shannon	Program Services Coordinator	ACBH
Smith	Freddie	Division Director	ACBH
Smith	Shanice	QA/BH Program Administrator	ROOTS Community
Smith	Sarah	Behavioral Health Clinician	ACBH Oakland Children's Clinic
Sneed	Rose	Program Director, Behavioral Health	Tri-City Health
Spilly	Stacey	Clinical Supervisor	La Familia
Stenson	Jon	ACCESS Supervisor	ACBH
Sudduth	Nicole	Associate Director	West Oakland Health
Sunzeri	Monica	Director of Programs	The Hume Center
Taizan	Juan	JJC Health Care Director	ACBH
Tenenbaum	Francesa	Director	Patient Rights Advocate

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Terry	DeAndrea (DeeDee)	Clinical Review Specialist	ACBH
Thomas	Karen	Clinical Social Worker	UCSF Benioff Children's Hospital
Tribble	Karyn	Director	ACBH
Trotman	Misa	Clinical Director	Family Paths
Trotter	Tanya Ronald	Social Worker	WOHC
Tubtim	Meay	Personnel Officer	HCSA
Turner	Joe	Director of Quality Management	Felton Institute
Tzudiker	Jane	ACCESS Supervisor	ACBH
Uwaeme	Chidi	MSW, Intern, Care Connect	ACHCSA
Vargas	Wendi	Network Office	ACBH
Vogel-Stone	Carla	Director of Clinical Programs	CHAA
Wagner	James	Deputy Director	ACBH
Warder	Rosa	Family Empowerment Director	ACBH
Ware-Kawamoto	Carrie	Behavioral Health Clinician	ACBH Children's Specialized
Wheat	Kimberly	Clinical Supervisor	La Familia
Wilkins	Quincy	Management Analyst	SSA
Williams	Donna	Clinician	ACBH
Wilma	Gaines		MHAAC
Wilson	Javarre	Ethnic Services Manager	ACBH
Wolff	Laura	Regional Operations Director	Telecare
Yates	Deb	Program Supervisor	ACBH
Yglecias	Jovan	Director of Programs	BACS
Yip	Amos	Clinical Manager	AHS

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Young	Yvonne	ISA	ACBH
Yuan	Eric	Program Services Coordinator	ACBH
Zelaya	Rosaura	Bilingual Clinician	Building Hope Early Childhood

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 penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Alameda 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
Large	1,833,373	69,835	3.81%	$406,057,927	$5,815
MHP	134,437	4,478	3.33%	$28,790,415	$6,429

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
Alameda 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	19,067	88.04%	93.16%	$93,093,572	$4,882	$3,802	46.88%	54.88%
>$20K - $30K	1,177	5.43%	3.10%	$28,816,820	$24,483	$24,272	14.51%	11.65%
>$30K	1,413	6.52%	3.74%	$76,648,595	$54,245	$57,725	38.60%	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: Alameda	
PIP Title: Incorporating Reentry Peer Specialists into Treatment Teams	
Start Date: July 01, 2018 **Completion Date**: December 31, 2019 **Projected Study Period**: 18 Months **Completed**: Yes ☐ No ☒ **Dates of On-Site Review**: November 5-7, 2019 **Name of Reviewer**: Della Dash	**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: The goal of this clinical PIP is to improve treatment outcomes for justice-involved reentry beneficiaries in outpatient treatment and case management programs, including engagement in treatment, reduced psychiatric hospitalizations, increased retention in	

treatment programs, and reduced further incarceration. The MHP sought and received funding for this new reentry treatment and case management program through the California Proposition 47 grant in late 2017.

This PIP focuses on integrating reentry peer specialists into treatment and case management teams that work directly with reentry beneficiaries. While mental health peer specialists have participated at varying levels in MHP programs, the staffing of this program is novel in that it pairs peer specialists with clinicians in the case management and treatment of the beneficiaries. In addition, this program requires that the peer specialists themselves have prior justice involvement and/or have been systems-impacted by the criminal justice system (i.e. have a family member who was involved in the criminal justice system).

The three primary agencies implementing this PIP include the MHP, Bay Area Community Services (BACS) and La Familia Counseling Services (La Familia). The MHP oversees the design, implementation, and data analysis for this project, while BACS and La Familia each launched a "reentry treatment team" including peer case managers, with a caseload of 80 clients in North and South Alameda County, respectively.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP developed a multi-functional team with an array of stakeholders including those with lived experience. Three agencies are implementing the PIP together: Alameda County Behavioral Health Bay Area Community Services (BACS) La Familia Counseling Services (La Familia).

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 PIP topic was substantiated through the use of relevant data and a full literature review. In FY 2017-2018, 6,616 or 33.8 percent of Alameda County's 19,578 beneficiaries were identified as being reentry individuals based on having been in Alameda County Jail in the past two years. Overall, the reentry beneficiaries were more likely to be male, African American, and between the ages of 26 to 43.
Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☒ High volume services ☒ High risk ☒ Care for an acute or chronic condition 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 PIP focuses on increasing engagement with justice-involved reentry beneficiaries in order to improve their attainment of treatment goals, connect to family and community supports, reduce episodes in psychiatric emergency services, and reduce episodes in jail.

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: Justice-involved adults with severe mental illness meeting criteria for specialty mental health services	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population is adult beneficiaries who are or were previously involved in the criminal justice system, including arrest, conviction, or incarceration, but who are not currently in correctional settings. The criminal justice involvement can be either 1) self-identified or 2) identified through referrals from clinicians or law enforcement officials in criminal justice settings. Because the two provider agencies, BACS and La Familia cover different geographic areas within Alameda County, they cross-refer clients as needed to ensure that beneficiaries across the county are served.
	Totals	**4 Met** Partially Met Not Met UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* "Does incorporating reentry peer specialists in interdisciplinary case management teams for justice-involved clients improve their treatment outcomes overall by 20 percent?"	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is clearly stated and measurable.
	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: Justice-involved beneficiaries	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population is adult beneficiaries who are or were previously involved in the criminal justice system, including arrest, conviction, or incarceration, but who are not currently in correctional settings. The criminal justice involvement can be either 1) self-identified or 2) identified through referrals from clinicians or law enforcement officials in criminal justice settings.
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 is unable to identify all individuals with any prior justice involvement because such data is not tracked, and most public protection agencies do not have access to or cannot easily share the entire criminal history, including arrests, of all Alameda County residents. For this reason, the MHP uses the measure of all individuals who have been in Alameda County jails in the past two years as the proxy indicator for reentry beneficiaries. While this is an undercount of all beneficiaries with criminal justice-involvement, it is likely representative of the demographic and mental health characteristics of the full target population.
	Totals	**1 Met** **1 Partially Met** Not Met UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Percent of study population who engage in treatment at least three times within 30 days following enrollment in outpatient treatment and case management program. 2. Percent of study population who engage in treatment at least three times within 60 days following enrollment in outpatient treatment and case management program 3. Percent of study population who are still receiving services 180 days after enrollment 4. Percent of study population who have reduced jail admissions in the year following program enrollment compared to the year prior to enrollment. 5. Percent of study population who completed their treatment goals and/or left the program with successful progress on their treatment goals. 6. Percent of peer specialists who remain in reentry peer specialists for at least 6 months. 7. Percent of peer specialists who remain in position for at least one year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study used objective, clearly defined and measurable indicators.

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 indicators measure changes in health status, functional status, beneficiary satisfaction (measured by engagement and retention), and reentry peer specialists continued employment (retention).
	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	No sampling was used for this PIP.

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 PIP provided a detailed list of the specific data to be collected. To ensure program consistency between the two teams, the MHP program managers met with BACS and La Familia leadership on a weekly basis during the implementation phase of 10-12 months, reducing the meeting frequency to bimonthly for an additional six months, and then monthly thereafter. At these meetings, the MHP, BACS, and La Familia reviewed and discussed program outcomes, clinician and peer staff productivity, and how to address any program implementation challenges. In addition, MHP program managers met with clinical staff and peer case managers from both teams on a regular basis (at least biweekly) to conduct trainings on the Reentry Treatment Team Program Model, incentives structure, and modes of working effectively with criminal justice partners.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☒ Claims ☐ Provider ☒ Other: Alameda County Sherriff	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The sources of data were identified for all of the data to be collected. The MHP will use: a) Administrative data from billing records; b) Alameda County Sheriff's daily jail census; and c) BACS/La Familia staffing information.

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	Only the following require instruments for data collection: For the indicator regarding peer staff retention, data will be collected on a simple tool that states the person's employment tenure with the program as a peer case manager. For the indicator regarding the former reentry peer specialist's position, data will be collected on a simple tool that confirms the person's employment and description of job duties. In both cases, a standardized form will be used by MHP staff for data collection from both BACS and La Familia to ensure consistent and accurate data collection over time. Training will be provided by the PIP team staff.
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: a) Administrative data from billing records; b) Alameda County Sheriff's daily jail census; and c) BACS/La Familia staffing information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The instruments used for data collected provided for consistent and accurate data collection over the time periods studied.

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 will analyze the indicators on an ongoing, and at least quarterly. ACBH created dashboards that provide up-to-date data on the first four indicators in order to support regular program monitoring by the PIP team. These dashboards can filter by time period, provider, demographics, and other factors. The MHP will analyze the data to determine whether the indicators reflect performance outcomes as a result of the interventions, or whether there may be other factors impacting the results. They will work closely with the providers, including both the peer case managers and the provider leadership to interpret the data. If the MHP is unable to gather the non-administrative data in a sufficient manner, they will examine alternative indicators or remove that indicator from the PIP.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Sophia Lai Title: Senior Program Specialist Role: PIP Project Manager *Other team members:* Janet Biblin, Principal Performance Analyst, QI, ACBH Rashad Eady, BA, Program Specialist, QI, ACBH Sophia Lai, Senior Program Specialist, QI, ACBH John Engstrom, JD, QI Manager, QI, ACBH Jamie Almanza, Executive Director, BACS Shanice Kelley, Program Director, BACS Clinicians, BACS Peer Specialists, BACS Aaron Ortiz, Executive Director, La Familia Ande Pena, Program Director, La Familia Clinicians, La Familia Peer Specialists, La Familia	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Janet Biblin will be the primary staff collecting and analyzing administrative data. John Engstrom will provide support for collecting and analyzing administrative data. Rashad Eady will conduct the consumer satisfaction surveys. Gabriel Orozco, MSW, Management Analyst, Data Services will create the dashboards that allow the PIP team to monitor program outcomes.
	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. Integrate reentry peer specialists into interdisciplinary treatment and case management teams for justice-involved reentry beneficiaries. 2. Recruit, hire, and train reentry peer specialists to work on interdisciplinary treatment and case management teams for reentry beneficiaries.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP has one intervention which focuses on an interdisciplinary treatment team approach that includes a reentry peer specialist (with previous justice involvement) to provide case management for justice-involved reentry beneficiaries. While a second intervention was listed, this activity of recruiting, hiring and training the reentry peer specialists occurred prior to the PIP becoming active.
	Totals	**1 Met** 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	MHP staff reviewed the indicators drawn from administrative data on at least a quarterly basis to determine the impact of the interventions. This enabled them to provide feedback to service providers at the weekly/biweekly meetings to discuss the underlying basis for the performance outcomes and whether interventions or data collection methods needed to be adjusted. The data analysis regarding the peer reentry specialist retention both within the program and external to the program was supposed to occur on a quarterly basis. However, since there were only a maximum of six peer case managers at any time, with whom MHP program staff regularly met for training, the MHP stated that "it was not as critical to document these results on a regular basis, as long as the program tracked the employment tenure of the peer case managers".
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: Quarterly, monthly Indicate the statistical analysis used: Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Chi-Square tests were utilized to examine statistical significance for all five beneficiary-related performance indicators. All indicators showed positive and statistically significant results. The baseline data examined all reentry beneficiaries in outpatient treatment and case management programs. However, only a subset of reentry beneficiaries participated in the PIP programs due to limited capacity, even though the services were available to all beneficiaries who met the qualifications. It is possible that both self-selection and the referral process directly from a recent reentry program may have resulted in the PIP reentry treatment teams serving a subset that is not necessarily representative of all beneficiaries. The indicator, “Percent of study population who completed their treatment goals and/or left the program with successful progress on their treatment goals,” had a somewhat limited baseline population due to the fact that 56.6 percent of the baseline population had “Unknown” for the treatment outcome and was therefore excluded from the data. This left only 33 clients upon whom to compare treatment results. Though the differences were large enough to be statistically significant, the MHP considered this a limitation of the study.

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:* Not all program participants have been enrolled in the program for at least a year; thus, the comparability of the jail episodes decrease is limited because the recent data is limited to the subgroup that has been in the program for a least a year. *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:* Finally, due to the early positive results of these interventions, reentry peer specialists have been integrated as core team members in the other recently developed new reentry outpatient treatment and case management teams, including a team serving beneficiaries on Probation (capacity 120 beneficiaries), a team focused on providing culturally responsive services to African American beneficiaries who are justice involved (capacity: 20 beneficiaries), and two teams focused on serving individuals with mild to moderate mental illness (capacity: 160 clients).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The significant improvement in performance outcomes indicates that the reentry treatment teams were very successful in producing favorable results. The hiring, training, and incorporation of reentry peer specialists as case managers who actively work with clinical staff is a critical and distinguishing factor of these reentry teams relative to the MHP's other outpatient treatment and case management programs serving and/or focusing on criminal justice-involved populations. The MHP stated that for this reason it is highly likely that the intervention was the major contributing factor to the successful outcomes.
Totals	**4 Met** 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	The MHP used the same methodology for each indicator: For indicators one through four, the same administrative data and formulas were used to process the outcomes. For indicators five and six, the MHP requested personnel data from the two agency providers regarding the start/hire data. The same MHP staff followed up with the peer case managers for indicators six and analyzed the data under the same rules, to ensure consistency.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The analyses indicated that all of the indicators demonstrated positive results that were statistically significant. The two reentry treatment teams initiated through this PIP will be integrated into the Adult and Older Adult System of Care as part of their portfolio of outpatient case management programs to serve the justice-involved population. In addition, this program model will be replicated through the creation of any additional reentry treatment team through a new round of Proposition 47 funding from California's Bureau of State and Community Corrections.

9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☒ High	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The significant improvement in performance outcomes indicates that the reentry treatment teams implemented for this PIP were very successful in producing favorable results. The hiring, training, and incorporation of reentry peer specialists as case managers who actively work with clinical staff is a critical and distinguishing factor of these reentry teams relative to the MHP's other outpatient treatment and case management programs serving and/or focusing on criminal justice-involved populations. The MHP stated that for this reason, it is highly likely that this specific intervention was the major contributing factor to the successful outcomes.
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	Significance testing indicated that the improvement is a true improvement. The P-Score on every indicator was below five percent.

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Monthly measurements indicate that the improvement was sustained overall for the indicators selected. The PIP has been active for 15 months, and is scheduled to run for three more months, ending on December 31, 2019.
Totals	**5 Met**	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 goal of this clinical PIP is to improve treatment outcomes for justice-involved reentry beneficiaries in outpatient treatment and case management programs, including engagement in treatment, reduced psychiatric hospitalizations, increased retention in treatment programs, and reduced further incarceration. The MHP sought and received funding for this new reentry treatment and case management program through the California Proposition 47 grant in late 2017.

This PIP focuses on integrating reentry peer specialists into treatment and case management teams that work directly with reentry beneficiaries. While mental health peer specialists have participated at varying levels in MHP programs, the staffing of this program is novel in that it pairs peer specialists with clinicians in the case management and treatment of the beneficiaries. In addition, this program requires that the peer specialists themselves have prior justice involvement and/or have been systems-impacted by the criminal justice system (i.e. have a family member who was involved in the criminal justice system).

The three primary agencies implementing this PIP include the MHP, Bay Area Community Services (BACS) and La Familia Counseling Services (La Familia). The MHP oversees the design, implementation, and data analysis for this project, while BACS and La Familia each launched a “reentry treatment team” including peer case managers, with a caseload of 80 clients in North and South Alameda County, respectively.

The MHP developed a multi-functional team with an array of stakeholders including those with lived experience. The PIP topic was substantiated through the use of relevant data and a full literature review. The study question is clearly stated and measurable. The study used objective, clearly defined and measurable indicators. The PIP has one intervention which focuses on an interdisciplinary treatment team approach that includes a reentry peer specialist (with previous justice involvement) to provide case management for justice-involved reentry beneficiaries.

MHP staff reviewed the indicators drawn from administrative data on at least a quarterly basis to determine the impact of the interventions, enabling them to provide feedback to service providers at the weekly/biweekly meetings and discuss the underlying basis for the performance outcomes including whether interventions or data collection methods needed to be adjusted. All indicators showed positive and statistically significant results. The MHP stated that the significant improvement in performance outcomes indicates that the reentry treatment teams were very successful in producing favorable results.

Due to the early positive results of these interventions, the MHP has integrated reentry peer specialists as core team members in the other recently developed new reentry outpatient treatment and case management teams, including a team serving beneficiaries on Probation (capacity 120 beneficiaries), a team focused on providing culturally responsive services to African American beneficiaries

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

who are justice involved (capacity: 20 beneficiaries), and two teams focused on serving individuals with mild to moderate mental illness (capacity: 160 clients).

Recommendations:

The MHP should completed this PIP by December 31, 2019 as planned.

A new clinical PIP topic should be developed and implemented as this current PIP comes to a close in order for the MHP to have two active PIPs throughout the year.

Summary Totals for PIP Validation	Clinical PIP
Number Met	24
Number Partially Met	1
Number Not Met	0
Unable to Determine	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**98%**

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

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

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 NON-CLINICAL PIP

GENERAL INFORMATION

MHP: Alameda

PIP Title: Using Language Assistance Lines to Improve Penetration

Start Date: June 01, 2019

Completion Date: December 31, 2020

Projected Study Period: 19 Months

Completed: Yes ☐ No ☒

Dates of On-Site Review: November 5-7, 2019

Name of Reviewer: Della Dash

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:

The goal of the non-clinical PIP is to examine whether providing a language assistance line for all providers and all services will improve the penetration rates for beneficiaries who primarily speak a non-English threshold language, especially for Asians and Pacific Islanders and/or those who speak an Asian or Pacific Islander language.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
The MHP has five non-English threshold languages (Spanish, Cantonese, Vietnamese, Mandarin, Tagalog), in addition to numerous other primary languages spoken by beneficiaries. Nearly 40 percent of Alameda County Medi-Cal beneficiaries speak a language other than English as their primary language. The penetration rate for beneficiaries speaking a primary language other than English is less than half of the penetration rate for English-speaking beneficiaries. Overall, the penetration rate was 5.7 percent for primarily English-speaking vs. 2.7 percent for beneficiaries who are not primarily English-speaking. The outpatient penetration rate was 4.3 percent for primarily English-speaking vs. 2.4 percent for beneficiaries who are not primarily English-speaking. Currently, 106 different organizational providers are contracted to provide services through the Alameda MHP, comprising approximately 84 percent of services provided. The new language line provides on-demand access to over 200 languages, ensuring that all beneficiaries will have access to some level of interpretation at their appointments.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP topic was selected using stakeholder input. The MHP developed a multi-functional team with an array of stakeholders including those with lived experience (Consumer QI Workgroup, and Family QI Workgroup).

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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	For many years, the MHP's penetration rates for beneficiaries 1) who identify as Asian and Pacific Islander (API) and/or 2) primarily speak non-English Asian threshold languages have been significantly lower than for beneficiaries from other race/ethnicity groups and/or who primarily speak English. Two provider surveys conducted by the QA Unit regarding language line access indicated that many providers did not have sufficient capacity to provide linguistically appropriate services for beneficiaries speaking not only threshold languages, but also the many non-threshold languages spoken by beneficiaries. The volume of non-English API language needs by beneficiaries is not high enough to justify hiring full or part-time staff to provide on-demand interpretation, as most providers receive fewer than 20 calls or in-person encounters per month for any language other than Spanish.

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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	Telephonic interpretation through a language line can help increase access to linguistically responsive services and improve the clinical outcomes for the MHP's diverse non-English-speaking beneficiaries. By providing on-demand interpretation, the MHP and its' contractors may ensure access to diverse languages at any time, increase patient comprehension, improve compliance with treatment and follow-up, reduce usage of non-professional interpreters (e.g., family members), and therefore potentially improve consumer engagement and outcomes.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☒ Race/Ethnicity ☐ Gender ☒ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population for this PIP is all beneficiaries who speak a primary language other than English (n=195,186). Nearly 40 percent of Alameda County Medi-Cal Beneficiaries speak a language other than English as their primary language.
	Totals	**4 Met** Partially Met Not Met UTD

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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 increased access to language interpretation services through implementation of a language line across the entire specialty mental health system improve access to care by: • Increasing the Medi-Cal outpatient penetration rate for beneficiaries with a primary language other than English 2.4 to 2.88 percent; • Increasing the Medi-Cal outpatient penetration rate for API beneficiaries who speak a primary language other than English from 1.02 to 1.25 percent; • Improving connection rates for referrals for primarily non-English speaking beneficiaries from 50.3 to 60 percent; • Increase the number of providers serving each non-English API language by 20 percent; and • Increase the median number API clients with a primary language other than English served per provider by 20 percent?"	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is clearly written and measurable.
	Totals	**1 Met** Partially Met Not Met UTD

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☒ Race/Ethnicity ☐ Gender ☒ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study population for this PIP is all beneficiaries who speak a primary language other than English (n=195,186). Nearly 40 percent of Alameda County Medi-Cal Beneficiaries speak a language other than English as their primary language.
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: Language Line Data	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	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:* 1. Outpatient penetration rate for beneficiaries speaking a primary language other than English 2. Outpatient penetration rate for API beneficiaries primarily speaking a non-English language 3. Number of providers serving each non-English API language	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators are objective, clearly defined and measurable. Measuring whether beneficiaries are offered the use of the language line would also be helpful.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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 indicators measure changes in processes of care with strong associations with improved outcomes (e.g., penetration rates, engagement). The PIP lists the following problems: less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction. These issues need to be measured to ascertain whether introducing the language line is enough to impact these problems.
	Totals	**1 Met 1 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 PIP does not use sampling.

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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	Medi-Cal outpatient penetration rate for beneficiaries with a primary language other than English. Medi-Cal outpatient penetration rate for API beneficiaries speaking primarily a non-English language. The number of providers serving each non-English API language. The median number API clients with a primary language other than English served per provider.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: MEDS, INSYST, Contact Tracking Database, language line vendor	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data will be collected from a variety of sources. Primary language and eligibility data will be gathered from MEDS, service data from INSYST, contact and referral data from the Contact Tracking Database, and language line utilization data from vendor. The language line data includes numbers of encounters and duration of time spent interpreting by language and by provider.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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	Service data used to measure penetration is required for billing purposes and monitored through quality assurance and contract oversight staff for accuracy and consistency. The data will be gathered through administrative data reported through the MHP's billing and health record system, representing all county and contracted services for this beneficiary population. When a provider requests interpretation via the language line they will use their unique code with the language line vendor so the PIP team can track utilization of the language by provider. This section lacks a timeline indicating the frequency for data collection and analysis.
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: INSYST, Contact Tracking Database, language line vendor	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The same processes and instruments will be used for data collection throughout the study period.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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 data analysis plan lacks a specific timeline and frequencies for data collection and analysis, stating only that, "throughout the PIP these measures will be analyzed and compared to similar time periods from the prior year". The MHP will analyze the outpatient penetration rate data for beneficiaries who speak API threshold languages and for API beneficiaries who speak a non-English language. The analysis will review and compare penetration rates for English and non-API language-speaking beneficiaries and for other race/ethnic groups to assess whether the impact on penetration rates is a result of this intervention or other factors. The MHP states that they will calculate the connection, engagement, and retention rates for clients whose primary language is not English. However, this is not included in the indicators, and there is no information on how this will be carried out, when, by whom, and for what purpose. Additionally, the MHP will analyze the metrics for providers who make use of the language line interpretation services as a way of measuring whether this intervention might directly have an impact.

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Sophia Lai Title: Senior Program Specialist Role: Project Coordinator *Other team members:* Sophia Lai, Senior Program Specialist, QI John Engstrom, Quality Improvement Manager, QI Rashad Eady, Program Specialist, QI Donna Fone, Quality Assurance Administrator, QA Jeffery Sammis, Clinical Review Specialist, QA Tiffany Lynch, Administrative Manager, QA Language Line Services, Contractor	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Janet Biblin will be the primary staff collecting and analyzing administrative data. John Engstrom will provide support for collecting and analyzing administrative data.
Totals	**4 Met**	**2 Partially Met** Not Met UTD

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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. Implement language line for all providers and services. 2. Develop ACBH policy requiring that all providers use language line as necessary to accommodate all language needs especially for Alameda County Threshold Languages. 3. Develop and implement a training for providers on best practices using phone interpretation services.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	This section lacks sufficient detail to explain how each of these interventions will be carried out. What is involved in implementing the language line? Is this a new contract that is being developed? How will it be rolled out? Is this a phased approach? Is there hardware and/or software involved? Intervention three lacks a start date. Beyond the language line, or in addition to it, are there other interventions that could be considered to help address the problems listed and improve penetration rates (e.g., less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction).
	Totals	Met **1 Partially Met** Not Met UTD

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____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:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	Met Partially Met Not Met **4 NA** UTD	

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

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
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 **5 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 goal of the non-clinical PIP is to examine whether providing a language assistance line for all providers and all services will improve the penetration rates for beneficiaries who primarily speak a non-English threshold language, especially for Asians and Pacific Islanders and/or those who speak an Asian or Pacific Islander language.

The MHP has seven non-English threshold languages (Spanish, Cantonese, Vietnamese, Mandarin, Tagalog, Arabic, and Farsi), in addition to numerous other primary languages spoken by beneficiaries. Nearly 40 percent of Alameda County Medi-Cal beneficiaries speak a language other than English as their primary language. The penetration rate for beneficiaries speaking a primary language other than English is less than half of the penetration rate for English-speaking beneficiaries. Overall, the penetration rate was 5.7 percent for primarily English-speaking vs. 2.7 percent for beneficiaries who are not primarily English-speaking. The outpatient penetration rate was 4.3 percent for primarily English-speaking vs. 2.4 percent for beneficiaries who are not primarily English-speaking.

Currently, 106 different organizational providers are contracted to provide services through the Alameda MHP, comprising approximately 84 percent of services provided.

The new language line provides on-demand access to over 200 languages, ensuring that all beneficiaries will have access to some level of interpretation at their appointments.

The PIP topic was selected using stakeholder input. The MHP developed a multi-functional team with an array of stakeholders including those with lived experience (Consumer QI Workgroup, and Family QI Workgroup). The study population for this PIP is all beneficiaries who speak a primary language other than English (n=195,186). The study question is clearly written and measurable. The indicators are objective, clearly defined and measurable. However, the PIP lists the following problems which are not being measured (less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction). The data analysis plan lacks a specific timeline and frequencies for data collection and analysis. The interventions lack sufficient detail to explain how each will be carried out. What is involved in implementing the language line? Is this a new contract that is being developed? How will it be rolled out? Is this a phased approach? Is there hardware and/or software involved? Intervention three lacks a start date.

Recommendations:

The PIP is active and ongoing, and should be continued for another year. However, the PIP needs to measure the issues raised to ascertain whether introducing the language line is enough to impact the problems. Measuring whether beneficiaries are offered the use of the language line would also be helpful. Beyond the language line, or in addition to it, the MHP may wish to consider adding other interventions to help address the problems listed and to improve penetration rates (e.g., less treatment engagement; poor understanding of diagnosis, treatment, and medication instructions; poor understanding of and compliance with recommendations for treatment follow-up; significantly greater likelihood of a serious medical event; and lower patient satisfaction).

Additional detail is needed to fully explain what the interventions are, how they will be done, when, by whom, how often, and if there is a phased approach. All of the interventions need to have a start date. At least one new intervention needs to be initiated within the next year for the PIP to remain active and ongoing.

The data analysis plan needs to include a specific timeline and frequencies for data collection and analysis.

Summary Totals for PIP Validation	Non-clinical PIP
Number Met	12
Number Partially Met	4
Number Not Met	0
Unable to Determine	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	16
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**87.50%**

Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible
☒ Confidence in PIP results cannot be determined at this time