FY 14-15

Medi-Cal Specialty Mental Health

External Quality Review

County MHP FINAL Report

Alameda

Conducted on

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INTRODUCTION

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

The State of California Department of Health Care Services (DHCS) contracts with fifty-six (56) county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

- MHP information:
  - Beneficiaries served in CY13—21,744
  - MHP Size—Large
  - MHP Region—Bay Area
  - MHP Threshold Languages—Spanish, Cantonese, Vietnamese, Mandarin
  - MHP Location—Oakland

This report presents the fiscal year 2014-2015 (FY 14-15) findings of an external quality review of the Alameda County mental health plan (MHP) by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

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

(1) VALIDATING PERFORMANCE MEASURES[1]

This report contains the results of the EQRO's validation of **seven (7) Mandatory Performance Measures** as defined by DHCS. The seven performance measures include:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP

[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.

- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark.
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

(2) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS[2]

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Alameda MHP submitted one PIP for validation through the EQRO review. The PIP is discussed in detail later in this report.

(3) MHP HEALTH INFORMATION SYSTEM (HIS) CAPABILITIES[3]

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

(4) VALIDATION OF STATE AND COUNTY CONSUMER SATISFACTION SURVEYS

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

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

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

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

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

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[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.

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

PRIOR YEAR REVIEW FINDINGS, FY13-14

In this section we first discuss the status of last year's (FY13-14) recommendations, as well as changes within the MHP's environment since its last review.

STATUS OF FY13-14 REVIEW RECOMMENDATIONS

In the FY13-14 site review report, the prior EQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY14-15 site visit, CalEQRO and MHP staff discussed the status of those FY13-14 recommendations, which are summarized below.

Assignment of Ratings

- Fully addressed—
  - resolved the identified issue
- Partially addressed—Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues
- Not addressed—The MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY13-14

- Recommendation #1: Examine the system impact of current 5150 policies on the MHP and its consumers; compare with 5150 practices of similar large urban counties. Consider methods to improve MHP policies regarding entry to involuntary acute treatment, including offering involuntary detention training and privileges to an expanded cohort of licensed mental health professionals.

☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP initiated a county wide process which addressed this recommendation. The MHP leadership, with the 5150 county wide workgroup, indicated it plans to conceptualize a specific Performance Improvement Project (PIP) geared to improve the 5150 Involuntary detention policy, procedures, and

processes. Forums continue to address this initiative. To date, the following activities have been completed:

- ▷ AB1421 planning process looked at the 5150 rates for people who had more than four encounters at Psychiatric Emergency Services and two incarcerations at the jail during the prior fiscal year to target system changes for this population.
- ▷ Crisis Intervention Training (CIT) resulted in 433 trained law enforcement staff from various law enforcement agencies countywide. This led to the Oakland Police Department and the police departments of Berkeley, Fremont and the Bay Area Rapid Transit (BART) system to make CIT training mandatory.
- ▷ The CIT has resulted in two patrols teaming a MHP clinician with an Oakland police officer in the field. In addition, the Bay Area Rapid Transit (BART) system has employed a mental health liaison.
- ▷ County wide training was conducted to inform consumers on what to expect during the 5150 process, how to best access crisis care and follow up support.
- ▷ The new leadership has engaged in discussions to expand the crisis residential beds within the community however, this has not resulted in a concrete action plan.

- Recommendation #2: Analyze existing data sources to create a more representative picture of the overall trend of attrition through the period from Access contact to treatment in Crisis Response Program (CRP) and Level I and II service teams. If current data regarding dropout rates is validated, design and implement strategies to improve the rate of treatment entry.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP did not address this recommendation and continued the customary practice in its access process. Currently a strategic initiative is underway which includes examining data and the system components contributing to the attrition.

- Recommendation #3: Develop a process to improve coordination and communication between the Network Office, Provider Relations, Authorizations, the Executive Team and contract providers.

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

  - The process adopted to address this recommendation included three components:

- ▷ The MHP Leadership Team initiated all correspondence sent from Provider Relations and Quality Improvement to members of the contracted provider network for consistency.
- ▷ The Quality Assurance, Provider Relations, Authorizations and Network Office held quarterly meetings to ensure that policy and procedures that impact the provider network are aligned.
- ▷ Leadership began on-site visits within the provider network to increase visibility and initiate enhanced working relationships.

  - While the MHP made efforts to work on these processes, the impact of its efforts were not experienced. The provider community offered feedback in multiple venues at the review to the ineffectiveness of these efforts due to the contradictory and inconsistent communications from the Network office, indicating that an atmosphere of one-way communication continues.

- Recommendation #4: Develop an electronic tracking mechanism that would enable real time tracking and representation of demand for treatment and service availability as well as wait times by language and location.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP did not initiate a process to address this recommendation. It expects to have this capacity once its electronic health record (EHR) system is implemented and becomes fully operational, it will ultimately have the ability to centralize the appointment scheduling system for all planned services. This will provide the daily capacity to allocate respective resources where they are in demand by language and location.

- Recommendation #5: Work with contractors to identify and provide dashboard reports similar to those being developed for county programs.

☐ Fully addressed ☐ Partially addressed ☒ Not addressed

  - The MHP Decision Support Unit, in collaboration with system of care operational leads and network office staff, began discussions with contractors and agreed to provide dashboard reports similar to those being developed for the MHP programs. The MHP Decision Support Unit will be surveying contract providers to determine their data/reporting needs to help design and build their customized dashboards. As these needs are identified, the MHP intends to roll out standardized dashboard reports to contractors.
  - Contracted organizational providers indicated that reporting has not been developed or provided in any consistent manner. This may be a result of an already impacted MHP information systems unit with limited staffing resources.

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

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

- Access to Care
    - The MHP continues to address access to care primarily through its contracted organizational provider system of care accounting for greater than 80% of service delivery.
- Timeliness of Services
    - Leadership began to develop protocols designed to consistently collect, report and analyze timeliness indicators with the initiation of the new electronic health record.
    - Data collection, reporting, review and analysis of timeliness indicators have been highlighted as an initiative.
- Quality of Care
    - The leadership team is comprised of new executive staff which occurred following the retirement of the former historical long-standing team which served more than thirty years. The Deputy Director position remains vacant. The new leadership and management teams meet regularly to formulate and monitor consistencies for care.
    - The recruitment and hiring of MHP staff to fill critical vacant positions continues. Locally private health plans have successfully recruited staff, leaving unanticipated vacancies.
    - The implementation of a new electronic health records system is underway, addressing a critical need.
    - Strategies for improved communication and transparency have been prioritized by the new leadership team.
- Consumer Outcomes
    - The training of staff in the use of the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths (ANSA) outcome measures to inform stakeholders of consumer needs and treatment progress was begun in the fall of 2014 and system wide roll-out is anticipated in July 2015.

- The MHP continues to embrace the efforts of the Pool of Consumer Champions (POCC) which is fully integrated into the system. This year the POCC produced its own strategic plan with thirteen active subcommittees infused county wide.

PERFORMANCE MEASUREMENT

CalEQRO is required to validate the following seven (7) Mandatory Performance Measures (PMs) as defined by DHCS:

- Total Beneficiaries Served by each county MHP
- Total Costs per Beneficiary Served by each county MHP
- Penetration Rates in each county MHP
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served Compared to the four percent (4%) Emily Q. Benchmark
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

In addition to the seven PMs above, CalEQRO will include evaluation of five (5) additional PMs in the Annual Statewide Report, which will apply to all MHPs; this report will be provided to DHCS by August 31, 2015.

TOTAL BENEFICIARIES SERVED

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

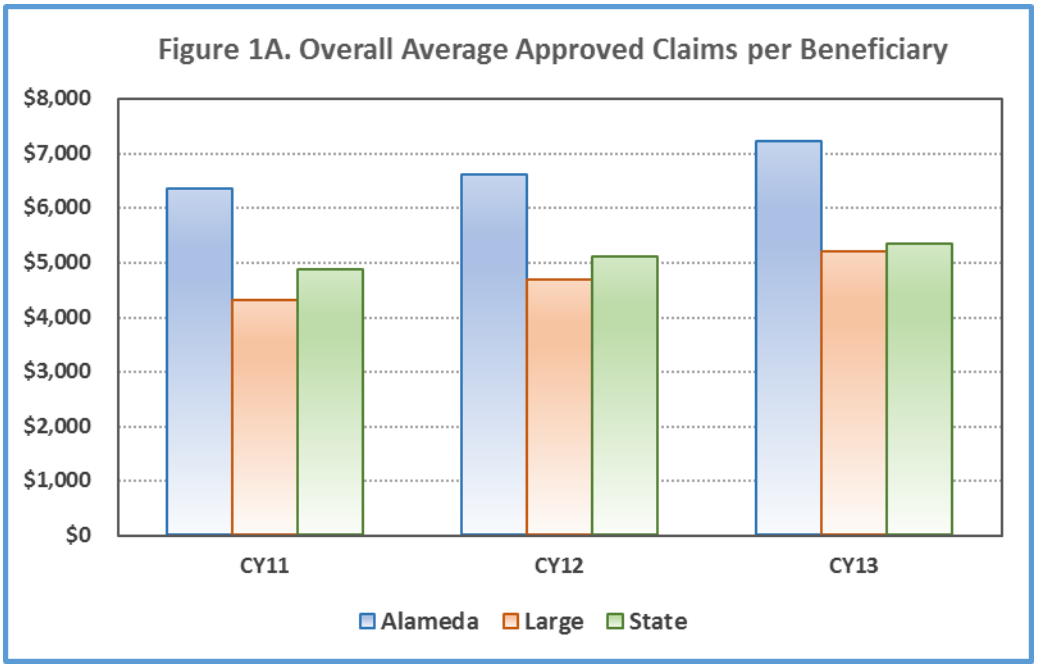
Table 1—Alameda MHP Medi-Cal Enrollees and Beneficiaries Served in CY13 by Race/Ethnicity

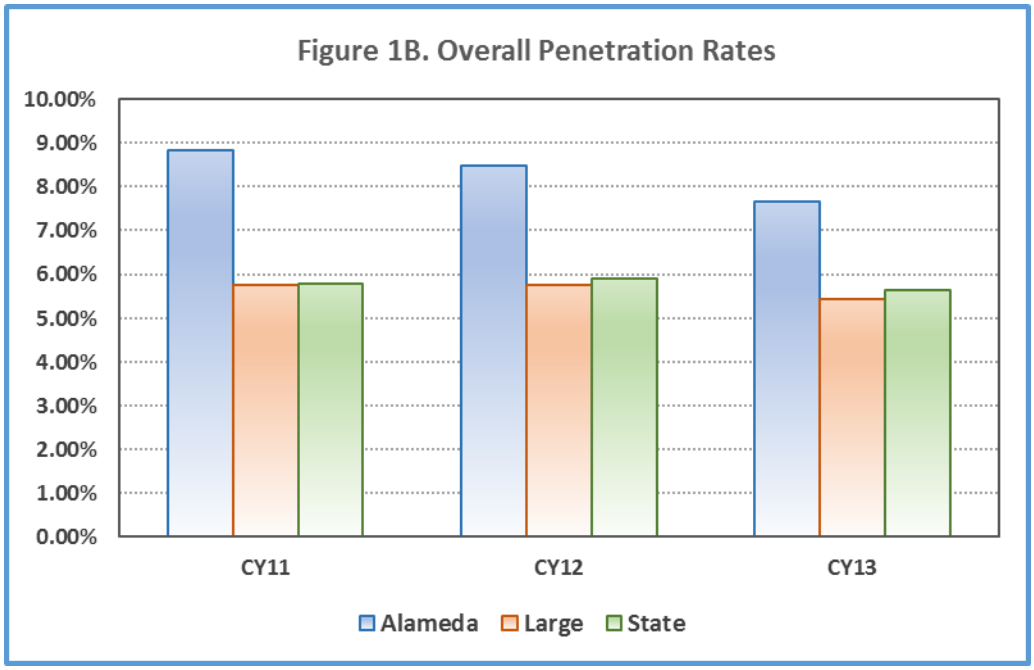
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	Unduplicated Annual Count of Beneficiaries Served
White	21,744	3,891
Hispanic	93,476	5,049
African-American	65,389	8,074
Asian/Pacific Islander	61,906	2,170
Native American	837	103
Other	32,839	2,457
Total	284,043	21,744

PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

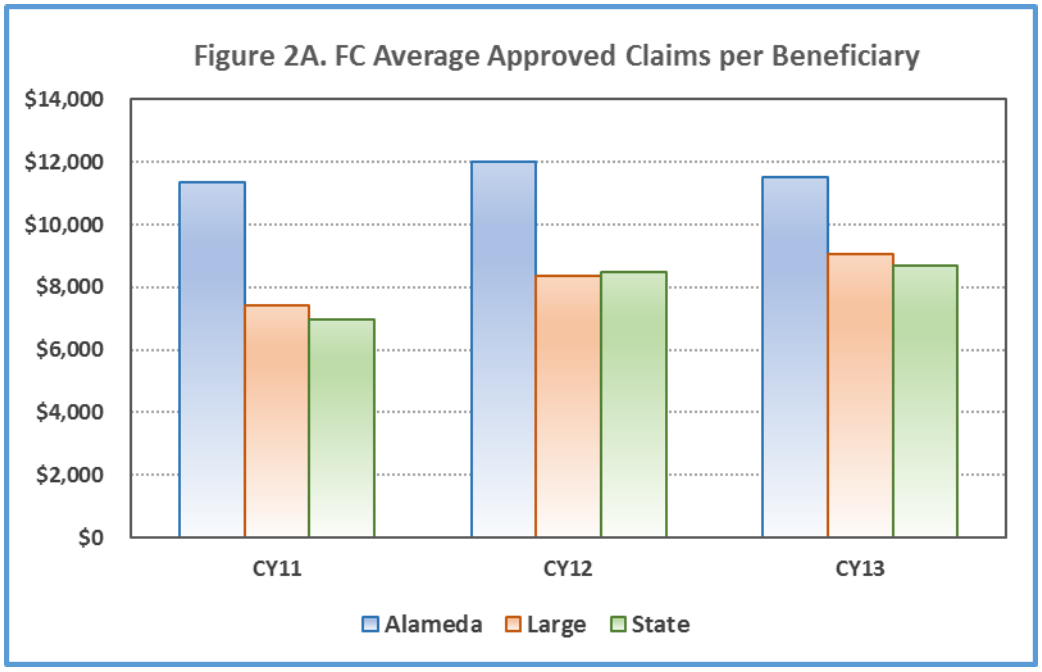
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

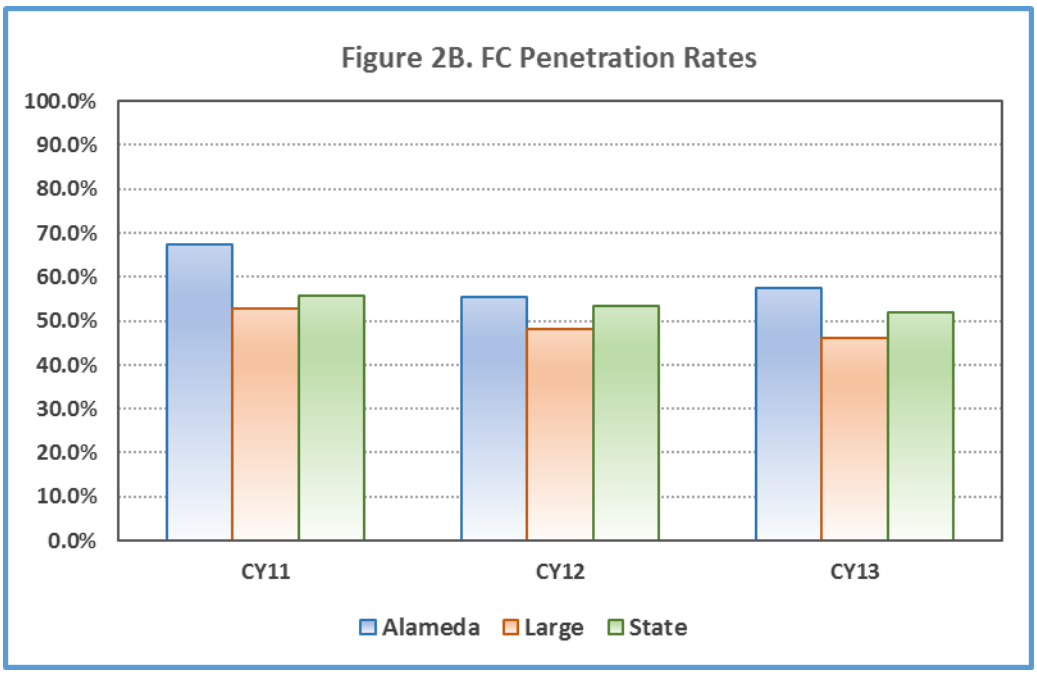
Figures 1A and 1B show 3-year trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



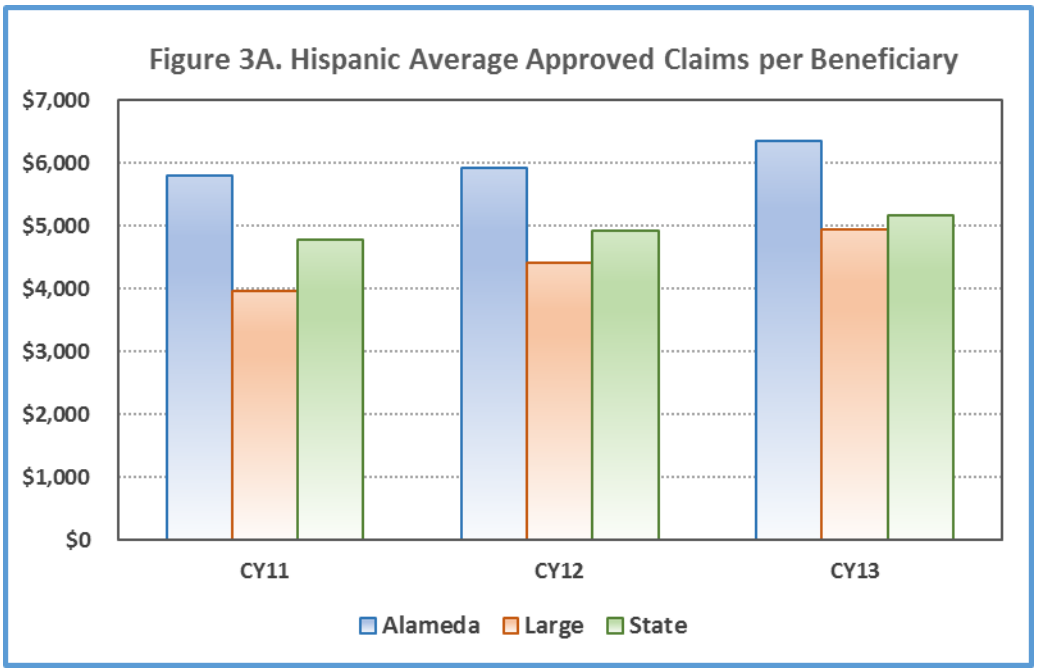


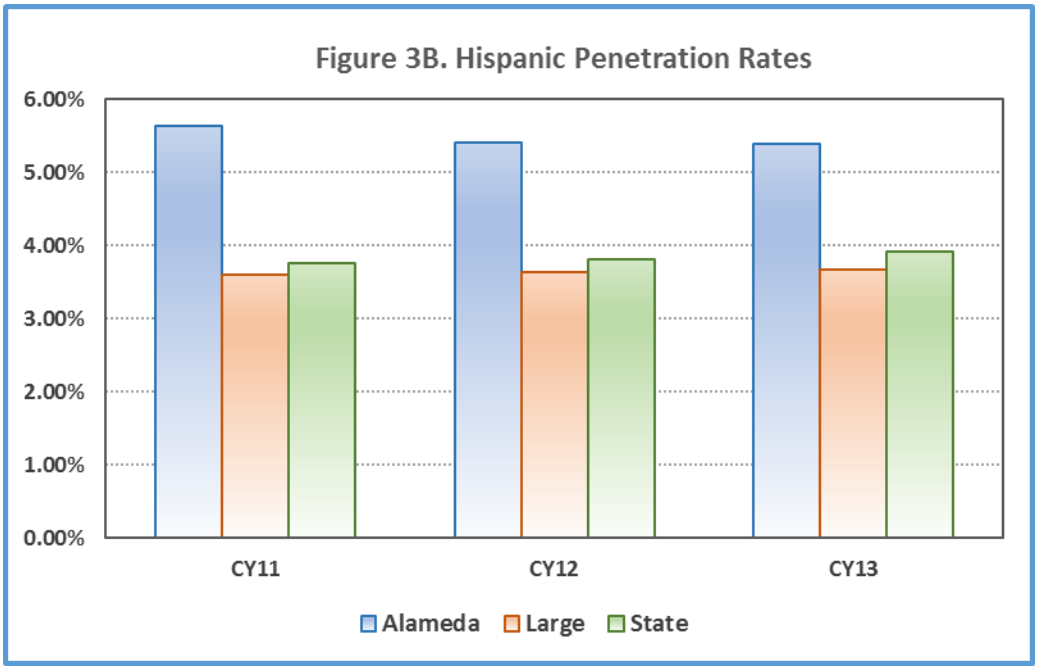
Figures 2A and 2B show 3-year trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.





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





HIGH-COST BENEFICIARIES

Table 2 compares the statewide data for high-cost beneficiaries (HCB) for CY13 with the MHP's data for CY13, as well as the prior 2 years. High-cost beneficiaries in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2—High-Cost Beneficiaries

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY13	13,523	485,798	2.78%	$51,003	$689,710,350	26.54%
Alameda	CY13	1,073	21,744	4.93%	$49,514	$53,128,819	33.81%
	CY12	1,008	22,812	4.42%	$49,856	$50,254,411	33.39%
	CY11	1,069	23,338	4.58%	$49,040	$52,423,665	35.16%

THERAPEUTIC BEHAVIORAL SERVICES (TBS) BENEFICIARIES SERVED

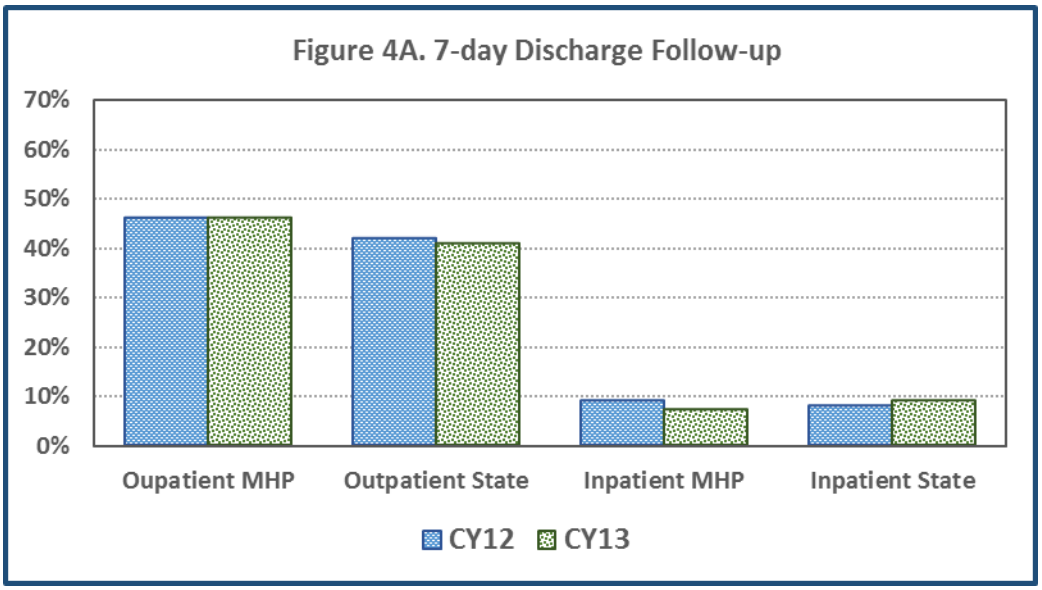
Table 3 compares the CY13 statewide data for TBS beneficiary count and penetration rate with the MHP's data. These figures only reflect statistics available from Medi-Cal claims data and therefore do not take into account TBS-like services that were previously approved by DHCS for individual MHPs.

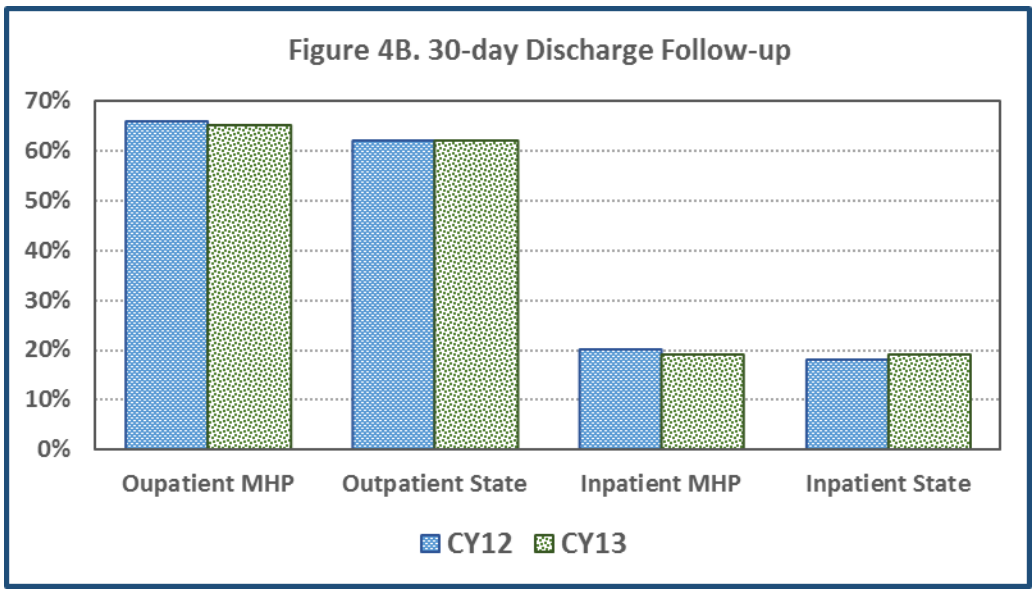
Table 3—TBS Beneficiary Count and Penetration Rate, CY13

MHP	TBS Level II	EPSDT Beneficiaries Served by MHP	TBS Beneficiary Count	TBS Penetration Rate
Alameda	Yes	10,767	347	3.22%
Statewide	No	15,621	199	1.27%
	Yes	222,295	7,499	3.37%
	Total	237,916	7,698	3.24%

TIMELY FOLLOW-UP AFTER PSYCHIATRIC INPATIENT DISCHARGE

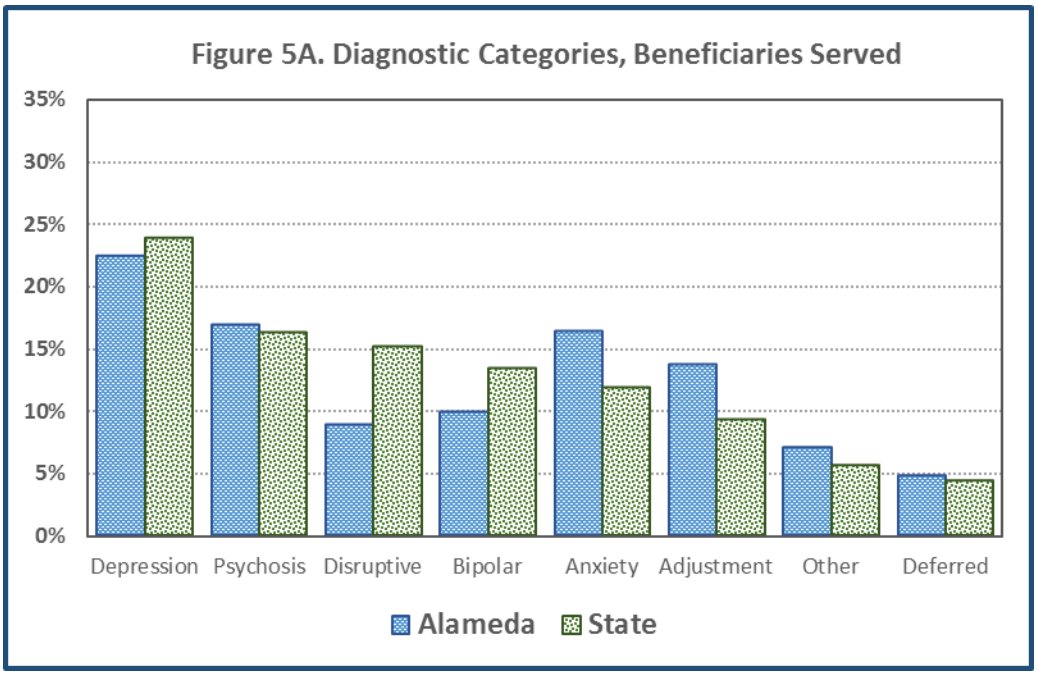
Figures 4A and 4B show the statewide and MHP 7-day and 30-day psychiatric inpatient follow-up rates, respectively, by type of service for CY12 and CY13.

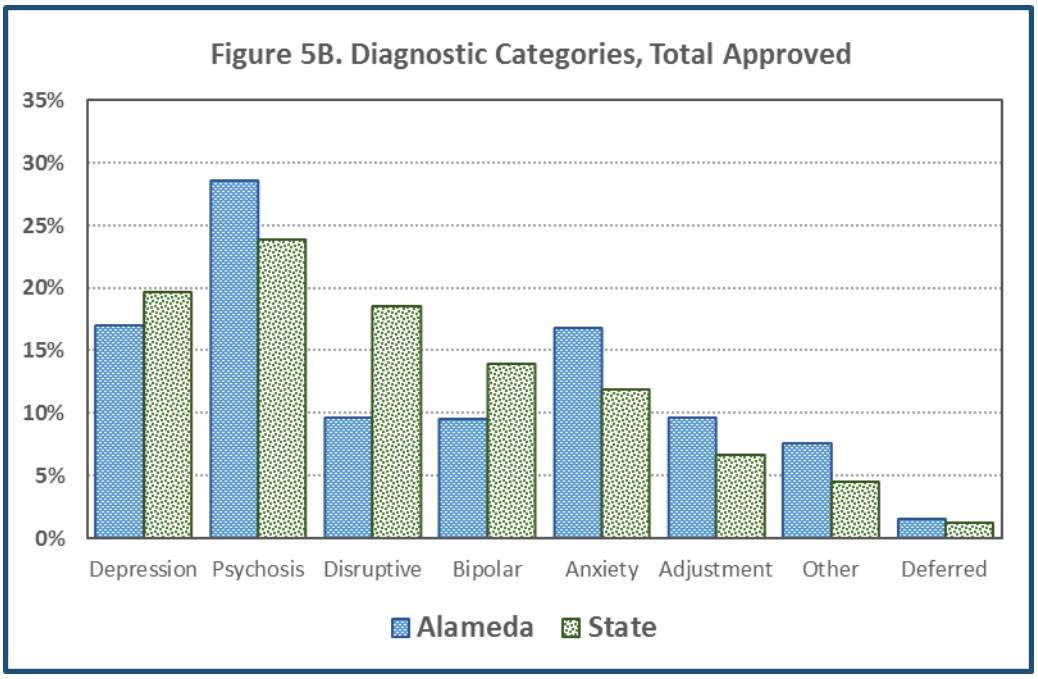




DIAGNOSTIC CATEGORIES

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY13.





PERFORMANCE MEASURES FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP's overall, foster care and Hispanic penetration rates are greater than large MHP and statewide averages.
  - The MHP is a TBS Level II county. The TBS penetration is slightly less than the TBS Level II statewide average and comparable to the overall statewide average.
- Timeliness of Services
  - The MHP's 7 and 30 day outpatient follow-up rates after psychiatric inpatient discharge are greater than statewide rates.
  - While the MHP's 7 day inpatient recidivism rate is less than the statewide average, the 30 day recidivism rate is comparable to the statewide average.
- Quality of Care
  - The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are greater than statewide averages.
  - The MHP's overall, foster care and Hispanic average approved claims per beneficiary are greater than the corresponding large MHP and statewide averages.
  - The MHP has higher rates of anxiety and adjustment disorders and lower rates of disruptive and bipolar disorders compared to statewide averages. The MHP has a comparable rate of individuals with a deferred diagnosis.
- Consumer Outcomes
  - None noted.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care … that is designed, conducted and reported in a methodologically sound manner." The *Validating Performance Improvement Projects Protocol* specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year 2013.

ALAMEDA MHP PIPS IDENTIFIED FOR VALIDATION

Each MHP is required to conduct two performance improvement projects (PIPs) during the 12 months preceding the review; Alameda MHP submitted one PIP for validation through the EQRO review, as shown below.

PIPs for Validation	PIP Titles
Clinical PIP	The MHP did not submit a clinical PIP. Onsite technical assistance was provided to identify future PIP topics.
Non-Clinical PIP	First Request for Service to First Psychiatric Appointment. Onsite technical assistance was provided to identify future PIP topics.

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

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

Table 4A—PIP Validation Review					
				Item Rating*	
Step	PIP Section	Validation Item		Clinical PIP	Non-Clinical PIP
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NM	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	NM	NM
		1.4	All enrolled populations	NM	PM
2	Study Question	2.1	Clearly stated	NM	PM
3	Study Population	3.1	Clear definition of study population	NM	PM
		3.2	Inclusion of the entire study population	NM	NM
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NM	PM
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NM	NM
5	Improvement Strategies	5.1	Address causes/barriers identified through data analysis and QI processes	NM	NM
6	Data Collection Procedures	6.1	Clear specification of data	NM	PM
		6.2	Clear specification of sources of data	NM	NM
		6.3	Systematic collection of reliable and valid data for the study population	NM	NM
		6.4	Plan for consistent and accurate data collection	NM	NM
		6.5	Prospective data analysis plan including contingencies	NM	NM
		6.6	Qualified data collection personnel	NM	NM
7	Analysis and Interpretation of Study Results	7.1	Analysis as planned	NM	NA
		7.2	Interim data triggering modifications as needed	NM	NA
		7.3	Data presented in adherence to the plan	NM	NA
		7.4	Initial and repeat measurements, statistical significance, threats to validity	NM	NA
		7.5	Interpretation of results and follow-up	NM	NA

Table 4A—PIP Validation Review					
Step	PIP Section	Validation Item		Item Rating*	
				Clinical PIP	Non-Clinical PIP
8	Review Assessment Of PIP Outcomes	8.1	Results and findings presented clearly	NM	NA
		8.2	Issues identified through analysis, times when measurements occurred, and statistical significance	NM	NA
		8.3	Threats to comparability, internal and external validity	NM	NA
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NM	NA
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NM	NA
		9.2	Documented, quantitative improvement in processes or outcomes of care	NM	NA
		9.3	Improvement in performance linked to the PIP	NM	NA
		9.4	Statistical evidence of true improvement	NM	NA
		9.5	Sustained improvement demonstrated through repeated measures.	NM	NA

**M = Met; PM = Partially Met; NM = Not Met; NA = Not Applicable; UTD = Unable to Determine*

Table 4B gives the overall rating for each PIP, based on the ratings given to the validation items.

Table 4B—PIP Validation Review Summary		
Summary Totals for PIP Validation	Clinical PIP	Non-Clinical PIP
Number Met	0	2
Number Partially Met	0	5
Number Not Met	30	9
Number Applicable	30	16
Overall PIP Rating ((#Met*2)+(#Partially Met))/(NA*2)	0%	28.13%

CLINICAL PIP—THE MHP DID NOT SUBMIT A CLINICAL PIP

- Status of PIP:

  ☐ Active and ongoing

  ☐ Completed

  ☐ Inactive, developed in a prior year

  ☐ Concept only, not yet active

  ☒ No PIP submitted

The technical assistance provided to the MHP by CalEQRO consisted of suggestions to formulate a PIP around the on-going activities and enhanced initiatives under the new leadership. Some of these discussions focused on the permanency project involving the youth in foster care. The MHP is engaged in an initiative for permanence for youth within the foster care system.

Another initiative underway is the focus on reducing hospitalizations and rehospitalization for the adult population. The strategies used in these initiatives could potentially be utilized to measure change and lends itself to the intentions of performance improvement activities.

The strategies involved in creating a dynamic, multi-disciplinary team with champions were promoted. The emphasis on consistent, regularly scheduled and brief meetings was discussed to infuse the team and entice a new project. The relevancy of the topic and the use of champions create the passion for quality improvement. Ultimately, the study question will become a business practice if successful and hence a PIP does best when momentum is continuous and time limited.

The MHP was encouraged to continue its discussion and engage in dialogue as needed with CalEQRO for technical assistance. The CalEQRO staff emphasized the necessity to pursue the PIP activities and the need to maintain regulatory compliance.

NON-CLINICAL PIP—FIRST REQUEST FOR SERVICE TO FIRST PSYCHIATRIC APPOINTMENT

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

- "What is the impact on consumer wait times and consumer outcomes (i.e., improved consumer satisfaction, change in hospitalization or psychiatric emergency services rates) with a change in administrative protocol (using a brief assessment module) for

consumers referred through the 1-800-ACCESS process to a designated Level III Outpatient Medication provider".

- Date PIP began: 2014
- Status of PIP:

☐ Active and ongoing

☐ Completed

☐ Inactive, developed in a prior year

☒ Concept only, not yet active

☐ No PIP submitted

The PIP is focused on reducing consumer wait time for the initial psychiatric medications support evaluation. The MHP intends to accomplish this without assuming additional psychiatry staff resources. The topic was initiated by the medical support staff with the intention to provide timely services aimed at addressing psychiatric symptoms at the earliest possible identification. The multi-disciplinary PIP team analyzed some of the more recent wait timelines and found the average wait between four to six weeks, an indicator clearly requiring marked improvement to meet the MHP goal within 21 days.

The PIP is in the initial phase of implementation and will require further development of its study question to clarify the intended goal. The PIP team will require defining its interventions, timelines for data collection, and a mechanism to obtain real-time feedback regarding its efforts. Strategies to revise its service delivery protocols were discussed on-site and will require consistent monitoring for effectiveness.

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

The technical assistance provided to the MHP by CalEQRO consisted of suggestions to identify and quantify the actual study question. In addition, data collection for all clinics and potential utilization of telepsychiatry for initial evaluations could be reviewed to determine the feasibility of adding this resource. The team was encouraged to consider consistent and regularly scheduled meetings using the Plan, Do, Study, Act (PDSA) methodology for timely feedback leading to business protocol successes.

CalEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this PIP and develops other PIPs. . The CalEQRO staff addressed the necessity to complete the PIP activities to maintain regulatory compliance.

PERFORMANCE IMPROVEMENT PROJECT FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
    - The non- clinical PIP addresses creating new and updated protocols for access to medications support services care. Research supports timely access to adjudicate symptoms at the earliest recognition.
- Timeliness of Services
    - The non-clinical PIP is focused on reducing wait times for initial psychiatry evaluations and improving timely service for consumers. Potentially, the secondary gain for consumers would be less restrictive services.
- Quality of Care
    - The non-clinical PIP would have a direct impact on the quality of care with timely service delivery. Consumer benefits include potential improved functioning and reduction in symptom escalation.
    - The MHP did not present any clinical PIP during the FY14-15 Review.
- Consumer Outcomes
    - The impact of the non-clinical PIP on consumers would potentially signify addressing symptoms at the earliest indication of need and ultimately lead to improved functioning, community engagement and satisfaction.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management—an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs—are discussed below.

Access to Care

As shown in Table 5, CalEQRO identifies the following components as representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 5—Access to Care			
Component		Compliant (FC/PC/NC)*	Comments
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PC	The MHP did not demonstrate system-wide evaluation of the effectiveness of its strategies or outcomes. The MHP does not provide consistent data collection, reporting or analyzing service accessibility reflecting cultural competency. Data elements will need to be addressed consistently and to work more closely with contract providers, and update the annual Quality Improvement Work Plan to better evaluate the access strategies to address the cultural, ethnic, racial and linguistic needs of Medi-Cal eligibles.
1B	Manages and adapts its capacity to meet beneficiary service needs	PC	The MHP did not demonstrate system-wide evaluation of the effectiveness of its strategies or outcomes. The MHP has engaged in tracking its target population geographically however, it has not demonstrated its use to manage service capacity and needs. It is prudent that the MHP engage with its contracted organizational providers and analyze data regularly to ascertain service capacity needs.
1C	Integration and/or collaboration with community based services to improve access	FC	The MHP has developed collaborations with multiple service providers to continually address access. Some of these include law enforcement, housing, transitional age youth, and older adult service providers.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Timeliness of Services

As shown in Table 6, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2A	Tracks and trends access data from initial contact to first appointment	PC	The MHP reports a standard of 14 days. The MHP submitted data based on the first quarter of FY13-14 for a limited number of the target population with an overall of 46.39% meeting the goal. MHP did not demonstrate consistent analysis with reasonable performance improvement across the system of care. There is no evidence that the MHP routinely analyzes data, has not identified reasons for not meeting the 14 day standard, and is not developing any performance improvement activities to improve timeliness to first appointment. It is essential that the MHP engage with its organizational providers to evaluate and determine if this metric is met.
2B	Tracks and trends access data from initial contact to first psychiatric appointment	PC	The MHP reports a current standard of 21 days with a new goal of 14 days. The MHP submitted data for the second quarter of FY13-14 from the Access unit and reports meeting this goal 35.80% of the time. The MHP has initiated a PIP project to reduce time and needs to establish an improved metric for time to service and establish reporting standards.
2C	Tracks and trends access data for timely appointments for urgent conditions	NC	MHP reports it does not track this metric. The MHP has not established a definition for “urgent conditions” including how such conditions reflect a lower level of consumer need than emergency conditions.

Table 6—Timeliness of Services			
Component		Compliant (FC/PC/NC)*	Comments
2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	The MHP has a 7 day follow up standard and reports meeting this goal 100%, with an average overall of 5.58 days. This metric is reported at the QI meetings, and would benefit from on-going analysis in conjunction with other timeliness metrics.
2E	Tracks and trends data on rehospitalizations	NC	MHP does not meet its goals in this area which could potentially be linked to poor performance in timely psychiatric evaluations. This may be highly correlated to law enforcement involvement in the 5150 process locally and data may reflect changes underway if collected.
2F	Tracks and trends No Shows	NC	MHP reports it does not track this metric.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

Quality of Care

As shown in Table 7, CalEQRO identifies the following components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3A	Quality management and performance improvement are organizational priorities	PC	The MHP does have a Quality Improvement Work Plan (QIWP) and it did complete an Evaluation of the prior year's activities. The QIWP is based upon the required compliance regulations and is devoid of measurable indicators and current thresholds of comparison to make improvements. The membership has consumer representatives and few organizational providers who represent a majority of service providers.
3B	Data are used to inform management and guide decisions	PC	A missing component pertains to the consistent documentation of its efforts in using data to inform decisions. The tracking, reporting and analyzing for data activities, especially in regard to collaborative efforts with the organizational providers, leaving the leadership void of the system of care activities. While data may be available, it is distributed at the level of the individual staff/unit request and overall excludes the organizational providers, who deliver 85% of services.
3C	Evidence of effective communication from MHP administration	PC	A broad base of feedback from various stakeholder groups indicated inconsistent, contradictory communications, lacking a centralized point of contact to acquire information or updates. This included a sense of one way communication primarily via email distribution, which was also reported to be inconsistent, often with outdated information and unreliable.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3D	Evidence of stakeholder input and involvement in system planning and implementation	PC	Aligned with communication concerns, stakeholder involvement with organizational providers and other stakeholders indicated little inclusion or predictability with input, involvement and planning with systems issues.
3E	Integration and/or collaboration with community-based services to improve quality of care	FC	The MHP continues its practice with collaborative and integrated service delivery among a broad spectrum of community agencies, including supportive employment, housing assistance, substance use and physical health care services.
3F	Measures clinical and/or functional outcomes of beneficiaries served	NC	The MHP does not measure consumer outcomes on a system-wide basis as yet The MHP did not adequately demonstrate the use of outcomes data beyond individual treatment for broad clinical treatment. Little evidence of a comprehensive system to determine lower service need or the higher care service need was apparent. A few community agencies do use evidence based practices, however outcome tools remain inconsistently applied and it was unclear how these tools were used to measure progress. The MHP reports it has trained its children's system of care staff in the use of the Child Adolescent Needs and Strength (CANS) and will implement it beginning July 1, 2015. The MHP indicates its next steps include training staff in the use of the Adult Needs and Strengths Assessment (ANSA). The MHP has not begun the training cycle for this.

Table 7—Quality of Care			
Component		Compliant (FC/PC/NC)*	Comments
3G	Utilizes information from Consumer Satisfaction Surveys	FC	The MHP participates in the annual statewide Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey. The ethnic services unit in conjunction with consumers developed a cultural specific short survey used in five threshold languages.
3H	Evidence of consumer and family member employment in key roles throughout the system	FC	The MHP continues to have meaningful input and involvement of consumers and family members. Consumers continue to be employed at all levels, including supervisory and executive representation. The Pool of Consumer Champions (POCC) continues to expand the consumer voice with thirteen subcommittees each with an action plan and implemented its own Strategic Plan in August 2014.
3I	Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery	FC	The MHP continues to embrace consumer run programs and drop-in centers through the Alameda Network of Mental Health.

**FC = Fully Compliant; PC = Partially Compliant; NC = Not Compliant*

KEY COMPONENTS FINDINGS—IMPACT AND IMPLICATIONS

- Access to Care
  - The MHP demonstrates integration and collaboration with community agencies to engage consumers and provide a breadth of services to meet the needs of a multi-cultural population. The MHP has not undergone a revision to its access to care protocols which may inhibit its ability to respond and provide improved accessibility.
  - The MHP has begun to develop a geographic mapping of its target population for analyzing accessibility for both cultural, linguistic, and age factors.
  - The MHP continues with system wide clinical trainings for staff and provides continuing education units. Consider inclusion efforts for organizational providers.

  - The MHP continues its initiatives with constituents which serve targeted foster care youth populations.

- Timeliness of Services
  - The MHP has partially established standards for the timeliness metrics and MHP reports that it has not performed two categories of these metrics.
  - Overall, it has not demonstrated its ability to set performance improvements when timeliness standards are not met.
  - The MHP continues to set performance measurement requirements for its organizational providers without effective monitoring of these metrics.
  - The MHP has not established consistent and broad reporting timelines or venues for most of its timeliness of service metrics.
  - Timeliness performance to first psychiatric service, which the MHP is actively working to remediate, may have had a cascade effect in the MHP's re-hospitalization rates. Data has shown direct correlation between consumers to medication support services within seven days and significantly lower re-hospitalization rates.

- Quality of Care
  - The MHP did not successfully demonstrate broad system-wide commitment to clinical quality improvement processes but rather emphasized the need to address compliance issues as a priority. This may be a result of a recent state review. Given the recent findings of the tri-annual state review cycle, the MHP has engaged in pro-active compliance trainings to remediate future shortcomings.
  - Recent creation of key senior quality improvement staffing positions may allow the MHP to demonstrate the intended change toward quality now that management positions have been filled.
  - Stakeholder feedback consistently pointed to inconsistent communications from the MHP's leadership, Quality Management and Network team. Communications around billing standards and training were particularly observed to be problematic and contradictory.
  - In the era of integrated health care with substance use disorders and physical health care, consistency and clarity surrounding quality goals remains essential to coordinated care.
  - Creating a model of leadership transparency would benefit the MHP and align with values of collaboration.

- Consumer Outcomes

- The MHP conducts the statewide annual Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey. The MHP has not engaged in comparisons of MHSIP findings against prior year data or in using the findings to improve quality.
- The Ethnic Services Office engaged in a consumer endeavor producing a satisfaction survey with broad reflection in all five threshold languages. Results are reported on-going at the consumer subcommittee meetings.
- While the MHP is moving toward the broad use of Level of Service/Level of Care tools there is little evidence that the MHP is currently utilizing this data for other than targeted individual treatment.
- Shared data is prevented with multiple EHR systems and outcome measures amongst organizational providers, leaving a paucity of integrated knowledge for stakeholders.
- The MHP has not infused the system with business practices for the purposing of data to system-wide level of care applications. This impacts the MHP's ability to answer the question "How do you know your consumers are getting well?"

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted two 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups, which included the following participant demographics or criteria:

- Adults beneficiaries receiving services within the past year in a variety of programs
- Parents/caregivers of child beneficiaries receiving services within the past year in a variety of programs.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This focus group of adult s receiving services within the past twelve months and was held at the Hedco Wellness Center in Berkeley and included twelve participants.

The general feeling expressed by this group was that of encouragement from the providers. Group participants indicated staff had genuine concern for their well-being and felt each staff embraced recovery. However, at times, a conflicting message was received to graduate from the Wellness Center. Several group participants agreed that there is pressure to "graduate" from programs with others expressing that after care is available. Other concerns regarding excessive staffing turnover left consumers having to repeat their story or were left unprepared for a change in provider. Continuity of service was impacted for the transition age youth as this group aged-out of children's services. Consumers expressed the desire for clarity and predictability regarding services.

Group participants shared that there are workshop calendars, bulletins and flyers available at provider locations to inform them of activities. Materials were prominently displayed in several locations at the focus group site. Overall opportunities were presented for group participants to initiate activities within the community and staff readily incorporated consumer ideas into agenda planning and individual care plans. Several of the group participants were gaining work experience at the centers.

Recommendations arising from this group include:

- Better management of provider change to ensure continuity of care.
- Close the gap in service delivery between children's system of care and transition age youth services.
- Increase transportation resources, such as transit passes.

Table 8A displays demographic information for the participants in group 1:

Table 8A—Consumer/Family Member Focus Group 1		
Category		Number
Total Number of Participants		**10**
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	9
Ages of Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	 2 2
Preferred Languages	English Spanish Bilingual Other	10
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	2 4 4
Gender	Male Female	5 4

Interpreter used for focus group 1: ☒ No ☐ Yes Language:

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This focus group of parents/caregivers of Asian/Pacific Islander youth was held at the Asian Community Mental Health Center in Oakland and included three participants. The limited number of participants may not accurately reflect the system wide service delivery.

For participants who entered services within the past year, the experience was described as

- Positive and helpful in addressing the mental health needs of their youth.
- The group participants indicated that staff was helpful in addressing the youth's needs.
- The primary concern centered on the excessive time for the medications support service appointment.

- At times, connections on the phone service were dropped causing unanticipated barriers.
- This group indicated services were provided in their preferred language.

Recommendations arising from this group include:

- Increase educational outreach to the community.
- Increase staffing to add availability of appointments.
- Address the phone system functioning at the center which often results in disconnections.

Table 8B displays demographic information for the participants in group 2:

Table 8B—Consumer/Family Member Focus Group 2

Category		Number
Total Number of Participants		**3**
Number/Type of Participants	Consumer Only Consumer and Family Member Family Member	3
Ages of Participants	Under 18 Young Adult (18-24) Adult (25–59) Older Adult (60+)	3
Preferred Languages	English Spanish Bilingual Other	3
Race/Ethnicity	Caucasian/White Hispanic/Latino Other	3
Gender	Male Female	0 3

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Mandarin, Chinese

CONSUMER/FAMILY MEMBER FOCUS GROUP FINDINGS—IMPLICATIONS

- Access to Care
    - Limited outreach to the API community prevented some from knowing that the Center exists.
- Timeliness of Services
    - Once identified, entry into service was generally timely and very culturally respectful.
- Quality of Care
    - The Center staff went out of their way to be helpful to the youth and caregivers especially in acculturation issues.
    - Overall concerns were expressed that the Center is understaffed.
- Consumer Outcomes
    - The Center staff was supportive and oriented in wellness and recovery concerns.

INFORMATION SYSTEMS REVIEW

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

KEY ISCA INFORMATION PROVIDED BY THE MHP

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

Table 9 shows the percentage of services provided by type of service provider:

Table 9—Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	16.94%
Contract providers	81.33%
Network providers	1.73%
Total	100%

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

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

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

16.1%

- MHP self-reported average monthly percent of missed appointments:

N/A

- Does MHP calculate Medi-Cal beneficiary penetration rates?

☐ Yes ☒ No

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

- The MHP notes that there are systemic barriers to capturing and reporting an accurate co-occurring disorder (COD) rate within its system of care and this may account for the low COD rates reported.
- The MHP reported that it does not currently capture No Show data within its data system and an inconsistent practice in recording missed appointments at the clinical level makes calculating a missed appointment rate problematic.
- The MHP does not engage in penetration rate calculations but rather has done prevalence calculations. This analogous methodology has also proven to be problematic for the MHP leadership. The Decision Support group has created alternative beneficiary tracking methods which provide more clinically relevant information to management on its underserved populations.

CURRENT OPERATIONS

- The MHP continues to use its legacy practice management system Insyst to meet operational MIS requirements for the agency. It also uses the legacy Clinician's Gateway system to fulfill some clinical reporting capability.

MAJOR CHANGES SINCE LAST YEAR

- Completed implementation of a record management (document imaging) system.
- Expanded electronic prescriptions (eRx) using Clinician's Gateway.
- Upgrades to Clinician's Gateway in order to meet requirements for Meaningful Use.

PRIORITIES FOR THE COMING YEAR

- Procure a new electronic health record product that will replace Insyst and eCura.
- Continued deployment of a document imaging system that provides electronic storage and retrieval of clinical documents.

- Continue to support Clinician's Gateway.
- Implement the CANS and the Objective Arts analytic toolset to facilitate scoring and distribution of the measure.
- Upgrade the Citrix infrastructure. Implement the XenDesktop environment (desktop virtualization) to assist with user support.
- Acquire helpdesk software.

OTHER SIGNIFICANT ISSUES

- The MHP continues to demonstrate considerable systemic inertia slowing the acquisition of an EHR and its attendant clinical tools. The transition in the executive staff during the past few years has impacted movement in the procurement process. The MHP appears to utilize a legacy MIS that is heavily weighted to fiscal management over solid clinical tools and clinically relevant data collection. A clear impression was conveyed that the development of data reporting in the area of clinical quality is in a holding pattern until the new EHR is implemented. MHP projections expect this to be at least two years in the future.
- The MHP noted communication and regulatory issues with DHCS often impact business processes statewide. The issues noted consisted of the following:
    - Inconsistent billing rules and protocols among physical health, mental health and substance use disorders create undue burden to integrated care and operational functionality.
    - Lengthy wait times to implement Aid Code changes in the adjudications system impact claiming processes.
    - Conflicting information is distributed between the claiming system remediation/upgrade efforts and the settlement process.
    - Remediation of issues within the claims adjudication system appears to be neither timely nor transparent.
- While the MHP maintains significant resources in the form of its Decision Support (DS) Unit it is less clear that the agency as a whole is aware of the work of this business intelligence unit. The DS project acknowledges that it could document its functionality and utilization of its end products system-wide. This leaves a gap in getting the regular and systemic distribution to clinical line staff to make for a fully data driven clinical quality improvement paradigm within the agency.

Table 10 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 10—Current Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
Insyst	Practice Management	Echo Management	24	County/MHP
Clinician's Gateway	Clinical Record	Platton Technologies	7	County/MHP
eCura	Managed Care	InfoMC	15	County/MHP

PLANS FOR INFORMATION SYSTEMS CHANGE

- The MHP is in the final negotiations stages for procuring the Share Care system from Echo Management.

ELECTRONIC HEALTH RECORD STATUS

Table 11 summarizes the ratings given to the MHP for Electronic Health Record (EHR) functionality.

Table 11—Current EHR Functionality

Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Clinician's Gateway	x			
Clinical decision support	Clinician's Gateway	x			
Document imaging	Clinician's Gateway		x		
Electronic signature—client					x
Electronic signature—provider		x			
Laboratory results (eLab)					x
Outcomes				x	
Prescriptions (eRx)	Clinician's Gateway	x			
Progress notes	Clinician's Gateway	x			

Table 11—Current EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Treatment plans	Clinician's Gateway	x			
Summary Totals for EHR Functionality		6	1	1	2

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

- While the MHP notes that it has implemented document imaging, significant feedback from focus group participants indicated that this functionality is not usable due to slow response times and poor search functionality.
- The Decision Support group appears to be providing useful clinical decision support tools (e.g.; Alerts) to the clinical users.
- While the MHP is using an interim EMR product (Clinician's Gateway) for some clinical functionality it is evident that use of this product could be contributing to the slow pace of adoption of a contemporary EHR suite and ancillary clinical quality improvement projects. This pace is causing significant issues for the MHP's organizational provider community who are getting little to no guidance on where to direct their MIS procurements.

INFORMATION SYSTEMS REVIEW FINDINGS—IMPLICATIONS

- Access to Care
  - While the MHP demonstrated several analyses related to underserved beneficiaries it did not demonstrate recent system-wide program changes that had been the result of these projects. This may however, be more an artifact present because of the recent changes in senior leadership and quality improvement which are moving in this direction rather than a direct under-utilization of IT efforts.
- Timeliness of Services
  - The Decision Support can contribute to this effort with continued work with QI management in defining reporting parameters addressing clinically useful timeliness of service reporting.
  - The lack of No Show and timeliness to urgent care reporting appears to be more a function of the slow adoption of a new EHR than any lack of capability on the

part of Decision Support. Lack of this reporting is denying management hard data with which to make relevant program allocation decisions.

- Quality of Care
  - The MHP is cognizant of issues it has around timely psychiatric care and is exploring solutions to improve issues identified via analysis.
  - The MHP may be experiencing both systemic and operational barriers to appropriate COD reporting which is denying the executive team the appropriate information it needs to adequately structure program capacity and service mix.
- Consumer Outcomes
  - The MHP has been slow to adopt Level of Service/Level of Care tool sets in a broad fashion across the system of care. This is preventing the objective analysis of program effectiveness as well as the timely dissemination of individual treatment feedback. The quality management team did not demonstrate broad protocols in using outcomes data to assess level of care transitions.
  - The MHP does not appear to have an objective system in place system-wide to determine the level of progress for consumer wellness.
  - Given the orientation of the MHP to embrace wellness and recovery, it is unclear why it is not implementing specific Wellness and Recovery outcomes tools especially after it specifically investigated the possibility. These tools have been shown to have positive impacts for "right-sizing" clinical care with associated positive fiscal impacts.

SITE REVIEW PROCESS BARRIERS

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

- There was very low turnout to the Consumer/Family Member focus group for API beneficiaries.
- Translators, while provided, were either inexperienced in behavioral healthcare or they were departmental staff. This affected the usefulness of at least one focus group.

CONCLUSIONS

During the FY14-15 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

STRENGTHS AND OPPORTUNITIES

Access to Care

- Strengths:
    - The MHP has developed strong relationships amongst law enforcement agencies resulting in a mental health staff teaming with an officer and deployed for crisis response.

Timeliness of Services

- Opportunities:
    - While access is a priority, timeliness standards were recently set and consistent tracking of access/timeliness indicators is not present.

Quality of Care

- Strengths:
    - The MHP leadership has begun to imprint its vision amongst stakeholders with initial meet/greet meetings in community settings.
    - Newly hired and deployed staff to the QI unit provides a stronger basis to conduct its quality initiatives.
- Opportunities:
    - The MHP has been slow to determine which EHR system upgrade/updates it will migrate to in order support its data collection of service operations.
    - Stakeholders remain unclear and uniformed of the overall mission and vision of the newly formed leadership.
    - There is a continuing need for increased and consistent communication with organizational providers which provide the majority of services.

Consumer Outcomes

- Strengths:
  - The MHP has strengthened and continues to enhance its consumer involvement with the Consumer Empowerment Department, consisting of 13 subcommittees each equipped with a strategic plan.
  - Focused on the transition aged youth (TAY), the MHP created a collaboration with Merritt College resulting in the forum "Bright Young Minds" to model career choices/success.
- Opportunities:
  - The MHP has yet to track its system wide outcome tools such as the Beck Scale, the CANS and ANSA, to measure consumer progress or clinical interventions.

RECOMMENDATIONS

- Proceed with the business of implementing its EHR as soon as possible to gain a unified data source for a comprehensive data source for clinical quality improvement efforts.
- Establish methods, venues or forums in which to regularly meet with contract provider staff on issues; provide regular training, establish a point of contact, and provide technical assistance to contract providers.
- Set parameters for timeliness standards, provide data collection and reporting timelines and distribute to stakeholders for analysis to inform service delivery improvements.
- Continue with the vision of the new executive management team and develop extensive bi-lateral communications with stakeholders to enhance system planning and development.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO PIP Validation Tools

ATTACHMENT A—REVIEW AGENDA

Double click on the icon below to open the MHP On-Site Review Agenda:

Alameda MHP CalEQRO Agenda
January 27-29, 2015

Time	Activity Day 1–JANUARY 27, 2015	
9:00 – 9:30	**Opening Session** • Introduction to BHC • MHP Team Introductions *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders*	
9:30 – 10:00	**Review of Past Year** • Significant Changes and Key Initiatives • Use of Data in the Past Year *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders*	
10:00 – 11:00	**Disparities and Performance Measures** • Access and Retention *Requested Participants: MHP Leadership, Quality Management Staff, Key Stakeholders, Cultural Competence Staff*	
11:00 – 12:00	**Performance Improvement Projects - Clinical PIP** • Technical Assistance *Requested Participants: MHP Leadership, Quality Management Staff, Key PIP Participants*	
12:00 pm – 1:00	BHC Cal-EQRO Working Lunch	
1:00- 2:30	**ISCA/Fiscal & Billing** • FY13-14 Recommendations • EHR implementation • Contract providers • Claim processing - denied & replaced transactions • Tele-psychiatry • Primary care collaboration • Meaningful use	**Evidence-Based, Evidence-Informed Or Best Practices** MHP-Wide Or Within Systems Of Care: Group Interview

ATTACHMENT B—REVIEW PARTICIPANTS

CalEQRO Reviewers

Jovonne Price, LMFT, CPHQ, Quality Reviewer
Duane Henderson, Information Systems Review Consultant
Mark Schmidt, Consumer/Family Member Consultant
Richard Hildebrand, Information Systems Reviewer

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

Sites of MHP Review

MHP SITES

Alameda County Administrative Office
2000 Embarcadero Cove
Oakland, CA 94606

Alameda County Administrative Office
1900 Embarcadero Cove
Oakland, CA 94606

CONTRACT PROVIDER SITES

Bay Area Community Services (BACS)
Hedco Wellness Center
590 B Street
Hayward, CA 94541

PEERS Community Center
333 Hegenberger
Oakland, CA 94606

Asian Community Mental Health Center
310 8th Street, Suite 201
Oakland, CA 94607

Participants Representing the MHP

Name	Position	Agency
Adrianne DeSantis	Consumer Relations Program Assistant	

Name	Position	Agency
Aimee Armata	BOSS	
Alan Jay Cohen	Lead Psychiatrist	
Alex Jackson		BHCS
Amanda Gibbon		Seneca Center
Andrea Judkins	Financial Services Specialist	
Ann Hoang	BOSS	
Annie Kim	Program Director	Family Education Resource Center
Barbara Saler	Director	ACCESS
Bettye Foster	Lead Family Advocate	Family Education and Resource Center
Blanca Navarro		UCSF
Brian Newton	CIS Director	Hume Center
Camille Peterson	Information Systems Application Specialist	
Carla C. Danby		BHCS
Cecilia Serrano	Financial Services Officer	
Charleen Stearns		BACA
Charleen White-Leach	Program Coordinator	
Charles Raynor	Clinical Pharmacist	
Cheryl Narvaez		Family Paths, Inc.
Chris L. Lorente		BACS
Chris Stoner-Merz		Lincoln School
David Worden	Information Systems Analyst	BHCS
Denah Nunes		Abode
Donna Fore		BHCS
Donna Williams		BHCS
Ellen Muir	EPSDT Coordinator	
Fiona Branagh	Network Office Director	
Freddie Smith	Project Director	PATH
Gabriela Castain	Bert Program Coordinator	Children's Hospital Oakland
Gabriel Orozco		BHCS
Gabriel Zuloaga		Family Education and Resource Center
Genica Robbins		EBCRP Day Treatment
Gigi Crowder	Ethnic Services Manager/Cultural Competency Coordinator	

Name	Position	Agency
Glenda Turner		Villa Fairmont
Haydee Cuza	Executive Director	PEERS
Hazel King	Patient's Right's Coordinator	
Heather Caruso-Maxey		The Hume Center
Howard Thurmond		Reach Out
Jackie Mortensen	Director	Provider Relations
Jackie Poque	IPS Trainer	
Jamie Works-Wright		Best Navi
Jan Marhway		Horizon Services
Janet Biblin	Decision Support Manager	
Jeff Roelwe		BHCS
Jenae Brown		East Bay Agency for Children
Jerri Greenberg		West Coast Children's Clinic
Jesse Pamper		Children's Services
John Engstrom	Decision Support Supervisor	
Joslin Herberich		Fred Finch Youth Services
Jovan Yglecias	Director of MH Housing	
Julie Leong		Community Health for Asian Americans
Kaitlin Bruner	Management Analyst	
Karla Carnahan		Abode
Karly Wiley,	Administrator	Stars
Keller Grayson		Pathways to Wellness
Ken Berrrick		Seneca
Ken Coelho	Decision Support	BHCS
Kenneth Kozi Arrington		PEERS
Khatera Aslami	Consumer Relations Manager	
Kirby Smith	Financial Services Officer	
Kristy Armstrong		Recovery Innovations
Kyah Khalsa		Recovery Innovations
Leda Frediani	Financial Services Director	
Linda Luong		Asian Community Mental Health
Lillian Schaechner		Older Adult Services Director
Lori Delay		BHCS
Lani Pallotta	Management Analyst	BHCS

Name	Position	Agency
Lornah Jones		Bonita House
Manuel Jimenez	Director	BHCS
Marc Diamond		Eden CSL
Margaret Walkover	Director	Wellness Recovery & Resiliency
Margie Giutierrez-Padilla		BHCS
Mark Rahnian	Family Advocate	
Mark Shotwell		Bonita House
Maria Jose Munoz		JFCS
Marie Murray	Authorization Director	BHCS
Maureen Costello		BHCS
Mary Hogden	Program Specialist	
Melanie Wartenberg		East Bay Agency for Children
Mercedes Marquez		UACF
Michael Kessler		BHCS
Michael Lisman	Director	Adult Community Support
Micheele Alvarez-Campos		La Clinica Casa del Sol
Michelle Fiorenzo	Recovery Coach	Recovery Innovations Choices
Michelle Norris		Telecare-CHANGES
Michelle Love	Assistant Agency Director	
Natasha Molony	Director of Training	Hume Center
Nathan Hobbs	Program Specialist	
Neisha Becton	Executive Director	Pathway to Wellness
Paul Takayanagi	Training Officer	
Penny Bernhisel		Telecare STAGES
Rachel Pepper		STARS
Radawn Alconrn		BHCS
Rashad Eudy	TAY Coordinator	Family Education Resource Center
Renwicke VIttito		Family Education Resource Center
R.K. Janmeja		The Hume Center
Richard Panell	Vice President, Operations	Telecare
Roger W. Daniels		Fred Finch Youth Center
Rudy C. Arrieta	Quality Manager	BHCS
Sally Zinman	Member	Pool of Consumer Champions (POCC)
Samantha Fryer	Director of QI	Bay Area Community Services

Name	Position	Agency
Sanjida Mazid	Workforce Education and Training Manager	
Satwinder Mahabir	Clinical Supervisor/Coordinator	Pathways to Wellness
Shannon Mong		Telecare Corporation
Sheryl Diedrick	Information Systems Analyst	
Sona Basra	Supervising Financial Services Specialist	
Sonia Estrada		La Familia Counseling Services
Sr. Mary Nolan		St. Mary's Center
Starr Stoddard		Abode
Stephanie Downs		Stars Community Services
Steve Kline	Systems Support	
Susannah MacKaye	Behavioral Health Clinician	BHCS
Terry Rubin-Ortiz		Bonita House
Tom Trabin	Adult System of Care Associate Director	
Tracy Hazel	Prevention Services	
Ursula Sears		BACS
Vickie McClary		BHCS
Yaffa Aldez		Berkeley Drop-In Center
Yvette Katnala		City of Berkeley
Wendi Vargas	Supervising PS	

ATTACHMENT C—APPROVED CLAIMS SOURCE DATA

These data are provided to the MHP separately in a HIPAA-compliant manner.

ATTACHMENT D—PIP VALIDATION TOOL

Double click on the icons below to open the PIP Validation Tools:

Clinical PIP:

None submitted.

Non-Clinical PIP:

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PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

DEMOGRAPHIC INFORMATION		
County: Alameda	☐ Clinical PIP	☒ Non-Clinical PIP
Name of PIP: First Request for Service to First Psychiatry Appointment		
Dates in Study Period: August 2014 and ongoing		
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 ☐ Not Applicable ☐ Unable to Determine	A multi-disciplinary team comprised of medical staff, analysts, quality management, adult clinical managers, and consumer stakeholders convened for this topic.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? ***Select the category for each PIP:*** *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions *Non-Clinical:* ☒ Process of accessing or delivering care	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP determined that a five week average wait time for the first psychiatric evaluation for medications support services existed. Further examination revealed the referral process was initiated fifteen years prior and was outdated for current service delivery needs.

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