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# FY17–18
# MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

## ALAMEDA MHP FINAL REPORT

Prepared for:

**California Department of Health Care Services (DHCS)**

Review Dates:

**October 31 - November 2, 2017**

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# ALAMEDA MHP SUMMARY OF FINDINGS

Beneficiaries Served in Calendar Year 2016 — 22,481

MHP Threshold Language(s) — Cantonese, Mandarin, Spanish, Vietnamese

MHP Size — Large

MHP Region — Bay Area

MHP Location — Oakland

MHP County Seat — Oakland

## Introduction

Alameda is a large Bay Area mental health plan (MHP), serving a county that is intensely urban, and the seventh most populous in the state. The county has been described as the fourth most diverse in the country, and one of the most diverse in the Bay Area. Oakland is the county seat, and the locus of operation for the MHP. The county is also home to significant higher education resources such as the University of California at Berkeley.

During the FY 2017-2018 (FY17-18) review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

## Access

The In-Home Outreach Team (IHOT) expansion occurred in the summer of 2016, providing engagement services with peer specialists, clinicians and others to seek to divert those who are reluctant to participate in outpatient services, and failing that, are evaluated for Assisted Outpatient Treatment (AOT). An outpatient conservatorship process has been established to support that legal track without requiring the person to be on inpatient status.

The St. Rose telemedicine pilot and the Welfare and Institutions Code (WIC) 5150 certification of staff for the process of involuntary hospitalization, enables emergency department (ED) consumers to be evaluated by a board-certified psychiatrist and treatment initiated without necessitating a transfer to John George Hospital. The ED may now establish a protocol for the WIC 5150 process. This innovation supports greater decentralization of care, and improves workflow for the crisis system.

The Alameda County Care Connect (AC3) Whole Person Care project provides integrated care to those with multiple psychiatric, medical and social needs, and is being supported through the Office of the Medical Director and the use of Plan, Do, Check, Act (PDCA)/Plan, Do, Study, Act (PDSA) processes to address and resolve barriers to care.

The diverse populations that live in Alameda County are met with Culturally and Linguistically Appropriate Services (CLAS), which includes trainings, standards, and annual review by the Network Office to assure compliance. Numerous CLAS initiatives exist, and include substance use disorder focus, African-Americans, Native Americans, Latinos, Asian Pacific Islanders (API), lesbian, gay, bisexual, transgender, questioning, intersex, and two spirit (LGBTQI2S), Afghan and other new immigrants. Efforts to address criminal justice re-entry individuals also exists, with targets of minimum employment levels established by county government.

# Timeliness

The MHP still experiences challenges in tracking all aspects of timeliness with sufficient scope to capture contract providers as well as directly operated programs. For timeliness, the MHP is awaiting the client and services information (CSI) based system under development by the State of California Department of Health Care Services (DHCS). Current timeliness data is limited to direct MHP services and does not include many children's points of access, a very small component of initial contacts, and other metrics, such as initial psychiatry service.

The MHP has discussed and set goals for timeliness metrics in the Quality Improvement Work Plan, but due to lack of data, program enhancements, such as outreach teams, developed with stakeholder input have been the most effective proxy for improving timeliness and access.

# Quality

Turnover in numerous key leadership positions has occurred during this last year, including the resignation of the Behavioral Health Director in December of 2016. That position has been covered on a temporary basis by a number of interim directors, culminating in the recent hire of yet another interim director through the California Institute of Behavioral Health Services (CIBHS). The recruitment and hiring of a permanent director is pending following the hire of a Health Care Services Agency Director.

Numerous other leadership position retirements and changes have occurred, in addition to a reorganization of service divisions. At the Behavioral Health division level, the Child and Young Adult System of Care was created from the merger of Transitional Age Youth (TAY) with the Children's system, and the Adult and Older Adult System of Care (AOASC) resulted from the combining of those previously separate divisions.

While some continuity and institutional knowledge has been retained by the remaining key leadership staff such as the Medical Director and Quality Management Director, the scope of these changes has inevitably impacted departmental vision and planning. A new permanent director is

needed to create, with stakeholders, a vision of the future, and prioritize response to current challenges, and fill the remaining leadership positions.

The MHP has achieved significant improvements in the area of program compliance. The MHP experienced a 90% compliance rate from the DHCS triennial outpatient Mental Health Plan (MHP) consolidated specialty mental health services system review conducted in 2017, an impressive improvement over the prior 62% in 2014. On the chart review component, the service disallowance rate was 16% versus the prior 42%. In October 2017, the inpatient review resulted in preliminary findings of 81% compliance versus the prior 32%. Achievement of this level of improvement indicates a largescale training and monitoring effort was put into place and was very effective.

# Outcomes

The use of the Child and Adolescent Needs and Strengths (CANS) survey and the Adult Needs and Strengths Assessment (ANSA) has been implemented, with more than 11,000 instruments available for aggregate analysis. These instruments are also incorporated in standards for assessment and treatment planning. These instruments reside in Objective Arts software, which is available to both directly operated and contract providers. The MHP has replaced the EMANIO dashboard with Yellowfin to improve system access to data on a variety of parameters and provides quick access to system information.

Improved consumer outcomes are targeted by a number of the engagement approaches already mentioned, as well as the disability benefits advocacy program. The intent is to offer individuals without benefits financial support while navigating the application, and where necessary, appeal process. The interim cash assistance subsidy is associated with decreased re-incarcerations, crisis events, and rehospitalizations. Additionally, the program reduces the financial drain on the public assistance budget of the Social Services Department.

# 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 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 State Medicaid 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.

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 FY17-18 findings of an EQR of the Alameda MHP by the California External Quality Review Organization, Behavioral Health Concepts, Inc. (BHC).

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

## 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. The eight PMs include:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);

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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] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

## Performance Improvement Projects[3]

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 discussed in detail later in this report.

## MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO 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 a review of the MHP's reporting systems and methodologies for calculating PMs.

## Validation of State and County Consumer Satisfaction Surveys

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

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

## 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:

[3] 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.

[4] 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, FY16-17

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

## Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which 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.

### Key Recommendations from FY16-17

**Recommendation #1: Address the collection of all timeliness indicators to include all county and community-based organization (CBO) programs, review performance at least quarterly, and develop immediate corrections when goals are not being met.**

**Status: Partially Met**

- The MHP reports DHCS initiated a committee that focused on the inclusion of timeliness data in the CSI reporting system. The MHP paused its own process to ensure inclusion of the elements that the state is requiring.
- The MHP has identified numerous data elements, business rules and analytic strategies that will be included in future system upgrades. The business rules include outline of workflow processes and guidelines for software development and programming. These will be applied to both directly operated and contract provider services.
- The MHP describes plans to include these elements in the Insyst data system currently in use. During the time of the review, timeliness data elements were added to Clinicians Gateway data entry screens, and a pilot of using resultant data had been initiated.

**Recommendation #2: Engage in a review of the outpatient care continuum to identify gaps and deficiencies. Continue to establish a comprehensive, integrated system offering a seamless continuum of care to seriously mentally ill populations.**

**Status: Met**

- The MHP has engaged in Level III program redesign which is focused on development of an effective network of providers that will meet network adequacy requirements.
- The MHP reports performing a budget and program review to determine gaps and unmet needs as well as unserved populations. It should be noted that feedback during the course of this review continued to identify areas that lack sufficient presence in some of the more distant locales of the county such as robust countywide supportive crisis services.
- The MHP did perform a crisis services redesign that chiefly impacted the more central areas of the county. Review feedback identified recent changes to centralized aspects of crisis response, but did not reflect significant changes in the outlying areas.
- Review participants identified the need for mobile services, beyond the crisis response, that are able to perform home visits and support family with some lengthy supportive session after hours and on weekend. This area does not seem to be addressed by any of the recent changes.

**Recommendation #3: Hire or assign dedicated project management staff or a team (Quality Improvement, clinical, leadership and Information Systems staff) to implement a fully functional electronic health record (EHR) system. Evaluate the staffing, training, and project management needs for the Practice Management and the electronic health record (EHR) implementations to ensure quick and successful outcomes.**

**Status: Partially Met**

- A fully functional EHR has not been implemented in the time following this recommendation.
- The MHP has engaged in conversations with Echo ShareCare Project Staff regarding system features and workflows. While discussions are still occurring, Echo and BHCS have paused ShareCare implementation in order to address the best course to move them forward with a system that best meets the needs of the MHP and stakeholders.

**Recommendation #4: Develop a stakeholder-driven initiative to reduce psychiatric emergency services (PES) disposition waiting time and reduce the use of inpatient administrative days at the John George Psychiatric Hospital.**

**Status: Met**

- The MHP implemented a triage psychiatrist at the John George Pavilion Psychiatric Emergency Service (Crisis Stabilization Unit – CSU). This change ensures individuals who present in crisis see the psychiatrist first and treatment is immediately initiated. There is reportedly a directly linked decrease in wait times. The hope for decreases in inpatient administrative days has not been realized. Increased step-down beds, such as crisis residential treatment programs, which are currently under development, will need to be in place and fully operational before the anticipated admin day reductions occur.

- The MHP has continued to implement expanded CSU, crisis residential, and peer respite resources with the Senate Bill (SB) 82 Mental Wellness Act and other funds, responding to a collaborative stakeholder design effort.

**Recommendation #5: Increase stakeholder input at all levels, including line staff and contract providers. Consider focus groups for the initiatives and appointing champions to working committees, consider the performance improvement projects and the electronic health record implementation.**

**Status: Not Met**

- The MHP identified expansion of leadership teams, assumption of responsibility for outcome measure development, and implementation of policy mandates.

- A PIP is being considered that would improve low penetration rates for Asian Pacific Islander beneficiaries, and promote development of culturally competent services.

- The MHP did not directly identify any input improvement mechanism relating to direct and contract programs.

**Recommendation #6: Develop goals and priorities for the Data Collection, Analysis and Reporting Quality Improvement subcommittee and incorporate into the Quality Improvement (QI) agenda.**

**Status: Partially Met**

- Review of the Quality Improvement Committee (QIC) minutes submitted for this review indicated continued presentation of policy and regulatory information, with no evidence of regular performance data review presenting timeliness or capacity.

- The MHP has hired a data manager (November 2016), and improved PostgreSQL warehouse functionality for data collection.

- Data collection and Management Information Systems (MIS) efforts focused on collection and publishing information on the Special Terms and Conditions of the Medi-Cal SMHS waiver, and the data requirements to support Whole Person Care pilot.

- Regular review of data elements relating to QI objectives benefits the MHP's resource allocation process throughout the year. To the extent that there exist QIC subcommittees, these minutes need to be included for reviews.

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

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

## Access to Care

- The MHP seeks to contract with small providers that are representative of the population served.
- Approximately 85% of all Level 1 and Level 3 direct service programs are operated by community-based organizations, both for-profit and non-profit.
- The IHOT expansion and Laura's Law related programs improve services to those who are reluctant to engage and have frequent jail or inpatient stays.
- The St. Rose telemedicine and 5150 authorization pilot improves the emergency department availability of definitive psychiatric consultation and care, and the ability to perform involuntary holds without requiring law enforcement or immediate transfer to John George Hospital.
- Assisted outpatient treatment increased slots from 25 to 30.
- The Peer Respite Program, the first in Alameda County and located in Hayward, is expected to open in 2018.
- The Access line is utilized for all providers, including county, contracted, and network providers, and all age groups.

## Timeliness of Services

- Current timeliness tracking and data represent a very limited subset of all services and consumers. The MHP suspended improvement efforts in this area until DHCS' CSI based data collection system is rolled out.

## Quality of Care

- The Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) are housed in the Objective Arts data system with direct entry or data uploads occurring by all programs.
- Turnover in the Director and Interim Director positions has occurred, as well as large scale changes of other top leadership positions, significantly impacting system knowledge and decision making.
- The Office of the Medical Director's Integrated Health Care Services is heavily focused on use of data to identify barriers to care. Through multiple channels, the MHP is looking to identify operational policies and developing procedures with the use of PDCA/PDSA cycles that improve access for SMI consumers.
- The data warehouse and Yellowfin analytic tool offer enhanced access to service data, including types, amounts, and demographics of served individuals.
- Trauma Informed Care initiative was started, with a relaunch of the website.
- The MHP is continuing to implement programming that stems from a community stakeholder input process in 2014, and has resulted in numerous program expansions, such as crisis stabilization and residential, as well as expanded mobile crisis services.

## Consumer Outcomes

- The systemwide use of CANS and ANSA instruments provides the MHP with data analysis opportunities to identify effective practices and also establish target areas for improvements. This type of usage has not yet occurred.
- The other instruments used by the MHP are limited to Mental Health Services Act (MHSA) services, and/or are not relevant for determining clinical outcomes or level of care.

# PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following 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 TBS Beneficiaries Served Compared to the 4% 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 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; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

## HIPAA Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). 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 detail on beneficiaries served by race/ethnicity.

**Table 1: Alameda MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity**

| Race/Ethnicity | Average Monthly Unduplicated Medi-Cal Enrollees | % Enrollees | Unduplicated Annual Count of Beneficiaries Served | % Served |
|---|---|---|---|---|
| White | 57,261 | 12.6% | 3,791 | 16.9% |
| Latino/Hispanic | 121,056 | 26.7% | 5,332 | 23.7% |
| African-American | 86,426 | 19.0% | 6,859 | 30.5% |
| Asian/Pacific Islander | 122,664 | 27.0% | 2,239 | 10.0% |
| Native American | 1,314 | 0.3% | 132 | 0.6% |
| Other | 64,991 | 14.3% | 4,128 | 18.4% |
| **Total** | **453,709** | **100%** | **22,481** | **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.

Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

# Penetration Rates and Approved Claim Dollars per Beneficiary

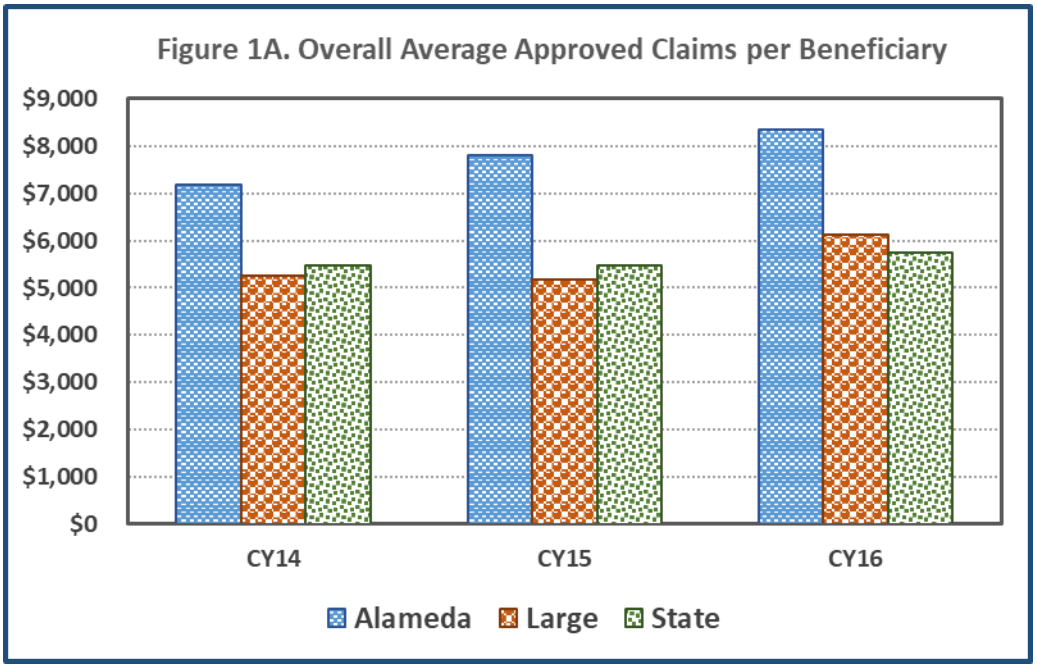
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number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

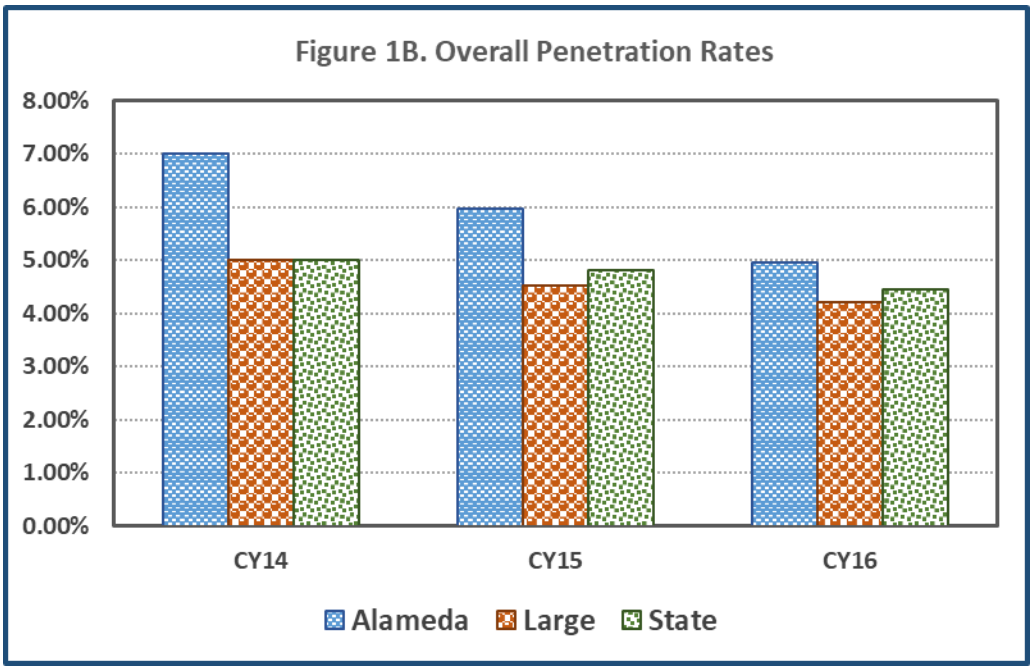
Regarding calculation of penetration rates, the Alameda MHP uses a different method than that used by CalEQRO.

Numerator: Total unduplicated number of Medi-Cal beneficiaries that received a Mental Health Service whether it is an approved or paid claim.

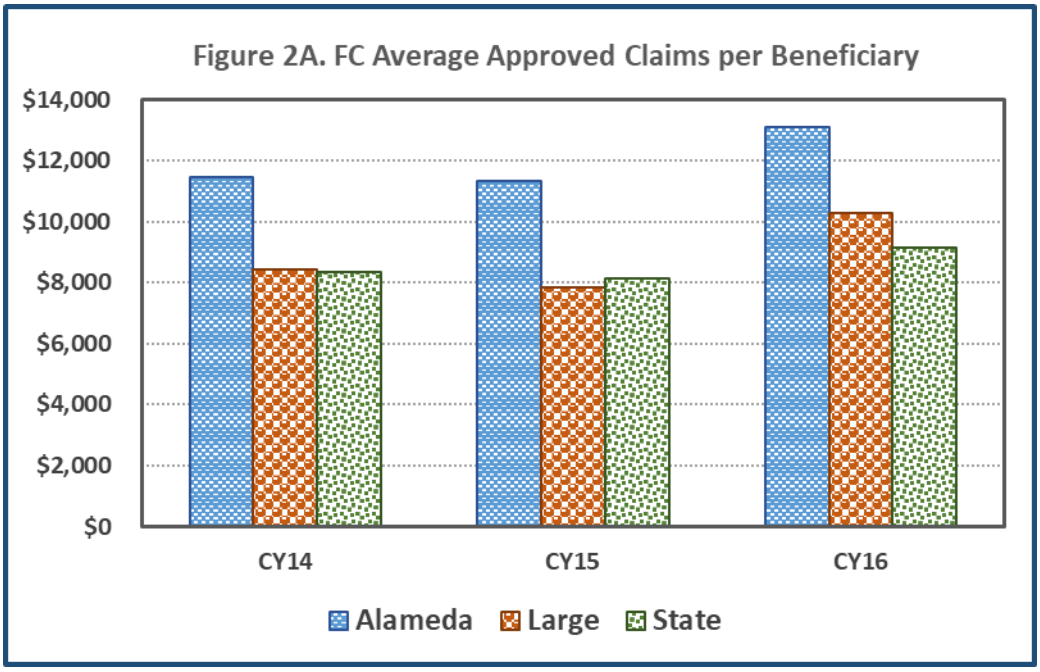
Denominator: Total number of Medi-Cal eligibles.

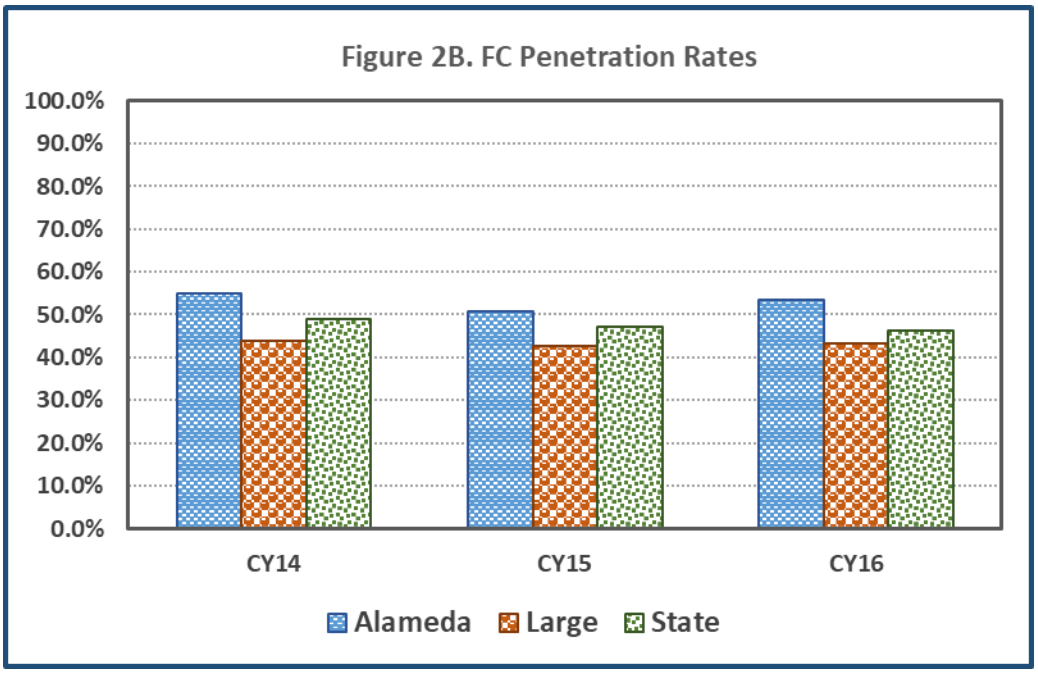
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



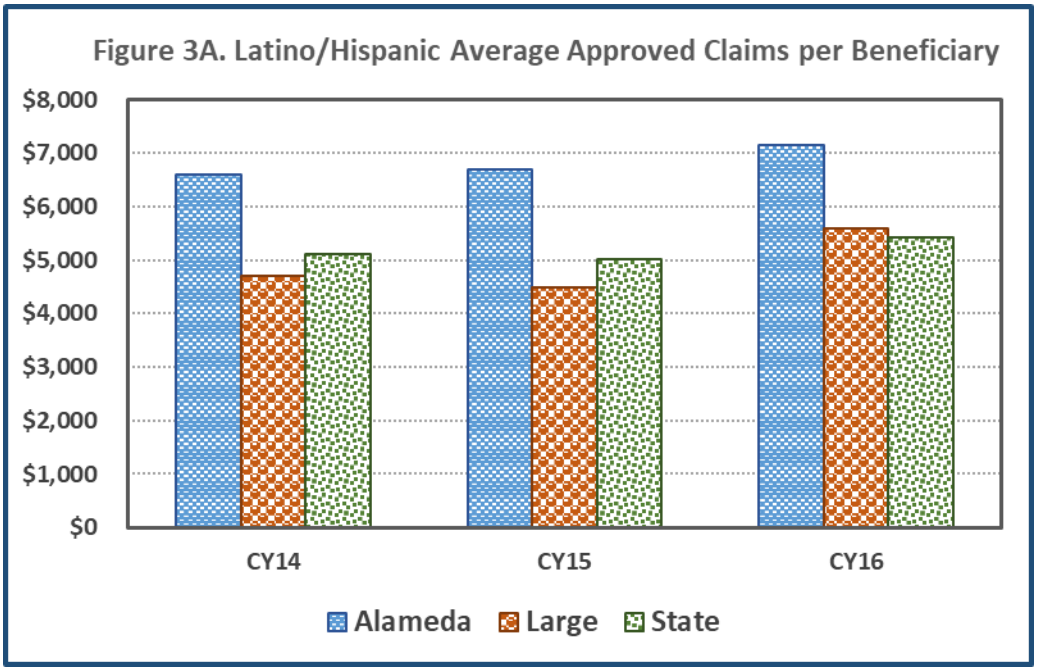



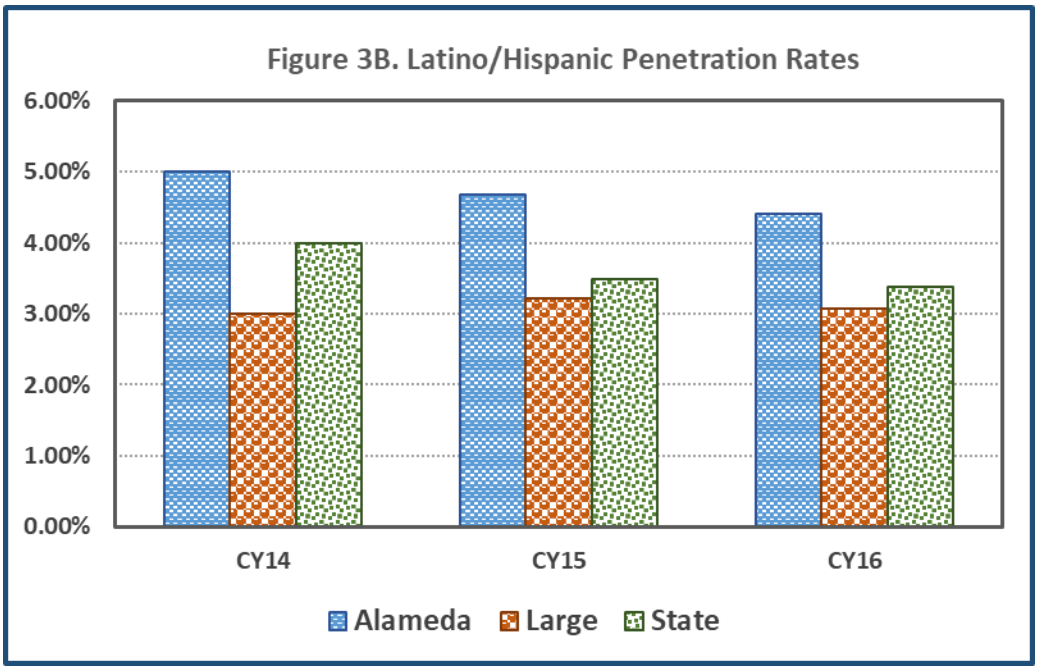
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for large MHPs.



Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/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 for CY16 with the MHP's data for CY16, 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.

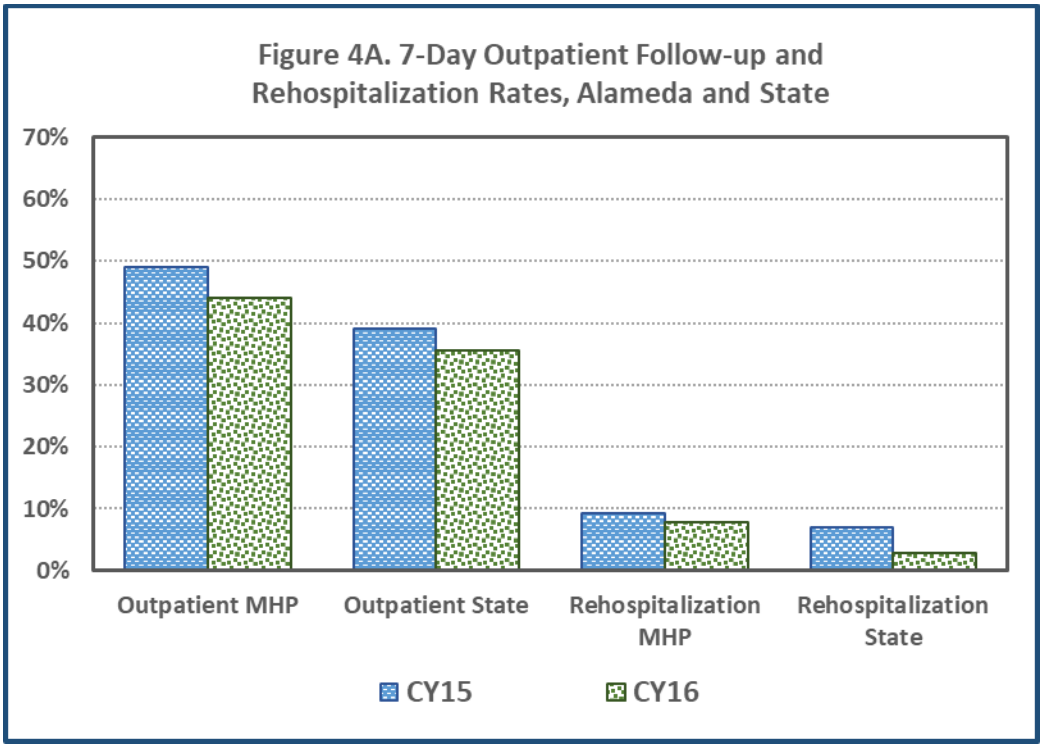
**Table 2: Alameda MHP High-Cost Beneficiaries**

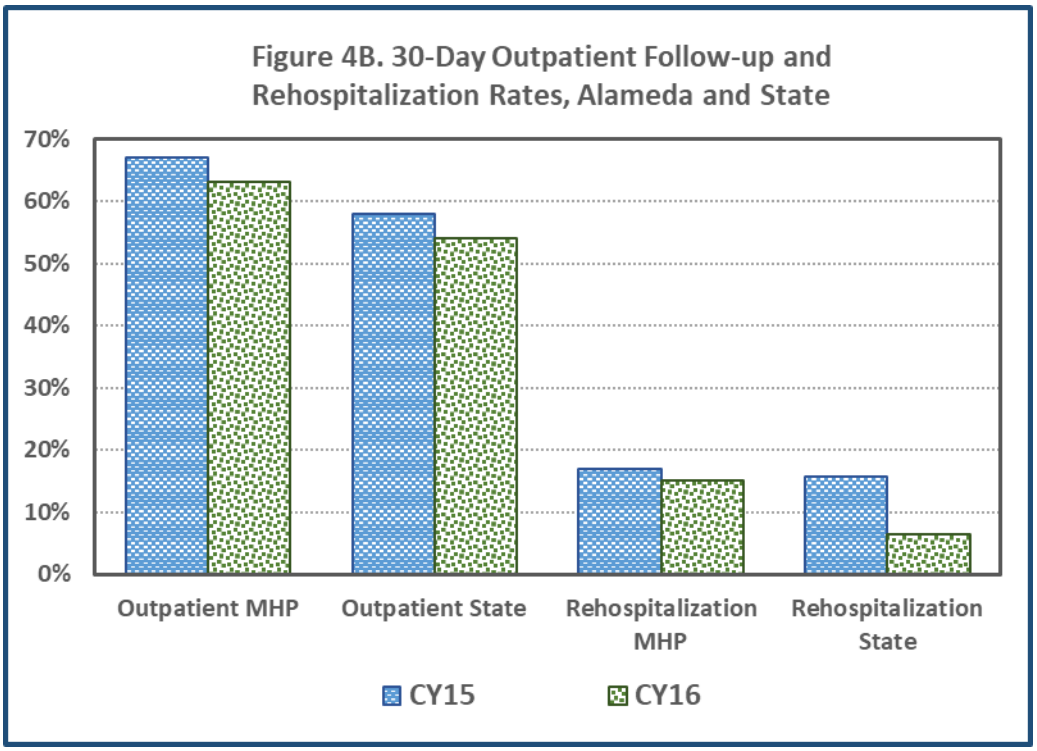
| MHP | Year | HCB Count | Total Beneficiary Count | HCB % by Count | Average Approved Claims per HCB | HCB Total Claims | HCB % by Approved Claims |
|---|---|---|---|---|---|---|---|
| Statewide | CY16 | 19,019 | 609,608 | 3.12% | $53,215 | $1,012,099,960 | 28.90% |
| Alameda | CY16 | 1,357 | 22,481 | 6.04% | $51,865 | $70,381,279 | 37.56% |
| | CY15 | 1,049 | 19,717 | 5.32% | $50,282 | $52,746,331 | 34.26% |
| | CY14 | 1,005 | 22,222 | 4.52% | $49,887 | $50,135,990 | 32.30% |

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

# Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

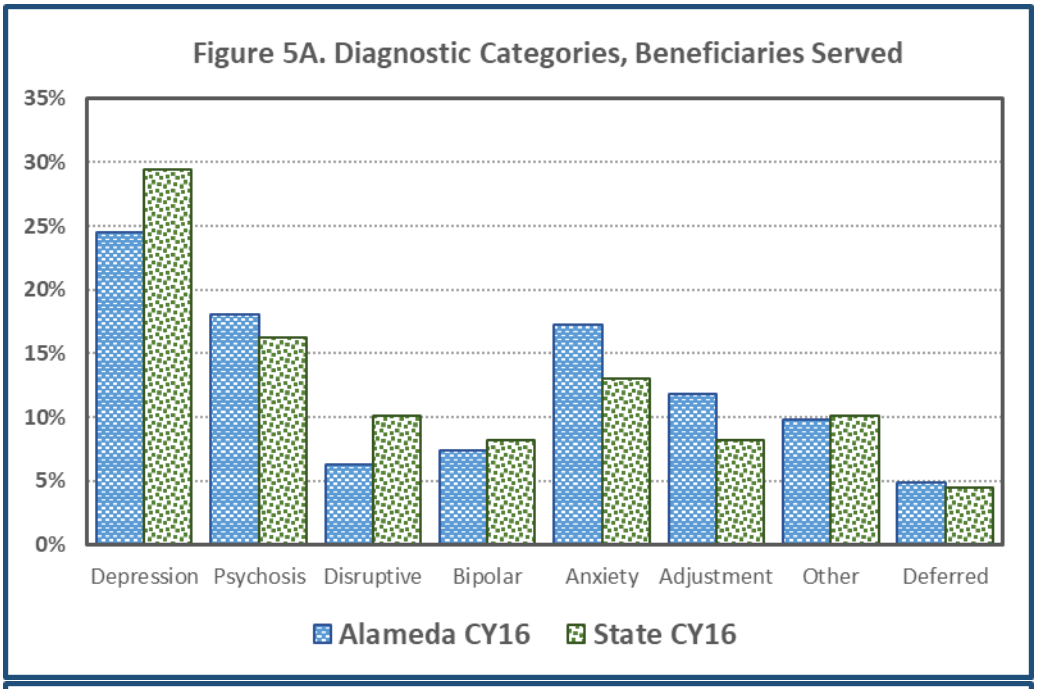


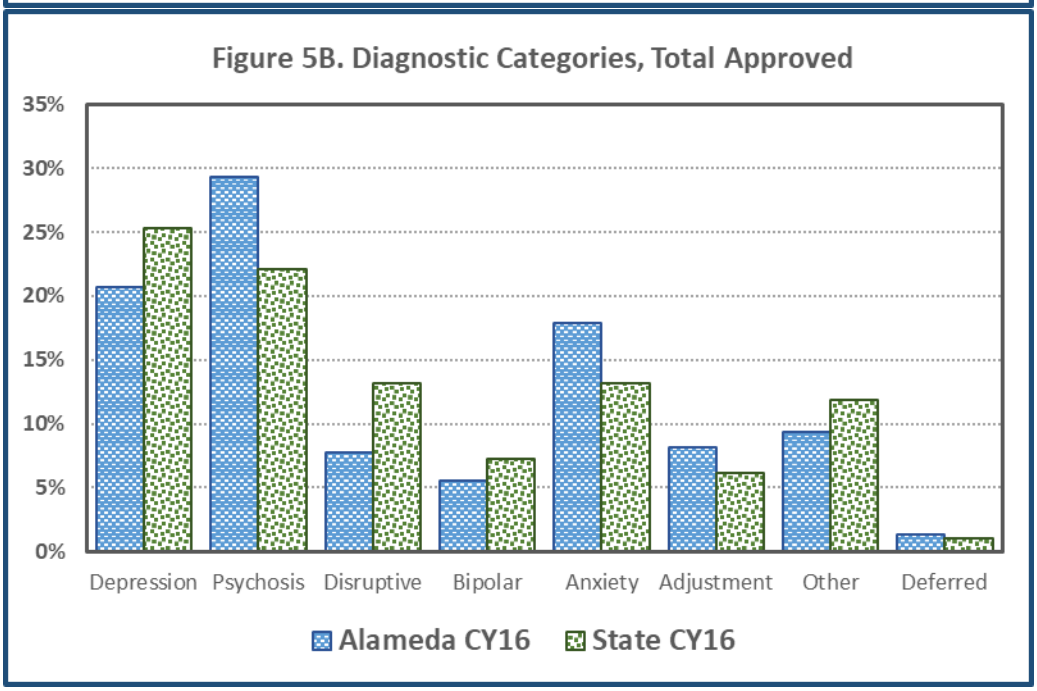



# Diagnostic Categories

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 CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 15.5%.



# Performance Measures Findings—Impact and Implications

## Access to Care

- While the number of eligibles increased from CY15 to CY16, the number of beneficiaries served decreased slightly, resulting in a year over year approximately 1% drop in overall penetration. The MHPs CY16 overall penetration rate was exceeded both large county and statewide averages.
- The MHP's foster care penetration rate was relatively constant from CY14 to CY16. It remains greater than both large county and statewide averages.
- The MHP's Latino/Hispanic penetration rate declined from CY14 through CY16, but remains greater than both large county and statewide averages.

## Timeliness of Services

- In CY16, the MHP's 7-day and 30-day outpatient follow-up rates after discharge from a psychiatric inpatient episode slightly declined from comparable rates in CY15, but remain greater than statewide averages.

## Quality of Care

- The MHP's overall average approved claims per beneficiary increased from CY14 to CY16, and is more than a third greater than both large county and statewide averages.
- The MHP's foster care average approved claims per beneficiary increased from CY15 to CY16. It is approximately a more than large county average and significantly greater than the statewide average in CY16.
- While the MHP's average Latino/Hispanic approved claims per beneficiary increase slightly from CY14 to CY16, and is approximately more than both large county and statewide averages in CY16.
- The MHP had approximately double the percent of high cost beneficiaries (HCBs) receiving more than $30,000 in services compared to the statewide average.
- Consistent with the statewide diagnostic pattern, a primary diagnosis of depressive disorders accounted for the largest percentage of beneficiaries served by the MHP. The MHP had a higher rate of adjustment and anxiety disorders, and lower rates of depressive and disruptive disorders when compared to statewide averages.
- Corresponding with their diagnostic pattern, the MHP's percentage of total approved claims for individuals with psychosis and anxiety disorders was significantly higher than that of the diagnostic category of other.

## Consumer Outcomes

- Both 7-day and 30-day rehospitalization rates dropped slightly from CY15 and are slightly greater compared to corresponding statewide averages.

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

## Alameda MHP PIPs Identified for Validation

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

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

**Table 3: PIPs Submitted by Alameda MHP**

| PIPs for Validation | # of PIPs | PIP Titles |
|---|---|---|
| **Clinical PIP** | 1 | Developing Culturally Informed Quality Psychiatric Protocols for Latinos |
| **Non-clinical PIP** | 1 | High Cost Utilizers |

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *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 4: PIP Validation Review

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

Table 5 provides a summary of the PIP validation review.

| Table 5: PIP Validation Review Summary | | |
|---|---|---|
| **Summary Totals for PIP Validation** | **Clinical PIP** | **Non-clinical PIP** |
| Number Met | NR | NR |
| Number Partially Met | NR | NR |
| Number Not Met | NR | NR |
| Number Applicable (AP)<br>(Maximum = 28 with Sampling; 25 without Sampling) | NR | NR |
| **Overall PIP Rating** ((#Met*2)+(#Partially Met))/(AP*2) | **0%** | **0%** |

## Clinical PIP—Developing Culturally Informed Quality Psychiatric Protocols for Latinos

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

"Does the inclusion of the client's therapist/case manager in psychiatric sessions improve the client experience of psychiatric care for Latinos?"

**Date PIP began:** March 2017

**Status of PIP:** Submission determined not to be a PIP (not rated)

This PIP was presented at the FY15-16 EQR onsite review, and at the time was determined to be "concept only." That review noted an absence of baseline data indicating the existence of a local problem for those who receive psychiatry services without the presence of a culturally informed clinician or case manager, and exclusive reliance upon a very brief literature reference and anecdotal staff observations. That report noted promise of the cited potential indicators, which were mentioned in the data analysis section, and included no-show rates, satisfaction survey scores, consumer increased willingness to raise questions, medication adherence, and accuracy of symptom reporting, and reduced medical errors. Significant guidance was provided at that time by EQRO as how to proceed.

For the current FY16-17 review cycle the sole tracked indicator was no-show rates, for which a 20% baseline was stated (timeframe unspecified) and goal of 15%. It was not clear what the overall no-show rate is for the MHP, and if the 20% was the local metric. Without comparison to a non-Hispanic population, the MHP cannot establish if this represents an atypical rate of the targeted population. The MHP is not able to report overall no-show information in the timeliness

self-assessment it produced for this current review. There was no apparent information considered about the other possible no-show factors such as forgetfulness, transportation or time of appointment which may also contribute. The single intervention of a clinician or case manager supporting consumers in psychiatry sessions was listed with a start date of March 2017.

Approximately six months has passed since the intervention started. The data tables for listing the performance indicator results are blank. There remains no baseline information indicating that in comparison to other populations there is a no-show problem for Hispanic/Latino consumers historically. Also, active PIPs must routinely report out results, usually by month or by quarter.

Looking back, the PIP topic of culturally informed psychiatric protocols is not founded in local data analysis. The thinking, supported by a brief reference to unattributed literature, is that the Hispanic culture may result in less open sharing of information with a person such as the psychiatrist who is in a position of authority due to a cultural attitude towards authority termed 'respeto.' The presence of a bilingual clinician or case manager who knows the consumer and can be a positive force in the session is the improvement activity the MHP is seeking to implement.

Study questions, as well, require formulation in a manner that inform the reader of the extent of improvement that is anticipated, and outline the problem and general intervention strategy. In this instance, the anticipated improvement extent or amount remains limited to no-shows, which are not clearly associated with "respeto" or need for staff sitting in on the session, and it is unclear if there will be movement in subjective (satisfaction) and/or objective indicators (such as: retention, completion of treatment goals, no-shows, etc.).

In establishment of the PIP, the MHP could have also presented no-show data for Caucasians/Whites, or the MHP overall no-shows, which might have served as the basis of identifying a disparity. Additionally, of the four contract providers that have a dedicated focus of serving Latino/Hispanic individuals, the PIP took a narrow focus upon La Clinica-Casa del Sol, a single location this intervention was to be tested, resulting in a much smaller number of included consumers.

In review of this PIP, the MHP also mentions a Patient Feedback Form V2, a seven-question instrument. This and other instruments are mentioned in the MHP's narrative but are not listed with the indicators. These instruments might have had the potential for reflecting some baseline data that could have supported the need for this activity.

In conclusion, this activity does not meet the requirements for a PIP; rather, it serves as more of a practice improvement which focuses on pre/post no-show rates to validate effectiveness. Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool, which is rated for instructional purposes only.

The technical assistance provided to the MHP by CalEQRO consisted of discussion of this PIP and the elements that would have helped in the PIP process. The MHP was encouraged to consult with EQRO early and often during PIP formulations.

# Non-clinical PIP—High Cost Utilizers

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

"Will a decrease in the utilization of High Cost Services and an increase in the utilization of outpatient services improve the functional status and wellbeing of HP beneficiaries?

**Date PIP began:** December 2016

**Status of PIP:** Submission determined not to be a PIP (not rated)

The MHP identified the topic of high cost and high service level consumers and determined a need to understand and improve the use of services. The MHP used the threshold of $49,000 of services in a 12-month period for high-cost consumers. The MHP recognized that some of these individuals were also in highly structured programs, such as state hospitals or institutes for mental disease (IMDs), others were open to intensive outpatient programs such as full-service partnerships. The last grouping (n=31) was those who received high levels of crisis or inpatient services, and were not served by outpatient clinics within 90 days or more. This latter population was the target of the PIP.

From this analysis, the MHP decided to focus on the cohort of high cost consumers (n=31) who were not connected to services, and apply the IHOT team, which included peer specialists and motivational interviewing, to engage with treatment. IHOT is an MHSA service team intended to engage consumers who otherwise fail to follow-up with care, and is associated with a set of program elements that comprise the local Laura's Law continuum of services.

PIPs are expected to have a significant population impact on consumers served. Clearly, there are large numbers of consumers who utilize high levels of intensive care (approximately 448). In this example, the MHP might have sought to simultaneously address both populations, and utilize differing strategies for those who do not engage in outpatient follow-up and another approach for those who do but continue using high levels of services. The number of consumers impacted and breadth and scope of improvement potential would have been much greater.

No information was provided about the IHOT team, outside of team composition, and how it would go about engaging consumers in a replicable way. Research Development Associates (RDA) has been a partner of the MHP for reporting the outcomes of IHOT in tandem with other recent system enhancements. RDA's information was included in a presentation provided at the onsite review, but was not included in the PIP. The data elements RDA reports out do not match the indicators identified in the MHP's PIP.

The use of the IHOT team began July 29, 2016 which means over one year has transpired since inception. No data was reported regarding the indicators listed in the PIP during this review. PIPs require ongoing reporting and analysis of data – usually monthly or quarterly at minimum, so that corrective actions can be taken if outcomes are as expected. Interventions must be described in a replicable manner. In this case, the IHOT team composition is described but nothing is mentioned about how it operates or what it does that is unique.

As written and presented, this current activity does not constitute a PIP.

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 onsite general discussions about PIP requirements, and efforts to understand the MHP PIP document. The MHP was advised to consult early and often with EQRO.

# PIP Findings—Impact and Implications

## Access to Care

- The IHOT concept offers sustained engagement efforts with individuals who either do not wish to accept services or have difficulties with follow through.

## Timeliness of Services

- Current PIPs do not directly impact timeliness of care.

## Quality of Care

- Provision of a culturally informed, knowledgeable clinician or case manager to support Hispanic/Latino consumers when receiving psychiatry services may improve results and other metrics of care, such as engagement, retention and accuracy of medical decisions.

## Consumer Outcomes

- The IHOT served consumers have the potential for achieving the positive outcomes of treatment and engagement with services, with stabilization of symptoms and attainment of housing.

# 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 an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

## Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

**Table 6: Access to Care Components**

| Component | | Quality Rating |
|---|---|---|
| 1A | Service accessibility and availability are reflective of cultural competence principles and practices | PM |
| The MHP continues to pursue meeting of the needs of the ethnic, cultural and other diverse populations which constitute Alameda County, using CLAS standards, including African-American, Latino, Asian, TAY, LGBTQI2S, and others. This includes specific initiatives to reach and serve these populations, and training for staff, followed by monitoring of programs. Contracting with small programs that serve specific cultural groups is part of the MHP's operating principles. The CLAS approach is imbedded in all aspects of system planning. Each year, a distinct cultural/ethnic group and their needs is brought into specific focus for improvement attention.<br><br>Currently, the largest single eligible population is the Asian, Pacific Islanders (API), which also experiences low and continuing to decline penetration rates. The MHP is contemplating targeting the API lower penetration rates with a PIP.<br><br>The MHP bases allocation of services on a value system, including social determinants. Whole Person Care is one aspect of this perspective, as are family partners and advocates special projects. | | |
| 1B | Manages and adapts its capacity to meet consumer service needs | M |

Continuing from the prior review is the focus on high-end services, and involved the crisis stabilization unit at John George Hospital. Psychiatry services were increased by 20 hours and moved to the point of entry, resulting in quicker treatment, fewer long-stay consumers and more effective care. Consumers are greeted by peer staff immediately. Staffing is more stable, and the ability to flex and to match staffing with census was created. CSU census, the focus of media reports in recent years, is down from 50-70 consumers each day to 30 on average.

Other actions by the MHP focused specifically on those who are not open to outpatient care and tend to exclusively receive services in the crisis or inpatient environment. A number of programs/teams that blend consumer-employees and licensed clinical staff are focused on helping individuals connect with services. In summer of 2016, an array of Assembly Bill (AB) 1421 funded services were launched, including the In-Home Outreach Teams to follow-up those who are not engaged in outpatient care at the time of CSU intake and are potential candidates for assisted outpatient treatment (AOT), and also outpatient conservatorship – a full continuum of care for the high-risk and difficult to engage population. Other innovative additions include the first Peer Respite Program in the county, in Hayward, with anticipated opening in 2018.

The St. Rose telemedicine pilot and authorization of staff to write 5150s has improved capacity to serve the highly acute individual outside of the crisis stabilization specialty. Broader expansion of individuals authorized to write 5150s was recommended in prior reviews and is an area the MHP should consider expanding.

The majority of children entering the child welfare system receive a mental health screening. Children removed from homes go through the assessment center, on the way to placement, which takes less than 23 hours. Those transitioning through the assessment center receive a minimum of 30 days of mental health services. Tracking remains an informal and imperfect process. There is monthly batching of data by child welfare, which is then sent to the MHP and compared to their records. The capacity exists to serve more than 70 children/youth.

Alameda places 40-45% of Katie A. subclass members out of county. One contract provider delivers ICC and IHBS within a 50-mile radius of Stockton. The MHP uses client satisfaction surveys to determine fidelity to the core practice model. The MHP has recently implemented full use of the CANS to determine clinical changes. Locally, a court order enabled data sharing between child welfare and mental health, resolving that potential barrier.

| | | |
|---|---|---|
| 1C | Integration and/or collaboration with community-based services to improve access | M |

With over 80% of all services delivered by contract organizational providers, community collaboration is part of the MHP's operating principles, with significant administrative resources devoted to working with contractors and provision of support and monitoring. This includes integration with physical health care, such as the Alameda County Care Connect program that strives to serve individuals with multiple health systems and social problems. Specialized programs serving Hispanic/Latino populations, TAY, LGBTQ12S and older adults exist, as well as the higher-level crisis stabilization and residential programs, are often contracted with partners such as Telecare Corporation and others. A recent area tax increase will produce more

housing, and involve the MHP in assisting consumers to obtain and retain housing, continuing its collaboration with local HUD funding and projects for low-income housing.

As a behavioral health department, which delivers both substance use and mental health services, the MHP has submitted a Substance Use Disorder- Organized Delivery Service (SUD-ODS) waiver. Expansion of services in this area and the requirements of the waiver will result in greater coordination between the two service areas. Already the department created a blended QI Work Plan that included both MHP and Drug Medi-Cal (DMC)-ODS quality elements. The Access Line is intended to handle both mental health and SUD requests. Increased involvement with SUD contracts, training, and oversight are occurring. The MHP has also created a unified QI Work Plan for both SUD and mental health quality issues.

The MHP's collaboration with law enforcement includes the crisis response teams, that involved mental health staff paired with law enforcement. Extensive contracts with area children's services includes contract providers that also serve school districts.

## Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

**Table 7: Timeliness of Services Components**

| Component | | Quality Rating |
|---|---|---|
| 2A | Tracks and trends access data from initial contact to first appointment | PM |

The MHP tracks the data from first request to first clinical assessment kept appointment.

A 14-day standard is utilized, with a mean of 16.6 days for adults and 20 days for children and youth. Achievement of standard ranged from 63.6% for adults and 55% for children and youth.

This data is limited to approximately 3,000 individuals or 9% of all requests, and only those wherein the Access Center is first contacted, which includes directly operated programs, and level III network providers that are authorized by Access. These providers represent approximately 15% of the direct units of service claimed to Medi-Cal for reimbursement.

The MHP has paused improvement efforts in this area pending the implementation of the timeliness tracking under development by DHCS, utilizing the CSI data collection system.

Staff that serve the adult population found it challenging to understand the concept of initial timeliness. They believe the capacity exists to see consumers immediately, but the barrier is

| | | |
|---|---|---|
| that the consumers often lack motivation to utilize services. This area would be a good opportunity to imbed consumer-employees to assist with outreach and engagement in all adult programs. | | |
| 2B | Tracks and trends access data from initial contact to first psychiatric appointment | PM |
| The MHP utilizes a 14-day standard for initial psychiatry service access, with means of 25.3 days for adults and 23.9 days for children and youth. Achievement of standard occurs 32.2% for adults, and 41.0% for children and youth.<br><br>The limitations of this dataset match those for initial access. Significant work is required for this information to provide meaningful analysis of system capacity and protocols.<br><br>The relatively low achievement of standard seems to make this area a potential target for improvement activities, perhaps even a PIP.<br><br>The anecdotal reporting of participants serving adults focused on the frequent limitations in prescription quantity for those discharged from hospital care. Often the consumer receives a paper prescription and has no way to pay for medications. | | |
| 2C | Tracks and trends access data for timely appointments for urgent conditions | NM |
| The MHP is not currently able to track the identification of urgent care service need, nor the provision of same. This topic was an objective in the FY16-17 QI Work Plan. | | |
| 2D | Tracks and trends timely access to follow-up appointments after hospitalization | PM |
| The MHP utilizes the HEDIS 7-day post-hospital follow-up standard, with data on 3903 total events, and aftercare timeliness with a mean of 6.5 days for adults and 5.2 days for children and youth.<br><br>Data for adults reflects achievement of standard rates of 27.5% for adults, and 82% for children and youth.<br><br>The high achievement rate for children and youth may reflect the support of parents and caregivers in follow-up activities.<br><br>Conversely, the low achievement of standard with adults should receive some investigatory attention to determine the extent that these numbers may include outliers where MHP follow-up would not be indicated nor required versus those events that reflect follow-up failures.<br><br>The MHP did identify this area in its prior FY16-17 QI Work Plan, targeting both 7- and 30-day follow-up periods for improvement. | | |
| 2E | Tracks and trends data on rehospitalizations | M |

| | | |
|---|---|---|
| The MHP data regarding readmissions within 30 days reflects 7.1% for adults and 7.5% for children and youth. This represents a significant decrease in both readmission rates from the prior year. Total readmission events are 277. | | |
| 2F | Tracks and trends no-shows | NM |
| The MHP is currently unable to track and report no-show rates. | | |

## Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

**Table 8: Quality of Care Components**

| Component | | Quality Rating |
|---|---|---|
| 3A | Quality management and performance improvement are organizational priorities | NM |
| The MHP does not yet have an FY17-18 finalized and approved QI Work Plan. This element is required to achieve a rating of Met or Partially Met. The EQR process allows for a three-month window following the end of the previous fiscal year for new plan to be generated.<br><br>The prior FY16-17 QI Work Plan contained objectives for post-hospital 7- and 30-day post-hospital discharge follow-up; 30-day readmission rates; non-urgent client follow-up; Access Line response time; semi-annual client satisfaction surveys; client grievance and appeal process satisfaction.<br><br>The submitted QIC minutes reflect regular meetings and robust participation. The minutes chiefly discussed policy changes and large scope initiatives, with very infrequent and limited review of quantifiable QI objectives. No review of any of the timeliness elements was evident. The MHP might wish to ensure that all objectives receive regular review of relevant data throughout the year, particularly those involving dynamic elements.<br><br>The requirement for two active PIPs is a key element of MHP expectations. The submitted PIPs were determined not to be PIPs, and had not received sufficient corrective attention to be scored | | |

| Table 8: Quality of Care Components | |
|---|---|
| **Component** | **Quality Rating** |

for this cycle. The PIPs lacked key problem/topic establishing data. The scope of impact for the proposed activities was extremely limited in scale. Going forward, the MHP was advised to consult with EQRO early and often in the process of PIP topic formulation and development.

During the review, stakeholders expressed appreciation about the leadership of the quality management division, and their willingness to undertake update of the outdated Quality Assurance (QA) manual. That update is but one step needed in the process, which requires a ground up process, incorporating the input of line staff and program supervisors. Streamlining and reduction of paperwork and merging documentation to reduce duplication of efforts is paramount to efficiency and prevention of staff burnout due to documentation fatigue.

The topic of overly complex documentation and institution of requirements that stakeholders believe are excessive arose in almost all sessions. Duplication of key data elements is a chronic frustration, one example being manual entry of consumer name and case number in a multitude of forms exists in a system that most believe should be automated and computer-based. Participants cited examples of colleagues resigning and going to work for competing organizations chiefly because of the excessive and redundant paperwork, and an environment that seems to add requirements continually without observable efforts to merge and streamline.

Within the compliance area, participants from different sessions universally identified problems with the identification of compliance resource individuals, which are assigned to the legal entity. Each program needs to have a specific MHP compliance contact so that communication can occur at a direct level and not flow through multiple levels, as occurs when compliance links to the overall corporate level instead of the program. Lacking direct connection with compliance, messages that arrive are often contradicted by subsequent information.

Review participants identified concerns about the increasing level of violent and criminal history within the served population. The presentation and content of risk assessment varies greatly among providers, and a uniform system format and process is needed so that adequate safety precautions can be taken when serving those with a violent history. This information also needs to be strategically placed in a highly visible location, and include recommendations for how best to serve the specific individual. For example, clinicians cite the risks associated with being unable to quickly distinguish between an individual identified with a history of violence who has previously attacked others with weapons from one who has merely shoved others.

With the extensive changes in management staff and organizational structure, the MHP would be well-served by creating a mechanism to obtain input and feedback from line staff and supervisors of all programs - contract as well as directly operated. This could occur through focus groups or periodic software surveys.

| Table 8: Quality of Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| It is important to note that the review feedback was extremely broad-based, and uniform as to topics identified, and including all disciplines – from psychiatry to case managers; from directly operated programs to contract providers.<br><br>The majority of sessions conducted for this review identified the need for the entire system to be connected electronically, through a robust and functional EHR that eliminates redundancy and operates on a fast, stable network. The current system does not capture adequate information to coordinate care across the system, nor to share critical documentation. Despite small improvements that have occurred, the challenges are experienced as outnumbering the successes. | | |
| 3B | Data are used to inform management and guide decisions | M |
| The MHP has established a data warehouse that has successfully linked a multitude of resources and utilizes the reporting function using Yellowfin, a business intelligence product. Throughout many of the review sessions, MHP staff were able to pull up relevant system data that would serve to answer questions about services and programs. This information is widely available and utilized by a variety of units, including Decision Support and others.<br><br>While data reporting on existing service elements is helpful and IS staff credited with being responsive. The system itself is considered inadequate for clinical operations. | | |
| 3C | Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation | NM |
| The review sessions identified numerous communication mechanisms, ranging from emails, website postings, to direct communication at staff meetings. Participants identified a categorization system need that distinguishes informational material from the required, must-see notices. The website contains a confusing blend of information which must be sorted by the end user. Operating in the midst of a technologic development area, participants do not understand why the web information is presented in such a dated format.<br><br>From an outside user perspective, the website is focused on crisis needs and the access line. As mentioned in the prior review, the website remains in English only, which is concerning due to the diversity of languages that are present in the county.<br><br>Comprehensive website updates, as often seen in other counties, may be restrained by the position of the MHP as a division within the Health Care Services Agency and resulting in a need for design changes to be uniform across the agency. It also does not present any helpful visual graphics of or map program locations, such as a consumer of family member might wish to use when looking for a clinic that is most convenient. As self-directed searching for services and | | |

| Table 8: Quality of Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| products is becoming common, the MHP should consider improving the presentation of available programs.<br><br>For instructional purposes, the Quality Assurance Manual and compliance updates needs to furnish examples that are formulated to the various populations and levels of care served. Participants mentioned the reluctance of compliance to provide examples in response to questions, and often simply restate the rules.<br><br>The need for an information officer was identified during a number of review sessions. This requires a clinically knowledgeable skilled communicator, who develops a structure for internal and external communications, and would be accessible to make changes with input, but would create a uniform communication template.<br><br>System design needs new initiatives to be reviewed by supervisors and line staff for implementation and design fine tuning, using staff from like programs to provide feedback before decisions on implementation are set.<br><br>This topic emerged as a problem area in the previous review. | | |
| 3D | Evidence of a systematic clinical continuum of care | M |
| The MHP possesses the full spectrum of services and is in the process of adding adult consumer respite care. The last few years have seen significant additions and improvements to the higher-level services, including crisis, crisis stabilization and residential, and small program, IHOT.<br><br>The MHP has also made operational changes to services, such increasing the psychiatry resources as the CSU and moving the psychiatry interventions to the point of admission. Another innovative change was telepsychiatry service at the St. Rose hospital ED, and 5150 certification of the physicians. These strategies have improved both timeliness and quality of care for consumers who present to those locations.<br><br>Areas within the continuum of care that were identified as needing greater attention and resources include the countywide availability of robust mobile crisis response. In the more rural areas mobile crisis response is not timely. There also exists a need for sub-crisis response, which was suggested to ideally include on-call services by the program serving the consumer, or subacute program that, like therapeutic behavioral services are able to provide immediately and flexible intensive in-home support.<br><br>The MHP has yet to develop data that would broadly measure and monitor consumer engagement with treatment planning and care. | | |

| Table 8: Quality of Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| The implementation was completed for the CANS and ANSA instruments, with data analysis has yet to be started. | | |
| 3E | Evidence of consumer and family member employment in key roles throughout the system | PM |
| The MHP has consumer and family members with a significant presence particularly within contract agencies (approaching 200). To the extent there exists a career ladder, most of these opportunities exist within contractors. A recent reorganization moved the top consumer-employees and representative of the consumers voice to a position that is experienced as significantly minimized, demoting their voice in planning.<br><br>The Pool Of Consumer Champions (POCC) still numbers some 1500 strong. POCC began in 2007, and functions to ensure the voice of consumers and family are heard within the system. There had been a direct connection between them and the consumers associated with the leadership team, but members now believe this has diminished since the loss of two key employees who had been at the leadership/management level. Consumers are called in less frequently for meetings, and feel distanced from the organization.<br><br>In the aspect of employment, it does appear that most new program initiatives include individuals with lived experience, from the IHOT programs to health care integration of the AC3 program.<br><br>This MHP historically has been viewed as one of the early adopters of the consumer empowerment movement, and the recent changes are experienced as steps backwards. MHP leadership would be well advised to meet with peer employees and hear their concerns, as well establish a mechanism that predictably obtains their feedback.<br><br>An area the MHP might benefit from exploring is the broader inclusion of peer employees in the directly operated adult outpatient programs, where their unique contribution can be of help with issues related to engagement and follow-up an area that was identified as a challenge by adult clinic staff.<br><br>While the MHP has programs to support tuition reimbursement and higher education, the specific needs and wishes of consumer-employees who would like to receive support in matriculating from undergraduate through pursuit of an advanced degree deserves investigation. While this may not be possible to provide to everyone, establishing a merit-based approach would be seen as acknowledging and supporting their unique contributions and encouraging them to go further, including obtaining professional degrees. | | |

| Table 8: Quality of Care Components | | |
|---|---|---|
| **Component** | | **Quality Rating** |
| Career ladder formulation, specific to consumer-family employees, appears to be within contract organizational providers. The MHP itself, through directly hired positions, does not offer a formal career ladder. | | |
| 3F | Consumer run and/or consumer driven programs exist to enhance wellness and recovery | M |
| The MHP's Berkeley transitional age youth wellness center will be opening in early 2018, which will be the sixth wellness center in the county. Casa Ubuntu Creative Wellness Center serves the East Oakland area, and was created to meet a specific community need.<br><br>The Wellness Centers are open during regular business hours, with some offering limited weekend operations. Peer-driven orientation of wellness and recovery services is offered by these sites, with the inclusion of activity-focused programming as well. There are no barriers to participation in these programs.<br><br>Wellness and Recovery Action Plans (WRAP) are an element of wellness center programs. | | |
| 3G | Measures clinical and/or functional outcomes of consumers served | PM |
| The MHP adopted the CANS for all children and youth served, with updates every six months and has completed implementation of the ANSA. Approximately 11,000 sets of administration data that is available for aggregate analysis. Both instruments are housed in the Objective Arts software, and in some cases providers report duplicate entry efforts occur in the process of collecting the survey information.<br><br>Regular and ongoing aggregate analysis of this information does not yet occur, and may provide very useful information for evaluating and planning service delivery.<br><br>Other instruments include the MHSA Key Event Tracking, and Partnership Assessment Form. The Community Function Evaluation is also utilized. These instruments are limited to MHSA programming. | | |
| 3H | Utilizes information from Consumer Satisfaction Surveys | M |
| The MHP provided the results of the consumer perception survey for this review. The FY16-17 QI Work Plan included items that focused on the collection, analysis and distribution of findings from consumer satisfaction surveys. The MHP expressed its intent to develop an internal consumer survey of satisfaction. They plan on reporting out based on continuum of care sector.<br><br>For this current review period, no specific deficits were identified which merit focused attention. | | |

# Key Components Findings—Impact and Implications

## Access to Care

- Improvements in services to the higher acuity consumers is evident in the current review. Particularly notable are efforts to improve the crisis stabilization and the crisis continuum. Mobile crisis team enhancements have also occurred.
- Services to those who have historically received only acute or emergency care have been bolstered with the Laura's Law enhancements that identify, link, and provide alternate opportunities for engagement. The development of an outpatient conservatorship model is an innovation that better serves the consumer while not using acute beds as a holding facility for this process.
- The MHP is aware of the high prevalence of API consumers, and their relatively low penetration rates, which it plans to address with a PIP.
- The Alameda County Care Connect (AC3) and other health integration activities such as the consultation services of psychiatrists with primary care have continued to provide improved integration, improved the ability of primary care to serve mental health conditions, and capacity to serve consumers.

## Timeliness of Services

- The MHP continues limited reporting on timeliness, which should improve for some elements with the roll-out of the CSI-based tracking system. With the limited tracking available, there are challenges in meeting the local 14-day initial access standard.
- Initial psychiatry access follows a similar pattern of limited data and challenges meeting local standard.
- The MHP's reporting and analysis of tracking of all timeliness elements is quite limited due to the limited data set current available. Consumer focus group reporting, albeit limited, did indicate reasonable access experiences by those consumers.
- The lack of no-show information reflects the need for a robust data system that can include scheduler information. For those CBOs that use a comprehensive system of their own, submission of no-show information is an important element for the MHP to be able to access and incorporate in the overall evaluation of quality.
- Information from focus consumer focus groups indicated there was good satisfaction with timeliness of initial and first psychiatric services. Reports from clinical line staff indicated challenges were related to consumers' attendance at the initial and first appointments and the challenge was not related to capacity issues.

## Quality of Care

- The MHP was not able to present an updated and approved QI Work Plan for FY17-18 by the time of this review. The prior work plan has been modified to include DMC-ODS waiver quality elements. The FY16-17 did include numerous tracked elements, such as 7-day and 30-day readmission rates, non-urgent care follow-up, Access Line response time, and others.

- QIC minutes reflect robust participation. The content focus tends to be upon broad initiative or policy changes, often relating to regulation changes. The MHP should consider ongoing review of data throughout the year for those quantifiable indicators.

- The requirement of two active PIPs remains an area in which the MHP continues to struggle. The PIPs lacked key establishing information, specifically local data. Neither PIP addressed the need for required data reporting on indicators is throughout and not only at the end of the project. The MHP needs to consult with the EQRO early and often in PIP development. The MHP also needs to establish internal capacity to provide guidance to the PIP team, in both concepts and development throughout the process.

- The MHP needs to renew efforts to obtain broad consumer and family member input about the recent organizational changes, and their level of inclusion in planning. Consumers report recently feeling excluded and lacking a voice within the MHP. There are also issues regarding the extent to which the MHP supports continued education that would merit examination and discussion.

- The function and communication processes of compliance merit close examination, with the inclusion of program supervisors and line staff. At the highest level, compliance and documentation requirements are experienced as duplicative, time-consuming, and excessive. The MHP would benefit from an initiative that seeks, to where possible, to merge documents and requirements and use electronic forms that reduce duplication of essential consumer information, with an end goal of the reduction of excessive complexity and streamlined processes.

## Consumer Outcomes

- With the implementation of the CANS and ANSA instruments for data collection completed, the MHP would benefit from developing concepts for how this information will be utilized in aggregate for level of care discussions within the programs.

- The desire of consumer-employees to have a greater voice, and to receive supports for further education up to and include attainment of professional degrees reflects the optimism these recovering consumers possess and their assertiveness in asking the MHP to support them.

# CONSUMER AND FAMILY MEMBER FOCUS GROUPS

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 with 8 to 10 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

## Consumer/Family Member Focus Group 1

CalEQRO requested a culturally diverse group of adult beneficiaries the majority of whom are clients who initiated and have utilized services within the past 12 months. The focus group consisted of a culturally diverse group of adult beneficiaries who utilized services at the Jay Mahler Recovery Center. The focus group was held at the Jay Mahler Recovery Center, 15430 Foothill Way, San Leandro, CA 94578.

**Number of participants: 7**

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

- Initial assessments and therapy appointments are provided in a timely manner, from one day to a few weeks, and follow-up appointments with a therapist occur from three times a week to not at all.
- Initial psychiatric appointments occur within a week or two. However there were concerns about accessibility of follow-up appointments.

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

- As a short-stay inpatient setting, focus group topics tend to be superficial, and do not necessarily align with individual consumer needs and issues each day.
- A few participants reported that the staff work hard, teach them about wellness, and help them with their recovery.
- Other participants reported that the staff is sometimes reactive and conforming to protocol rather than to the individual needs and behaviors of the clients,

misinterpreting behavior and responding in a punitive manner. They also reported feeling unsafe at times, and witnessing altercations where the sheriff had to be called in.

- A few participants reported having case managers from various out-patient programs who assisted them with their housing, medical, mental health and recovery needs.
- While a couple of participants knew of a crisis number to call, the majority reported using a local emergency room or calling 911 when they needed help in a crisis situation.
- None of the participants were familiar with the concept of a wellness center, or used these services.

Recommendations for improving care included the following:

- The language used in some of the information is beyond the level of comprehension of consumers, and it needs to be simplified. In addition, verbal communication needs to be more basic, checking in with clients to ensure they understand.
- The depth and breadth of focus group topics needs to be expanded, and presented in more creative and accessible ways, such as those used by interns who tend to be more interactive and innovative.
- The food needs to be improved in this in-patient setting.
- Fresh-air breaks are really helpful for this in-patient setting, and need to be extended for longer periods of time, particularly in the afternoons.

Interpreter used for focus group 1: No

## Consumer/Family Member Focus Group 2

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth, the majority of whom initiated and have utilized services within the past 12 months. The group consisted of a diverse group of parents of children who receive services from the MHP. The focus group was held at the Oakland Children's Services at Eastmont, 7200 Bancroft Ave., Suite 125, Oakland, CA.

**Number of participants: 5**

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

- Initial assessments and therapy appointments are provided in a timely manner, from a few days to a few weeks, and follow-up appointments with a therapist occur weekly.
- Initial psychiatric appointments occurred within one to three weeks, and access to follow-up appointments was mixed with some receiving regular care, and others not. It

was felt that access to the psychiatrist was controlled by the therapists who the parents may or may not have agreed with on the level of care needed for their child.

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

- Participants felt that the quality of therapeutic services was very good, and that their children were improving.
- Group therapy was offered to half of the participants, and case management was available to all of them. Services were accessible in both English and Spanish.
- Participants all reported the lack of staff availability after hours to assist with de-escalation and immediate support from a resource that is familiar with their child's case and who their child knows and trusts. Rather, emergency response escalates quickly with the police, and children are taken to the hospital where they are restrained both physically and chemically. Parents often do not know the disposition of their children for hours, and report that it is very difficult to get information.
- No support groups, activities nor events for socialization and behavioral skills building are available for children and their families.
- Staff are focused on productivity and lengths of stay, rather than individualized care and treatment. This is difficult for parents of severely ill children who need long term assistance and should not be subjected to time limited treatment. In addition, the lack of an exit plan with no step-down to a lower level of care leaves parents and children in limbo as children often decompensate after leaving treatment without additional supports in place.

Recommendations for improving care included the following:

- Staff should be available for after-hours support.
- Therapists should collaborate with school staff in concert with parents, to provide comprehensive care.
- Children should be allowed to remain in therapy for longer, as graduating and moving through various therapists, providers and programs interrupts the therapeutic process and slows long term progress.
- An exit plan needs to be developed for all children who are leaving service after completing their treatment goals.

Interpreter used for focus group 2: Yes Language: Spanish

# Consumer/Family Member Focus Group Findings—Implications

## Access to Care

- Having staff available for continuity of care in crisis situations that occur after hours would be helpful, and does not currently exist.
- Parents and adult consumers reported not having open access to a psychiatrist, but rather had to go through gatekeepers who may or may not agree with their verbalized need for services.
- Participants recommended that severely ill children should be allowed to remain in therapy for the long term, as graduating and moving through various therapists, providers and programs interrupts the therapeutic process and slows long term progress.

## Timeliness of Services

- Initial assessments and follow-up therapy appointments are provided in a timely manner.
- Initial psychiatric appointments occurred in a timely manner, and access to follow-up appointments was mixed.

## Quality of Care

- Participants felt that the quality of therapeutic services was very good, and that they, or their children, were improving.
- Police involvement with children and adult consumers result in additional trauma and interferes with building a therapeutic alliance with both parents, family members and clinical staff.

## Consumer Outcomes

- Continuity of care for children in crisis situations is needed to improve consumer outcomes.

# INFORMATION SYSTEMS REVIEW

Understanding an MHP's information system's capabilities 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 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 | 19.88% |
| Contract providers | 78.86% |
| Network providers | 1.26% |
| **Total** | **100%** |

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, IT staff): 2.50%

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

MHP currently provides services to consumers using a telepsychiatry application:

☐ Yes ☒ No ☐ In pilot phase

## Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

**Table 10: Technology Staff**

| IS FTEs (Include Employees and Contractors) | # of New FTEs | # Employees / Contractors Retired, Transferred, Terminated | Current # Unfilled Positions |
|---|---|---|---|
| 28 | 0 | 1 | 2 |

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

**Table 11: Data Analytical Staff**

| IS FTEs (Include Employees and Contractors) | # of New FTEs | # Employees / Contractors Retired, Transferred, Terminated | Current # Unfilled Positions |
|---|---|---|---|
| 13 | 3 | 0 | 2 |

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

- Table 10: MHP reported the net change of new FTEs and those who left since previous CalEQRO review. As a result, the gross number of new and FTEs who left were not reported in table 10 results. The MHP acknowledge that hiring of technology staff is an ongoing activity throughout the year.
- Table 10 includes staff who provide Help Desk support.
- The Information Systems Deputy Director position was filled January 2017, an internal promotion from within Alameda Health Care Services Agency.
- The MHP hired a technology staff person to provide project management support for ECHO ShareCare and Visual Health Record/Electronic Health Record system.
- The MHP hired Data Manager to coordinate and support data analytical requirements.

# Current Operations

- The MHP and community-based organizations (CBO's) continue to use InSyst for practice management functions, claims processing, and State data reporting requirements.
- Clinician's Gateway (CG) system is linked to InSyst and is used by all county-operated programs and many CBOs as their electronic health record system. The remaining CBOs who do not use CG have their own local EHR systems. The use of separate systems requires double data entry, into both the local EHR and InSyst.
- The MHP continues to use eCura Managed Care system to authorize client services, and process billing and payments for their fee-for-service network providers.
- The MHP completed the migration to the Yellowfin application for improved functionality, efficiency, and data integrity. Data is extracted daily from InSyst, Clinician's Gateway, and Objective Arts databases into PostgreSQL warehouse.

Currently, over 100 dashboards and reports are available to county-operated programs, and are being rolled out to community-based organizations.

- Alameda County Behavioral Health Care Services (ACBHCS) executive group suspended the ECHO ShareCare and Visual Health Record/Electronic Health Record (VHR/EHR) implementation to address multiple performance issues.

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 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 12: Primary EHR Systems/Applications**

| System/Application | Function | Vendor/Supplier | Years Used | Operated By |
|---|---|---|---|---|
| InSyst | Practice Management | The Echo Group | 27 | MHP/County |
| Clinician's Gateway | Clinical Record | Platton Technologies | 10 | MHP/County |
| eCura | Managed Care | InfoMC | 18 | MHP/County |
| Yellowfin | Business Intelligence | Yellowfin | 1 | Vendor/HCA |
| CANS | Outcomes | Objective Arts | 2 | Vendor/County |

# Priorities for the Coming Year

- Continue support of the Whole Person Care initiative (locally identified as AC3 - Alameda Community Care Connect). Coordinate over 20 disparate data sources into PostgreSQL warehouse.
- The MHP continues the work towards implementation of an electronic health record system. Discussions between ACBHCS executive group and The Echo Group are on-going regarding the next steps for ECHO ShareCare and Visual Health Record/Electronic Health Record (VHR/EHR) systems implementation.
- Implement Salesforce CRM application to support Contract Lifecycle Management software for contract generation and support.
- Migrate to Microsoft Office 365.
- Contract with XPIO for HIPAA Privacy and Security Risk Assessment and Analysis.
- Design and implement Disaster Recovery site to support BHCS Information Systems.
- Update Alameda Health Care Service Agency public-facing website. Phase 1 will update 'look and feel.' Phase 2 will review website content.
- Develop and configure Human Resources Tracking system to monitor and manage document business flows for the agency HR department.

# Major Changes Since Prior Year

- Implemented Help Desk Tracking database, automate help desk tickets and user requests for support.
- Complete ShareCare System Options for vendor implementation of ShareCare Pre-Production Database Shell.
- Upgrade InSyst and Clinician's Gateway systems to support ICD-10 compliance and charting requirements for DSM-5 diagnostic codes.
- Complete installation of Child and Adolescent Needs and Strengths (CANS) application.
- In preparation for Drug Medi-Cal Organized Delivery System Waiver project the following features were developed to enhance Clinician's Gateway functionality:
    - Bed Reservation system: support identification of residential bed availability by residential treatment facilities, which is used by the Call Center.
    - Pre-Consumer feature: Enable Call Center creation of default registrations for clients.

- Develop call screening, assessment, and follow-up documents for Call Center use.
- Create ASAM Level of Care assessment tools for standardized outcome measurement.

## Other Significant Issues

- Onsite group interview sessions identified that slow system response times from InSyst and/or Clinician's Gateway greatly impact clinicians and support staff productivity. It was undetermined if slow response times for end-users is related to server hardware, or a fragmented database, or network connectivity, or a combination of issues.
- Community-based organizations continue to note significant staff overhead performing double data entry into InSyst and their local system, and the validation of transactions between the two systems.
- Accurate and complete tracking of wait times for services, regardless of entry point, continues to remain an ongoing issue.

## Plans for Information Systems Change

- Implementation of ECHO ShareCare and VHR/EHR system project is currently on hold, pending decision by Alameda County Behavioral Health Care Services executive group to select from the following options:
  - Proceed with ECHO ShareCare and VHR/EHR project.
  - Issue a request for proposal.
  - Continue to place the Project on hold.

# Current Electronic Health Record 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 | | | | X | |
| Document imaging/storage | Laserfiche | X | | | |
| Electronic signature—consumer | Clinician's Gateway | | X | | |
| Laboratory results (eLab) | | | | X | |
| Level of Care/Level of Service | Clinician's Gateway | | X | | |
| Outcomes | CANS | | X | | |
| Prescriptions (eRx) | Clinician's Gateway | X | | | |
| Progress notes | Clinician's Gateway | X | | | |
| Referral Management | | | | X | |
| Treatment plans | Clinician's Gateway | X | | | |
| **Summary Totals for EHR Functionality:** | | 6 | 3 | 3 | 0 |

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

- Clinician's Gateway (CG) functions noted in Table 13 are utilized by all county-operated programs and a number of the community-based organizations (CBO's). Currently CBO's with CG authority can use Alerts, Assessments, and Document image/storage functions.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☒ Electronic ☐ Combination

# Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ 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:

Excel, Access databases

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

**Table 14: Alameda MHP Summary of CY16 Short Doyle/Medi-Cal Claims**

| Number Submitted | Gross Dollars Billed | Number Denied | Dollars Denied | Percent Denied | Gross Dollars Adjudicated | Claim Adjustments | Gross Dollars Approved |
|---|---|---|---|---|---|---|---|
| **696,318** | $193,882,953 | **14,758** | $4,538,082 | 2.34% | $189,344,871 | $9,381,022 | $179,963,849 |

Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017.
The statewide average denial rate for CY2016 was 4.48 percent.
Change to the FFP reimbursement percentage for ACA aid codes delayed all claim payments between the months of January-May 2017.

Table 15 summarizes the most frequently cited reasons for claim denial.

| Table 15: Alameda MHP Summary of CY16 Top Three Reasons for Claim Denial | | | |
|---|---|---|---|
| **Denial Reason Description** | **Number Denied** | **Dollars Denied** | **Percent of Total Denied** |
| Beneficiary not eligible or aid code invalid or restricted service indicator must be "Y" | 5,186 | $1,872,096 | 41% |
| Other coverage must be billed prior to submission of this claim | 4,720 | $1,067,130 | 24% |
| Invalid procedure code and modfier combination | 2,819 | $943,981 | 21% |
| Total Denied Claims | 14,758 | $4,538,082 | 100% |

- Denied claim transactions with 'Invalid procedure code modifier combination' are generally re-billable within the State claim resubmission guidelines.

# Information Systems Review Findings—Implications

## Access to Care

- The MHP continues to rely on legacy systems (Insyst and Clinician's Gateway) to monitor access to care, which provides limited information.

## Timeliness of Services

- Multiple service entry points for initial contact and multiple siloed data systems does not provide wait time data to accurately track initial services from community-based organizations with local EHR systems, services are uploaded or directly data entered into InSyst.

- Lack of a shared appointment scheduler prevents tracking of offered appointments, limiting initial timeliness to those who contact the Access Center (9% of all new consumers).

## Quality of Care

- As it is difficult to monitor quality of care for client/consumers using legacy systems that lack sophisticated functionality, the MHP compensates by implementing work flow processes that focus and rely on compliance and utilization management principles that do not adequately measure quality of care improvement activities.

## Consumer Outcomes

- The CANS tool is operational, with rollout plans for community-based organizations for tracking outcomes for children by client, clinician, provider and systemwide.

- An outcome tool for adults has not yet been selected, with consideration of the Adult Needs and Strengths Assessment (ANSA) tool.

# SITE REVIEW PROCESS BARRIERS

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

- The MHP experienced challenges in the submission of required documents as outlined in the notification letter.
- The MHP was unable to create a parent/caregiver focus group with the requested number of participants.

# CONCLUSIONS

During the FY17-18 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 utilizes an intensive multi-cultural inclusion process to develop services that meet the needs of the various communities and cultural concerns that make up the area. This is bolstered by the CLAS process, training, and monitoring of programs.
- The MHP's engagement in the Whole Person Care, psychiatry consultation to primary care, and the fellowship training offered to internal medicine practitioners helps to improve services across the care continuum.
- The services developed in support of the Laura's Law program offers alternatives to that legal process as well as Lanterman–Petris–Short (LPS) Act for conservatorship to those with engagement challenges who are also high risk for recidivating.

**Opportunities:**

- Consumer and family stakeholders consistently request after-hours and weekend support by staff who are familiar with the person receiving treatment. This would best fit developing an on-call system for each program, or a supportive sub-crisis support team that is able to respond and spend time resolving and problem-solving the pre-crisis events. Caregivers clearly draw the distinction between the mobile crisis intervention teams, and the requested level of care. It should be noted that this request is common among MHPs and describes a gap is service that is frequently mentioned.

### Timeliness of Services

**Strengths:**

- Anecdotal reports of consumer and family member focus groups for this review indicated high satisfaction with all aspects of timeliness from initial through psychiatry.

**Opportunities:**

- Key system challenges remain for the MHP to be able to reliably track timeliness through data, and as well to track no-shows, which can have a significant impact on capacity.
- The data available for initial access and psychiatry access remains largely unchanged from prior years, with most areas reflecting the continued inability of the MHP to meet its established standards and a low rate that standards are met.

## Quality of Care

**Strengths:**

- The MHP created an integrated SUD/MH Quality Improvement Work Plan in the prior year, integrating both elements into one plan.
- The MHP does identify improvement indicators that possess quantifiable aspects.
- The MHP has processes in place to communicate compliance and quality information to individuals in both internal and contract programs.

**Opportunities:**

- Development of a vision for services suffers when top leadership undergoes multiple rapid transitions.
- Revisit the communication process to include assuring consistency in the way that messages are identified, whether informational or action notices. Robust protocols for communication are required within an agency that has community-based organizations delivering over 80% of services, and multiple specialty programs in varied settings.
- Complete the development of a robust information system that meets the MHP's needs for both directly-operated and contract providers with a functional, effective EHR.
- Resolve IS system users slow-downs and failures, potentially encompassing Clinician's Gateway and Insyst end-users.
- Investigate denied claims transactions, particularly those with 'Invalid procedure code modifier combination,' which is generally re-billable within the State claim resubmission guidelines.

## Consumer Outcomes

**Strengths:**

- The MHP has completed systemwide implementation of the CANS and ANSA.

- The MHP has historically focused on achievement of consumer empowerment and wellness and recovery, including opportunities for employment.
- A greater use of consumer employees is evident in the IHOT program and health care integration efforts, using the unique skills and experiences of consumers to help those not receiving care to effectively link up with services.
- The MHP participation in the benefits advocacy process, which offers a stipend or subsidy for consumers who are in the disability application process, has resulted in lower incidence of hospital admissions and arrests.

**Opportunities:**

- Engage in an analysis of aggregate outcome data, and develop mechanisms that identify positive service patterns from this information, and use this to develop changes for a systemwide service delivery approach.

# Recommendations

- Leadership and Vision: The multiple leadership changes in the last several years, and more recent senior staff turnover has understandably impacted the experience of providers and line staff with departmental vision and priorities. Formulate and communicate departmental vision, including establishing a forum for direct input of the contract organizations and others, to help rejuvenate the link between leadership and providers and all stakeholders.
- Information Systems: Complete BHCS business decision analysis and processes to determine whether to proceed with Echo VHR system implementation or seek another solution that fully supports both county-operated programs and community-based organizations functional EHR requirements. In the interim, the causes for slow system response times for InSyst and/or Clinician's Gateway reported by end-users needs to be explored and remedied.
- Communication: Implement a vigorous communication effort to ensure consistency in the manner in which messages are sent, offer easy categorization as to "information" vs "action" messages, and include a clear feedback loop for submission of questions about messages that are received, followed by timely processing of response and circulation of updated information.
- Consumer Involvement: The recent retirements of key individuals with lived experience as well as the reorganization resulted in consumers feeling distanced from leadership and some consumers expressed that they felt their input had been devalued. Bring together the various consumer groups and solicit their suggestions, including rebuilding the roles and communication lines that existed. Consider key concerns of consumer

inclusion in system leadership and line work, including directly operated programs, and greater opportunities for higher education support.

- Quality and Compliance: In addition to the QA manual revision that is underway, review and streamline the forms and required documentation, bringing it back to the minimum permitted by standards, and bring documents into an electronic format that eliminates redundant information entry such as name and client number. Programs would also like to see the identification of a compliance contact at the individual program level, in addition to the agency level.

- Crisis Services: Explore the adequacy of crisis services capacity available to the less populated county areas, which could include tracking and reporting mobile crisis response by county region. The after-hours availability of clinic staff or a specialized team that can respond following a crisis, and immediately devote time in coaching parents, may prevent repeat episodes and hospitalizations.

# ATTACHMENTS

**Attachment A: CalEQRO On-site Review Agenda**

**Attachment B: On-site Review Participants**

**Attachment C: Approved Claims Source Data**

**Attachment D: CalEQRO Performance Improvement Plan (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 |
| Disparities and Performance Measures/Timeliness Performance Measures |
| Quality Improvement and Outcomes |
| Performance Improvement Projects |
| Primary and Specialty Care Collaboration and Integration |
| Acute Care/CSU Clinical Staff |
| Clinical Line Staff Group Interview |
| Consumer Employee Group Interview |
| Parent-Caregiver Focus Group |
| Adult Consumer Focus Group |
| Expedited Access to Care |
| Children's Provider Site Visit |
| Contract Provider Group Interview –Quality Management |
| Validation of Findings for Pathways to Mental Health Services (Katie A./CCR) |
| ISCA/Billing/Fiscal |
| Prescribers Session – NP/MD |
| Parent Partners Session |
| EHR Implementation |

# Attachment B—Review Participants

## CalEQRO Reviewers

Rob Walton, Lead Quality Reviewer Consultant
Della Dash, Senior Quality Reviewer
Saumitra SenGupta, Executive Director
Bill Ullom, Chief IS Reviewer
Luann Baldwin, 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 Care Services
2000 Embarcadero Cove
Oakland, CA 94606

Alameda County Behavioral Health Information Systems
1900 Embarcadero Cove
Oakland, CA 94606

Children's Specialized Services
7200 Bancroft Ave, Suite 125
Oakland, CA 94607

**Contract Provider Sites**

Telecare Corporation
Jay Mahler Recovery Center
15430 Foothill Blvd.
San Leandro, CA 94578

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Adam | John | Alvin | Willow Rock |
| Almanza | Jaime | Executive Director | Bay Area Community Services |
| Arrieta | Rudy | Quality Management Director | ACBHCS |
| Arrington | K. Kori | Program Outreach Coordinator | PEERS |
| Aslami | Khatera | Consumer Relations Manager | ACBHCS |
| Baggeroer | Cheryl | Lead Psychiatrist PC PCP | BHCS |
| Basra | Sona | Financial Services Officer | ACBHCS |
| Becton | Neisha | Executive Director | Pathways to Wellness |
| Bergman | Beverly | | MHAAC |
| Bernstein | Wendy | Assoc. Medical Director | Casa del Sol<br>La Clinica de la Raza |
| Biblin | Janet | Social Services Manager | ACBHCS |
| Blake | Ben | CECO | BHCS |
| Branagh | Fiona | Network Office Director | ACBHCS |
| Bui | Cortese | Social Services Manager | JCJPH |
| Burns | Greg | Counselor | Senior Support Services of Tri-Valley |
| Burton | Carol | Agency Director | ACBHCS |
| Capece | Karen | Interim Authorizations Services Manager | ACBHCS |
| Castaneda | Alfonso | Team leader | STRIDES |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Chapman | Aaron | Medical Director | ACBHCS |
| Chapman | Azou | Medical Director | BHCS |
| Coady | Kimberly | Clinical Program Specialist | ACBHCS |
| Courson | Natalie | Information Systems Deputy Director | ACBHCS |
| Davis | Hilary | Team Lead | Changes |
| De Jesus | Anne | Mental Health Specialist | STARS |
| Desmond | Bree | Quality Manager/Data Analyst | Fred Finch |
| Diedrick | Sheryl | Information Systems | ACBHCS |
| Engstrom | John | Decision Support Senior Management Analyst | ACBHCS |
| Farrell | David | VP Subacute Services | Telecare Corporation |
| Finnell | Caitlin | BH Director | TVHC |
| Flores | Linda | Sr MHSA Planner | ACBHCS |
| Flynn | Gillian | LCSW/Lead | Lifelong West Berkeley |
| Fredilani | Leda | Finance Director | ACBHCS |
| Friedrich | Alane | Family Member | Mental Health Board |
| Gaines | Wilma | Consumer and Family Assistance Specialist | ACBHCS/Mental Health Association of Alameda County |
| Gerber | Emily | | Children's Hospital Oakland |
| Gilbane | Brian | Clinical Director | Telecare Villa Fairmont |
| Goldstein | Brenda | Psychosocial Services Director | Lifelong Medical |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Grolnic-McClrug | Steven | Director of Mental Health | City of Berkeley |
| Gupte | Saleena | | Alameda Health Consortium |
| Hall | Lorenzo | Management Analyst | BHCS |
| Hamadanyan | Karen | BHCS II Case Manager | Alameda Community Support Center |
| Hamner | Scott | IS | ACBHCS |
| Harbaugh | Jesh | Asst. Director, Business Intelligence | ACBHCS |
| Hazelton | Tracy | MHSA Div. Director | ACBHCS |
| Herbst | Shawna | | City of Fremont |
| Hobbs | Nathan | Interim AOD Administrator | ACBHCS |
| Hogden | Mary | Consumer Relations Program Specialist | ACBHCS |
| Jackson | Alexander | Interim Transitional Age Youth Division Director | ACBHCS |
| Joneja | Smriti | QI Coordinator | Lifelong Medical |
| Jones | Katherine | Adult System of Care Director | ACBHCS |
| Jones | Katherine | Adult System of Care Division Director | ACBHCS |
| Jones | Yvonne | Director Adult Forensic | ACBHCS |
| Judkins | Andrea | Finance Department | ACBHCS |
| Kessler | Michael | Older Adult System of Care Program Specialist | ACBHCS |
| Konover | Kimberlee | Critical Care Manager | ACBHCS |
| Lebron | Patricia | Children & Young Adult SOC | BHCS |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Lendolin | Chelsea | PMHNP/Dir. Of Health Care Services | UCSF/Bonita House |
| Leonard | Josh | CEO | East Bay Agency for Children |
| Lestman | Lilian | Schnreiber Center | BHCS |
| Leung-Flores | Linda | MHSA | ACBHCS |
| Manoleas | Peter | | La Clinica |
| Mansoor | Yasin | Tri-City Staff Psychiatrist | BHCS |
| Marchman | Dani | Clinical Director | Changes |
| Marshland | Susanna | Regional Vice President | Fred Finch Youth Centers |
| Mayfield | Amber | Clinical Director | STEPS |
| Mazid | Sanjida | Workforce Education & Training Manager | BHCS |
| McKetney | Chuck | Compliance Officer | Health Care Services Agency |
| Meinzer | Chet | IS | ACBHCS |
| Miller | Laura | MD – CMO | CHCN Network |
| Mitchell | Anne | Program Manager | Pacific Center for Human Growth |
| Mortensen | Jackie | Provider Relations Director | ACBHCS |
| Mullane | Jennifer | Adult System of Care Assistant Division Director | ACBHCS |
| Mullane | Jennifer | Adult System of Care Assistant Division Director | ACBHCS |
| Navarez | Cheryl | Clinical Review Specialist | BHCS QA |
| Navoa | Marines | Clinician QA Specialist | Portia Hume Center |
| Nguyen | Tam | MD – Behavioral Health Director | Tri-City Health Center |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Orona | Margarita | Clinician | Multilingual Counseling |
| Orozco | Gabriel | Management Analyst | ACBHCS |
| Osborn | Scott | Regional Exec. Director | Seneca Center |
| Penney | Jennifer | Chief of BH | Axis Community Health |
| Perales | Joseph | | La Clinica |
| Perez | Lemny | IBH Director | West Oakland Health |
| Peterson | Camille | IS | ACBHCS |
| Pisani | Federico | IS | ACBHCS |
| Pritchard | Elaine | | Telecare Corporation |
| Rackmil | Jeff | Children's System of Care Director | ACBHCS |
| Rassette | Kim | Decision Support Staff | ACBHCS |
| Raynor | Charles | Director of Pharmacy Services | ACBHCS Council of Comm. |
| Romano | Dennis | Director | Alameda County Mental Health Agencies ACCMHA |
| Rowson | Kali | Mental Health Specialist | STARS |
| Salamy | Nancy | Executive Director | Crisis Support |
| Saldanha | Charles | | ACMC |
| Saler | Barbara | ACCESS Program Director | ACBHCS |
| Satchwell | Bridget | System Outreach Manager – Care Connect | HCSA |
| Sayers | Jaime | Clinician | Portia Hume Center |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Schreiber | Georgia | Program Manager/PHI | ACBHCS |
| Schultz | Henning | Clinical Manager Adult System of Care | ACBHCS |
| Scott | Jonah | Mental Health Clinician | East Bay Agency For Children |
| Serrano | Cecilia | Financial Services Officer | ACBHCS |
| Silverman | C. | | Telecare Corporation |
| Smith | Freddie | Primary Care Interface Services Division Director | ACBHCS |
| Smith | Kirby | Cost Reporting Unit | ACBHCS |
| Smith | Sarah | Behavioral Health Clinician II | Oakland Community Support |
| Smith | Freddie | Division Director | BHCS |
| Sohn | Haeyoung | | ACMC |
| Solorzano | Rosa | IBH Manager/LCSW | NAHC |
| Tannenbaum | Francesca | Director | Mental Health Association of Alameda County |
| Taylor | Robert | ED | Support Program |
| Trotter | Saun-Toy | Clinic Coordinator and Clinician | UCSF- CHO |
| Vallas | Melissa | Lead Child Psychiatrist | BHCS |
| Vosburg | Danielle | Clinical Director | STRIDES |
| Wagner | James | Agency Deputy Director | ACBHCS |
| Walker | Amy | Behavioral Health Clinician II | GART |
| Warder | Rosa | Family Relations Manager | ACBHCS |

| Table B1 - Participants Representing the MHP | | | |
|---|---|---|---|
| **Last Name** | **First Name** | **Position** | **Agency** |
| Waterman | Jandera | | Lifelong Medical |
| Wilkinson | Sindey | Behavioral Health Clinician II | Valley & Eden Children's Services |
| Williams | Donna | Behavioral Health Clinician | Oakland Community Support Center |
| Williams | Bree | Program Manager | PEERS |
| Wilson | Javarre | Ethnic Services Manager | ACBHCS |
| Wiltz | Ontreal | PSC II | STAGE |
| Wong | Jackie | BH Manager | Asian Health Services |
| Woodland | David | Quality Assurance | |
| Yu | Sophia | Behavioral Health Clinician II | Tri-City Clinic |
| Yuan | Eric | Deputy Director | BHCS |

# 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 eleven (*). 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 approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

**Table C1: Alameda MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary**

| Entity | Average Monthly ACA Enrollees | Number of Beneficiaries Served | Penetration Rate | Total Approved Claims | Approved Claims per Beneficiary |
|---|---|---|---|---|---|
| Statewide | 3,674,069 | 141,926 | 3.86% | $611,752,899 | $4,310 |
| Large | 1,778,582 | 67,721 | 3.81% | $318,050,214 | $4,696 |
| Alameda | 127,143 | 4,316 | 3.39% | $22,518,178 | $5,217 |

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

**Table C2: Alameda MHP CY16 Distribution of Beneficiaries by ACB Range**

| Range of ACB | MHP Count of Beneficiaries Served | MHP Percentage of Beneficiaries | Statewide Percentage of Beneficiaries | MHP Total Approved Claims | MHP Approved Claims per Beneficiary | Statewide Approved Claims per Beneficiary | MHP Percentage of Total Approved Claims | Statewide Percentage of Total Approved Claims |
|---|---|---|---|---|---|---|---|---|
| < $20K | 20,053 | 89.20% | 94.05% | $90,898,965 | $4,533 | $3,612 | 48.51% | 59.13% |
| >$20K - $30K | 1,071 | 4.76% | 2.83% | $26,108,317 | $24,378 | $24,282 | 13.93% | 11.98% |
| >$30K | 1,357 | 6.04% | 3.12% | $70,381,279 | $51,865 | $53,215 | 37.56% | 28.90% |

# Attachment D—PIP Validation Tools

| PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 CLINICAL PIP | |
|---|---|
| **GENERAL INFORMATION** | |
| **MHP**: Alameda | |
| **PIP Title**: Developing Culturally Informed Quality Psychiatric Protocols | |
| **Start Date** (MM/DD/YY): 3/1/17<br>**Completion Date** (MM/DD/YY): 3/1/18<br>**Projected Study Period** (#of Months): 12<br>**Completed**: Yes ☐ No ☐<br>**Date(s) of On-Site Review** (MM/DD/YY):<br>10/31-11/2/17<br>**Name of Reviewer**: Rob Walton | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br>**Rated**<br>☐ Active and ongoing (baseline established and interventions started)<br>☐ Completed since the prior External Quality Review (EQR)<br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br>☐ Concept only, not yet active (interventions not started)<br>☐ Inactive, developed in a prior year<br>☒ Submission determined not to be a PIP<br>☐ No Clinical PIP was submitted |
| **Brief Description of PIP** (including goal and what PIP is attempting to accomplish): The MHP hypothesized that consumers treated without the presence of a bilingual/bicultural clinician or case manager may experience limited participation due to lack of raising questions, inaccuracy of reporting, and lack of feeling understood. Substantiation of the existence of this issue is reliant upon clinician and medical providers' anecdotal reports and beliefs. The MHP | |

reports literature supports the selected approach, however specific sources are not identified. Much of the focus is upon Hispanic/Latino cultural attitudes of respeto.

**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<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The MHP identified this topic with the input of programs that primarily service the Hispanic/Latino populations and many who have Spanish language preferred. There was no description of the PIP team other than the project leader, and a general reference to line staff and medical staff at the clinic serving Hispanic consumers. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | There was no local data analyzed for the creation of this PIP topic. Brief mention of prevalence of the Latino culture based on external sources. There was an absence of citations and/or significant literature references by name. |

***Select the category for each PIP:***

*Clinical:*

☐ Prevention of an acute or chronic condition ☒ High volume services

☐ Care for an acute or chronic condition ☐ High risk conditions

*Non-clinical:*

☐ Process of accessing or delivering care

| | | |
|---|---|---|
| 1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The sole area of focus is in the accompanying of Hispanic or Latino consumers to psychiatry sessions. No other potential interventions were identified, and it is not clear why this was the sole focus.<br>As already mentioned, the specific literature was not cited that identified accompanying of consumers into these sessions, and whether or not a case manager or clinician was superior to that, for example, of a peer specialist – which might have been as effective and also preserved clinician time. |
| 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)?<br>*Demographics:*<br>☐ Age Range ☒ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The MHP targeted one of the four clinics that specifically serve Hispanic/Latino consumers, and is including these consumers through a convenience sampling of new consumers and a caseload review of existing consumers. This would seem to raise the issue of selection bias, which could emerge and be subject to many differing factors. Selection bias was not addressed. |
| | **Totals** | Met Partially Met Not Met UTD |
| **STEP 2: Review the Study Question(s)** | | |
| 2.1 Was the study question(s) stated clearly in writing?<br>Does the question have a measurable impact for the defined study population?<br>*Include study question as stated in narrative:*<br>*Does the inclusion of the client's therapist/case manager in psychiatric sessions improve the client experience of psychiatric care for Latinos?* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | There is no reference to anticipated quantitative result, required for a study question.<br>The SQ does not specify if this applies to all consumers served at this single site – including non-Hispanics – and whether it is intended to address Spanish speakers as well, or solely. |
| | **Totals** | 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?<br>*Demographics:*<br>☐ Age Range ☒ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | From review of the complete as-written PIP, the MHP specifies:<br>Existing patients/consumers will be considered;<br>Casa del Sol consumers that are reflective of the Latino population in Fruitvale district.<br>Are Spanish speakers the intended focus? Are they included?<br>New consumers who meet the study parameters. |
| 3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?<br>*Methods of identifying participants:*<br>☐ Utilization data ☐ Referral ☐ Self-identification<br>☐ Other: <Text if checked> | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | Seems to be case review will occur. Convenience sampling of new cases is mentioned as is case review of existing consumers. |
| | **Totals** | Met Partially Met Not Met UTD |
| **STEP 4: Review Selected Study Indicators** | | |
| 4.1 Did the study use objective, clearly defined, measurable indicators?<br>*List indicators:*<br>No Show rates | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | The PIP document identifies only No-Show rates in the performance indicator section, in which there is no baseline or subsequent data reported.<br>However, in the study design (section 6), the MHP identifies Patient Feedback Form V2, with other references to the PHQ=9, GAD-7, Kessler-6, Hamilton, PANNS, Survey Instrument B. These latter items have no baselines and are not listed as study indicators.<br>The data collection section also mentions consumer focus groups and session rating scales. Again, these are absent baselines or subsequent data, and not included as indicators.<br>Client satisfaction is mentioned as being surveyed after each session, at baseline, and 6 months, but there is no baseline or 6-month data presented. |

| | | |
|---|---|---|
| 4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.<br>☐ Health Status ☐ Functional Status<br>☐ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☐ Yes ☒ No<br><br>Are long-term outcomes implied? ☐ Yes ☒ No | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The sole indicator listed in the PIP is no-show rates. By itself, it is not reflective of satisfaction or functional status. No-show rates can reflect transportation, time of appointment, forgetting, and other elements. It is also not clear why numerous other instruments and mechanisms for collecting data are not included with the indicators listed, have no baseline information presented, and no subsequent data. |
| | **Totals** | Met Partially Met Not Met UTD |
| **STEP 5: Review Sampling Methods** | | |
| 5.1 Did the sampling technique consider and specify the:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The MHP states convenience sampling. |
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:*<br>Convenience | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | Nothing was mentioned that would address the issue of potential sampling bias. |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☒ Unable to Determine | Unable to determine who will be in the sampling. Seven months later no data was presented. |

| | Totals | Met Partially Met **N**ot Met NA UTD |
|---|---|---|
| **STEP 6: Review Data Collection Procedures** | | |
| 6.1 Did the study design clearly specify the data to be collected? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | No-shows.<br>The data collection section mentions a number of other instruments that are not included in the listing of indicators. It is unclear what data will be tracked. No-shows are not mentioned in the data collection section yet are the sole indicator listed. |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:*<br>☒ Member ☒ Claims ☐ Provider<br>☐ Other: <Text if checked> | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | |
| 6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The MHP mentions that data collection is being performed ongoing, and that no data reporting cycles were planned other than end-of-year/end-of-project. This area was mentioned as a requirement in the previous review, and that ongoing reporting was required.<br><br>Requirements of a PIP include the original presentation of data that supports existence of a problem, ongoing periodic reporting of the data, and analysis/changes when untoward findings emerge.<br><br>In this case no data is reported and the effort does not meet the requirements for a PIP. |

| | | |
|---|---|---|
| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☐ Survey ☐ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: <Text if checked> | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | The MHP apparently plans on no ongoing reporting and only end of project report.<br><br>The indicators list is limited to no-show, the data analysis plan calls for many other survey and data elements. No ongoing reporting is planned. |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | The data analysis plan includes many items not part of the indicator list, and has no plan for ongoing reporting. |
| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>Name:<br>Title:<br>Role:<br>*Other team members:*<br>Names: | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | Identification of staff involved in data collection is blank in the submitted document. There is no mention of who comprises the total PIP team. |
| | **Totals** | 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?<br><br>*Describe Interventions:*<br>*Clinician / Case Manager in psychiatry sessions to support the cultural and linguistic needs of Hispanic/Latino consumers.* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | There was no data presented on the problem, no efforts to include consumer input/satisfaction or comments about needs that resulted in the identification of this approach. The MHP selected the intervention based on their perception of need.<br><br>It appears the MHP may have identified a change the delivery of psychiatry services that was not founded on data analysis. There is nothing incorrect about making changes to service delivery, this simply is not a PIP. |

| | Totals | 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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | The MHP plans on analyzing no data until 2018 at the end of the PIP.<br>Technically, the MHP is in accord with their analysis plan, but that does not meet the requirements for a PIP. |
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled? ☐ Yes ☐ No<br>Are they labeled clearly and accurately? ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | Final analysis was not expected. However, there is no foundational local data nor literature referenced data upon which to base this PIP. Seven months into this PIP, there was an explicit plan not to report data until the early 2018 planned end. |
| 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?<br><br>Indicate the time periods of measurements: _____<br>Indicate the statistical analysis used: _____<br>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ 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?<br>*Limitations described:*<br>*Conclusions regarding the success of the interpretation:*<br>*Recommendations for follow-up:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | 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?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | No baseline was ever formulated nor presented. |
| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | 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<br>☒ No | Not performed. No data at all was presented. |

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

*Conclusions:*

This project is not a PIP, but is more the implementation of a change in the delivery of psychiatry services to Hispanic/Latino services, moving to a model where a culturally appropriate staffer accompanies the consumer to that visit, and helps facilitate communication between that person and the psychiatrist.

There are measures the MHP is considering tracking to determine efficacy of this approach, but the these are simply follow-up measures, with no baseline of comparison, unless it has plans to do some comparison with those who do not receive this change in service delivery.

| | | |
|---|---|---|
| *Recommendations:* | | |
| Check one: | ☐ High confidence in reported Plan PIP results | ☐ Low confidence in reported Plan PIP results |
| | ☐ Confidence in reported Plan PIP results | ☐ Reported Plan PIP results not credible |
| | ☐ Confidence in PIP results cannot be determined at this time | |

| PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18 NON-CLINICAL PIP | |
|---|---|
| **GENERAL INFORMATION** | |
| **MHP**: Alameda | |
| **PIP Title**: High Cost Utilizers | |
| **Start Date** (MM/DD/YY): 12/7/16<br><br>**Completion Date** (MM/DD/YY): 12/7/18<br><br>**Projected Study Period** (#of Months): 24<br><br>**Completed**: Yes ☐ No ☒<br><br>**Date(s) of On-Site Review** (MM/DD/YY):<br><br>10/31-11/2/17<br><br>**Name of Reviewer**: Rob Walton | **Status of PIP (Only Active and ongoing, and completed PIPs are rated):**<br><br>**Rated**<br><br>☐ Active and ongoing (baseline established and interventions started)<br><br>☐ Completed since the prior External Quality Review (EQR)<br><br>**Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.**<br><br>☐ Concept only, not yet active (interventions not started)<br><br>☐ Inactive, developed in a prior year<br><br>☒ Submission determined not to be a PIP<br><br>☐ No Non-clinical PIP was submitted |
| **Brief Description of PIP** (including goal and what PIP is attempting to accomplish): The MHP performed an analysis of high-cost (12 month average $49,000/3% of adult population) consumers, and decided to address that cohort which received only crisis and inpatient care with a PIP. This team is intended to perform outreach to discharged crisis and inpatient consumers, and is comprised of family and peer specialist, clinician. Upon a secondary review of data, 31 of the 73 25+ year-old cohort of consumers were referred to IHOT as part of this PIP.<br>The data included in the MHP's PIP was focused upon the high-cost and demographic information of the consumers. There existed no description of what was entailed by the IHOT intervention besides the general engagement purpose of this team, and the composition of personnel. This provided | |

insufficient information about the intervention for others to replicate. This could have included specific intervention strategies or approaches that are utilized by IHO. Numerous indicators were described in the PIP, but the relevant in-process reporting data was not included.

The majority of the data-related information presented by the MHP was contained in a presentation that was shown at the onsite review, and contained a 12-month evaluation of IHOT/Assisted Outpatient Treatment (AOT) and Community Conservatorship (CC) by Research Development Associates (RDA). This report indicated that 21% of IHOT referrals were from the High Utilizers List. Much of that data reflected information of the total IHOT served population (145), and the data on the 31 PIP referrals reflected metrics that considered different data than those in the PIP indicators list.

No data was provided for the indicators as formulated in the PIP. The PIP activity requires ongoing reporting and analysis of data, usually monthly or quarterly, so that mid-course corrections could be instituted. However, since the submission does not describe unique interventions that are embedded in IHOT, it is not clear how this team and interventions are constituted.

The MHP has stated its interest in the study of open, engaged high-cost consumers (448) that currently reside and are served within the community, and testing interventions that could positively impact their outcomes and utilization of services. This direction would offer an increased number of consumers impacted and would offer an appropriately significant target.

**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<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Wide system participation occurred, including peers. |
| 1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |

***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

| | | |
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| 1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services?<br>*Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Unable to Determine | In the current iteration of this PIP, the focus was upon the high-cost consumers who received their care from crisis, crisis stabilization and/or inpatient. The follow-up with a team comprised of clinician and lived-experience individuals is the singular intervention, the operation of which is not described in detail. |
| 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)?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other not open to outpatient | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | There are numerous other high cost consumers (448) that are engaged in care; however this PIP focused currently on the 31 who were not engaged in care. There is some discussion about future iterations targeting the larger group. |
| **Totals** | Met | Partially Met / Not Met / UTD |

| STEP 2: Review the Study Question(s) | | |
|---|---|---|
| 2.1 Was the study question(s) stated clearly in writing?<br>Does the question have a measurable impact for the defined study population?<br>*Include study question as stated in narrative:*<br>Will a decrease in the utilization of High Cost Services and an increase in the utilization of outpatient services improve the functional status and well being of HP beneficiaries?<br>The following areas will be measured by the PIP for high-cost beneficiaries not connected to outpatient care & referred to IHOT:<br>• Number of PES service days past 12 months<br>• Number of Inpatient hospital service days past 12 months<br>• Minutes of Outpatient service past 12 months<br>• Number of beneficiaries receiving outpatient care post PES discharge past 12 months<br>• Timeliness of beneficiaries receiving outpatient care post PES discharge of the past 12 months<br>• HOT program outcomes are being evaluated by an independent evaluator (RDA)<br>• Evaluation includes quantitative and qualitative measures<br>• Includes focus groups with beneficiaries, families & providers<br>• Self Sufficiency Matrix used to track client outcomes<br>• Baseline data is currently being collected | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The study question needs to include an overall quantifiable goal, and a broad description of what types of indicators will be identified that reflect wellbeing and functional status.<br>The MHP includes in the study question (SQ) a list of indicators and discussion of the evaluation process. This information belongs elsewhere in the write-up. |

| Totals | Met | Partially Met | Not Met | UTD |
|---|---|---|---|---|

| STEP 3: Review the Identified Study Population | | |
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| 3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant?<br>*Demographics:*<br>☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | Over $49k in 12 months from crisis/acute services, and those without outpatient treatment episode and treatment. |
| 3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied?<br>*Methods of identifying participants:*<br>☒ Utilization data ☐ Referral ☐ Self-identification<br>☒ Other: Crisis and acute care > $49k in services in 12 months | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | The PIP includes all individuals that represent the population parameters, which is a limited set of consumers. |
| | **Totals** | Met Partially Met Not Met UTD |
| **STEP 4: Review Selected Study Indicators** | | |
| 4.1 Did the study use objective, clearly defined, measurable indicators?<br>*List indicators:*<br>• Number of PES service days in 12 months<br>• Number of Inpatient Hospital days in 12 months<br>• Minutes of Outpatient Service in 12 months<br>• Number of beneficiaries receiving outpatient care post PES discharge over 12 months<br>• Timeliness beneficiaries received outpatient services 14 & 30 days post PES discharge over 12 months<br>• Self Sufficiency Matrix, gathered by IHOT teams<br>• Beneficiary & Provider Focus groups<br>• ***12 month period for initial baseline data is retrospective from | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | These indicators are not represented in the presentation made by the MHP in the onsite review. |

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| 4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused.<br>☒ Health Status ☒ Functional Status<br>☐ Member Satisfaction ☐ Provider Satisfaction<br><br>Are long-term outcomes clearly stated? ☒ Yes ☐ No<br><br>Are long-term outcomes implied? ☒ Yes ☐ No | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |
| | **Totals** | Met Partially Met Not Met UTD |
| **STEP 5: Review Sampling Methods** | | |
| 5.1 Did the sampling technique consider and specify the:<br>a) True (or estimated) frequency of occurrence of the event?<br>b) Confidence interval to be used?<br>c) Margin of error that will be acceptable? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | The MHP write-up does mention sampling, but it seems the intention is to include all non-outpatient served consumers who have received $49k of inpatient or crisis services in the past 12 months. It appears that is the target population and sampling is not used. |
| 5.2 Were valid sampling techniques that protected against bias employed?<br><br>*Specify the type of sampling or census used:* | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |
| 5.3 Did the sample contain a sufficient number of enrollees?<br><br>_____N of enrollees in sampling frame<br>_____N of sample<br>_____N of participants (i.e. – return rate) | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable<br>☐ Unable to Determine | |

| | Totals | Met Partially Met Not Met UTD |
|---|---|---|
| **STEP 6: Review Data Collection Procedures** | | |
| 6.1 Did the study design clearly specify the data to be collected? | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | • Service data<br>o Gathered from Insyst data<br>o Includes service modality, visits and charges<br>o Baseline is recorded at time of referral to IHOT<br>o Will be measured quarterly and presented to the multi-disciplinary team<br>o Sample size may be adjusted at the discretion of the multi-disciplinary team during quarterly meetings<br><br>• Program Evaluation<br>o IHOT program outcomes are being evaluated by an independent evaluator (RDA)<br>▪ Evaluation includes quantitative and qualitative measures<br>▪ Includes focus groups with beneficiaries, families & providers<br>▪ *Self Sufficiency* Matrix used to track client outcomes |
| 6.2 Did the study design clearly specify the sources of data?<br>*Sources of data:*<br>☒ Member ☒ Claims ☐ Provider<br>☒ Other: Self-sufficiency matrix, focus groups | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | o Gathered from State Medi-Cal data<br>o Includes HP status and SSI/SSDI benefit status<br>o Baseline is recorded at the time of the referral to IHOT<br>o Will be measured quarterly and presented to the multi-disciplinary team |
| 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<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | No data was presented for this review, more than a year after the PIP started, except for the presentation – which utilized different measures. |

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| 6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied?<br>*Instruments used:*<br>☐ Survey ☐ Medical record abstraction tool<br>☐ Outcomes tool ☐ Level of Care tools<br>☐ Other: <Text if checked> | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | |
| 6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | |

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| 6.6 Were qualified staff and personnel used to collect the data?<br>*Project leader:*<br>• ACBHCS QM Director- Rudy Arrieta; leadership and technical support around QI/QM standards<br>• ACBHCS Adult System of Care Director- James Wagner; oversees the services where adult beneficiaries are served, particularly John George Psychiatric Hospital Psychiatric Emergency Services (PES) and Inpatient Hospital as well as Adult Sub-Acutes<br>• BHCS ASOC Assistant Director- Jennifer Mullane; co-manages adult services & IHOT program.<br>• ACBHCS Older Adult SOC Division Director- Lillian Schaechner; Oversees Older Adult Services, particularly Older Adult Sub-Acutes. Technical expert about older adult specific treatment and resources<br>• Older Adult SOC Program Specialist- Michael Kessler; Expertise in client level work with Older Adults<br>• ACBHCS Interim TAY SOC Division Director- Radawn Alcorn; Oversees TAY Services. Technical expert about TAY treatment and resources<br>• ACBHCS Authorizations Supervisor- Karen Capece; directly authorizes care for Inpatient services. Has extensive experience working in crisis & sub-acute settings.<br>• ACBHCS IS Director- Natalie Courson; Oversees automated reporting and technical expertise with consumer data<br>• ACBHCS Decision Support Manager- John Engstrom; Created measures and metrics for the study. Expert in client data and outcome measures.<br>• ACBHCS Decision Support Supervisor- Chet Meinzer; Created measures and metrics for the study. Expert in client data and outcome measures. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Unable to Determine | |

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| • | ACBHCS Special Projects Manager ANSA/CANS- Alexander Jackson; Expertise in driving outcome measures across systems and levels of care to track consumer outcomes<br>• ACBHCS Ethnic Service Manager- Javarre Wilson; Expertise in analyzing beneficiary demographics and guiding ethnically appropriate engagement and treatment.<br>• Telecare (CBO) VP Sub Acute Services- David Ferrell; Oversees the Telecare Sub-Acutes for Alameda County. Has considerable expertise in quality management.<br>• John George Hospital Social Work Supervisor- Harjit Singh Gill; Oversees services at the busiest PES in the country and one of our highest cost, most restrictive settings. Has expertise in outpatient services as well.<br>• Peers (CBO) Executive Director- Haydee Cuza; Expertise in peer treatment and with peer providers<br>• Seneca Center (CBO) Quality Assurance Director-Jennifer Cardenas; Expertise with QI initiatives<br>• Telecare (CBO) Evaluation Director- Carole Silverman; Oversees QI at the HP's Sub-Acutes and has extensive expertise with QI Initiatives<br>• Hume Center (CBO) Manager of Data & Reporting Systems- Brian Newton; Oversees QI and metrics at a large outpatient provider. Has expertise with outpatient engagement and treatment program implementation | | | | | |
| | | **Totals** | 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?<br><br>*Describe Interventions:* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Unable to Determine | |
| | **Totals** | Met Partially Met Not Met NA 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?<br><br>*This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The MHP identifies the problem with the small size of the current study population (N=31) and difficulties with making any statistically valid determination. This section also details plans to expand the population to the larger, open to outpatient consumers.<br>The MHP does not describe any specific frequency for data collection, reporting, analysis and corrective actions. |
| 8.2 Were the PIP results and findings presented accurately and clearly?<br>Are tables and figures labeled? ☐ Yes ☒ No<br>Are they labeled clearly and accurately? ☐ Yes ☒ No | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | The data presented at the onsite review was limited to the RDA analysis of data elements that do not appear as part of the PIP. |

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| 8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?<br><br>Indicate the time periods of measurements: _____<br>Indicate the statistical analysis used: _____<br>Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ 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?<br>*Limitations described:*<br><br>*Conclusions regarding the success of the interpretation:*<br><br>*Recommendations for follow-up:* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | 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?<br>*Ask: At what interval(s) was the data measurement repeated?*<br>*Were the same sources of data used?*<br>*Did they use the same method of data collection?*<br>*Were the same participants examined?*<br>*Did they utilize the same measurement tools?* | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |

| | | |
|---|---|---|
| 9.2 Was there any documented, quantitative improvement in processes or outcomes of care?<br>Was there: ☐ Improvement ☐ Deterioration<br>Statistical significance: ☐ Yes ☐ No<br>Clinical significance: ☐ Yes ☐ No | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?<br>*Degree to which the intervention was the reason for change:*<br>☐ No relevance ☐ Small ☐ Fair ☐ High | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.4 Is there any statistical evidence that any observed performance improvement is true improvement?<br>☐ Weak ☐ Moderate ☐ Strong | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| 9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods? | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ Not Applicable<br>☐ Unable to Determine | |
| | **Totals** | 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<br>☒ No | |

| ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS | | |
|---|---|---|
| *Conclusions:*<br>As written, this does not meet the requirements of a PIP. The included target group (N=31) is too small to represent a PIP activity, the data reporting and analysis exists in a separate presentation, and does not reflect indicators of the PIP. | | |
| *Recommendations:*<br>The MHP would have possibly been better served were it to have initially addressed the larger population of consumers (N=448) who are open to outpatient services and receiving this care, and have received in excess of $49k in 12 months. | | |
| Check one: | ☐ High confidence in reported Plan PIP results<br>☐ Confidence in reported Plan PIP results<br>☒ No PIP results reported | ☐ Low confidence in reported Plan PIP results<br>☐ Reported Plan PIP results not credible |